MVM
HEART, VEIN AND VASCULAR CENTERS

VINOD CHAINANI, M.D., FACC, FSCAI
JOHN SOKOLOWICZ, M.D
XAVIER GONZALEZ, ARNP

Patient Combined Consent Form for Insurance and Office Policies

I certify that the information I have provided regarding my insurance coverage is correct and I authorize the office of John Sokolowicz, M.D., P.A., DBA MVM Heart, Vein and Vascular Centers to verify my insurance coverage and benefits allowed in accordance with my insurance plan's policies. I authorize those payments be made directly to John Sokolowicz, M.D., P.A., DBA MVM Heart, Vein and Vascular Centers for all medical/surgical benefits which are payable under the terms of my insurance policy for the services provided. I agree to pay any co-payments, co-insurance, deductible, failure of respond to insurance correspondence, exhausted auto coverage, Denied Worker's Compensation claims as required by my insurance plan for medical/surgical care provided to me or my dependent. I understand that I am responsible for knowing the terms and regulations of my insurance plan, and that specialist referrals are always my responsibility. I agree to accept full responsibility for payment if my insurance coverage is interrupted or terminated during my care.

☐ I authorize John Sokolowicz, M.D., P.A., DBA MVM Heart, Vein and Vascular Centers to submit a claim to my insurance company, for medical service provided to me or my dependent. I authorize release of any medical or incidental information that may be necessary for either medical care of in processing applications for financial benefit, including outside vendors that may be used on my behalf. I permit a copy of this authorization to be used in place of the original. My initials certify that I agree to the above stated responsibility and consent:

☐ **Receipt of Notice of Privacy Practices Acknowledgement**
My initials certify that I have been given access to a copy of MVM Heart, Vein and Vascular Centers Notice of Privacy Practices.

☐ **Receipt of Office and Financial Policies**
My initials certify I understand and agree to pay the following fees if they should arise:

1. $50 less than 24-hour notice of cancellation, or no show appt for all office visits.
2. $100 less than 24-hour notice for Ultrasound/Echocardiogram.
3. $270 less than 24-hour notice for Stress Test
4. $50 bounce check fee
5. $20.00 per form Completion
6. There is a processing fee in the State of Florida for all copies of medical records needed with fees set at up to $1.00 per page for the first 25 pages and $0.25 per page thereafter.

I have received a copy of MVM Heart, Vein and Vascular Centers Financial Policies and understand them as stated. I agree to abide by MVM Heart, Vein and Vascular Centers. Office, and financial policies.

Consent for Release of Medical Information

The office of MVM Heart, Vein and Vascular Centers is authorized to discuss my medical information, including test results, medications, appointment times, and both insurance and billing information, with the following individuals only. I understand that without prior consent, and without exception, and for my protection, my medical information will not be shared otherwise.

Name	Relationship	Phone #

Print Patients Name: _____ **Signature** _____ **Date** _____