



Steven L. Kaufman, Md, PhD, Facs
1136 E. Stuart Street, Suite 4102, Fort Collins, CO 80525
Phone: 970-498-8346 | Fax: 970-419-8346 | Email: info@totalvein.net

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Birth Date: _____ Age: _____

Employer: _____ Position: _____

Social Security #: _____ Marital Status _____

Drivers License No: _____

Name of Spouse: _____ Employer _____

Emergency Contact:

Name: _____ Phone Number: _____

INSURANCE INFORMATION: (please present your card at Check In)

Name of Insurance Carrier: _____ (please present card at check-in)

Primary Care Physician: _____ Referral Source: _____

LIFETIME AUTHORIZATION: I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS BE MADE ON MY BEHALF FOR SERVICES RENDERED TO ME. I AUTHORIZE STEVEN L. KAUFMAN MD TO RELEASE INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS AND OBTAIN PRE-DETERMINATION.

ASSIGNMENT OF BENEFITS: I HEREBY ASSIGN STEVEN L. KAUFMAN MD., PhD., PC ANY INSURANCE OR THIRD PARTY BENEFITS AVAILABLE FOR HEALTH CARE SERVICES PROVIDED TO ME. I AGREE TO FORWARD ALL HEALTH INSURANCE OR THIRD PARTY PAYMENTS THAT I RECEIVE FOR SERVICES RENDERED IMMEDIATELY UPON RECEIPT.

PATIENT SIGNATURE: _____ **DATE:** _____

STEVEN L. KAUFMAN, MD, PhD
OFFICE POLICY

We are dedicated to providing you the best care possible. If you have medical insurance we are committed to helping you receive your maximum allowable benefits.

- **Payment for service is due at the time services are rendered.** We accept cash, checks, MasterCard, Visa, Discover and American Express.
- **Returned checks area are all subject to a \$25.00 service fee. Repayment will be required in cash, money order or credit card only.**
- **Surgery and diagnostic procedures** ~ As a courtesy to you, we will assist with your insurance for surgical and diagnostic procedures. We will verify your benefits via phone and when necessary, will obtain pre-authorization or pre-determination prior to your procedure. Insurance providers do not “guarantee” their benefits quoted over the phone. We must emphasize that as a medical provider, our relationship is with you, not your insurance company. Your active participation is necessary when denials occur or payments are delayed from your insurance company. We will file claims forms with your primary insurer and you will be responsible for handling any secondary insurer.
- **As the Patient You Have the Ultimate Financial Responsibility.** All charges are expected at the time services are rendered by this practice. In the case that private insurance may pay a portion of your charges, your estimated payment (considering expected insurance coverage) will be required to be paid at the time of service. In the event that your insurance provider denies payments or pays less than expected, you are responsible for any balance on your account. The Insurance Company’s decisions and payment amounts are not within our control; however, we are happy to assist you in the insurance appeal process. If it becomes necessary to collect your unpaid using a collection agency, you will also be responsible for any charges incurred as a results of the collection activity (usually 20-50% of unpaid amount) as well as any other legal or court fees incurred.

AGREEMENT

I, (print name) _____ understand that I am financially responsible for any remaining balance after insurance processing. I have read and understand the terms and conditions of my financial obligation and agree to honor the office policies outlines above.

PATIENT SIGNATURE: _____ DATE: _____