

Cosmetic Vein Centers of Texas, P.A.
Mark E. Skellenger M.D. F.A.C.S.

Authorization to Release Information

I authorize Cosmetic Vein Centers of Texas, PA to furnish any consulting physician, insurance carrier, and/or Centers for Medicare and Medicaid Services (CMS) and its agents, and/or my Medigap insurer any information or copies of medical records, consultations, and prescriptions relating to my condition(s) and treatment(s). A copy of this authorization shall be effective and valid.

Authorization of Insurance Benefit Payments

I authorize direct payment to Cosmetic Vein Centers of Texas, PA the insurance benefits otherwise payable to me, but not to exceed my indebtedness to said practice on the account of charges listed herein. A copy of this authorization shall be effective and valid. *Please understand that you are responsible for any remaining balance your insurance company does not pay.

Authorization to Leave Messages

I authorize Cosmetic Vein Centers of Texas, PA to leave messages at my home and/or my place of employment.

General Consent for Treatment

I, knowing that I have a condition requiring diagnostic, medical, or surgical treatment, do hereby voluntarily consent to such procedures and care and to such medical, surgical, or other services under the general and specific instructions of Mark E. Skellenger, M.D., his assistant(s) or his designee, and Cosmetic Vein Centers of Texas, PA, as necessary in his judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as a result of treatments or examination by Mark E. Skellenger, M.D.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed COSMETIC VEIN CENTERS OF TEXAS, P.A. office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

I have read and understand the above terms and conditions and will verify so by giving my signature.

Signature of Patient

Date

