Insurance claim forms are processed by computer. Some are sent electronically to your insurance company. To facilitate this process your signature is maintained □on file□ for this purpose and for the use of this office only.
All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage. However, **Surgical Specialists of Wayne County, LLC and Vein Specialty Center, dba** does participate with the Medicare plan as well as other PPO□s and HMO□s which determine reimbursement for services.

I hereby authorize **Surgical Specialists of Wayne County, LLC and Vein Specialty Center, dba** to act as my agent to furnish information to my insurance carriers concerning my illness and treatment. I herby assign to **Surgical Specialists of Wayne County, LLC and Vein Specialty Center, dba** all payments for medical services rendered by **Surgical Specialists of Wayne County, LLC, and Vein Specialty Center, dba**. I permit a copy of this authorization to be used in place of the original. I understand that I am responsible for any amount not covered by my insurance.

_____ _____

Signature of patient (guardian if minor) **Date**

_____

Patient name, printed

REQUEST FOR RELEASE OF MEDICAL RECORDS

I authorize the release of all my medical records, laboratory results, radiographic films, etc.

To: **Surgical Specialists of Wayne County, LLC**
Vein Specialty Center, dba
Larry A. Stern, M.D.
2317 Gateway Drive, Suite C
Wooster, OH 44691

_____ _____

Signature of patient (guardian if minor) **Date**

_____

Patient name, printed

I have been informed of the HIPPA PRIVACY ACT.

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Patient **Date**