Office Visit Acknowledgement

Dear New Patient,

In an effort to ensure that our patients are fully informed of our office policies please read the below statement, then sign and date.

I, ____,
understand that this appointment is a New Patient Ultrasound and Consultation with Dr. Steven L. Kaufman, M.D. and/or Heather Roth, N.P., Total Vein Care. I acknowledge that this is not a Free Screening and will be billed to my insurance company. I also understand that Total Vein Care does not have any control over how much my insurance company compensates and what will be applied to my deductible and/or coinsurance. I am aware that I will be responsible for any remaining balance that is not paid by my insurance company.

Signature: ____

Initials:________ (The parties to this agreement acknowledge that signing their initials in place of a signature (including an electronic copy) may be used for any and all purposes for which the original signature may have been used.

Witness: ____

Date: _________________________________