



**Vanishing Veins**

*A Center Exclusively for the Treatment of Varicose and Spider Veins*



**Lori L. Greenwald, MD, FACS**  
**Medical Director**

**Insurance Authorization and Release of Information**

I hereby authorize direct payment to Lori L. Greenwald, MD, FACS of medical benefits otherwise payable to me. I understand I am financially responsible for all treatment provided by Vanishing Veins including insurance copayments, coinsurance amounts, and insurance deductible amounts. I further authorize Vanishing Veins to release information requested by my insurance carrier to support payment of my claim.

Patient Name: \_\_\_\_\_  
(Please Print)

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Vanishing Veins accepts VISA, MasterCard and personal checks.

**Medicare Patients**

I request payment of authorized Medicare benefits be paid on my behalf directly to Lori L. Greenwald, M.D., FACS for medical services provided to me. I authorize Dr. Greenwald and Vanishing Veins to release any healthcare information required by the Health Care Financing Administration and its agents to determine benefit payment for medical services provided.

Patient Name: \_\_\_\_\_  
(Please Print)

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**www.vanishingveins.net**