

**Symmetry Laser Vein Center**  
**2169 SE Ocean Boulevard**  
**Stuart, FL 34996**  
**Phone 772-286-5501**  
**Fax 772-781-7767**

***Consent for Treatment, Payment and Healthcare Operations***

*Signature Required*

I consent to the use or disclosure of my protected health information by **Symmetry Laser Vein Center** for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of **Symmetry Laser Vein Center**. I understand that diagnosis or treatment of me by Dr. \_\_\_\_\_ or any other physician of **Symmetry Laser Vein Center** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Symmetry Laser Vein Center** is not required to agree to the restrictions that I may request. \*Reverse side\*

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. \_\_\_\_\_, or any other physician of **Symmetry Laser Vein Center** has taken action in reliance on this consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health care information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review **Symmetry Laser Vein Center's** Notice of Privacy Practices prior to signing this document. The **Symmetry Laser Vein Center's** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **Symmetry Laser Vein Center**. The Notice of Privacy Practices for **Symmetry Laser Vein Center** is also provided in the patient waiting room. This Notice of Privacy Practices also describes my rights and **Symmetry Laser Vein Center's** duties with respect to my protected health information.

**Symmetry Laser Vein Center** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practice by calling and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

*Please initial where applicable*

\_\_\_\_\_ I have received a copy of the Notice of Privacy Practices for **Symmetry Laser Vein Center**.

\_\_\_\_\_ **Symmetry Laser Vein Center** may leave messages on my answering machine to confirm appointments.

\_\_\_\_\_ **Symmetry Laser Vein Center** may speak to family members in my house and leave me a message with them regarding my healthcare or billing arrangements.

\_\_\_\_\_ **Symmetry Laser Vein Center** may call me at my place of employment to confirm an appointment.

\_\_\_\_\_ **Symmetry Laser Vein Center** may leave minimal medical data on my answering machine regarding medications, treatments, and or test results.

\_\_\_\_\_ **I authorize payment of medical benefits to be paid directly to Symmetry Laser Vein Center for services provided to me. I understand that I am responsible for all charges regardless of insurance status as well as any associated cost for collection. I agree that this authorization shall be valid until rescinded in writing.**

I authorize **Symmetry Laser Vein Center** to be my personal representative, which allows **Symmetry Laser Vein Center** to: (1) Submit any and all appeals when my insurance company denies my benefits to which I am entitled. (2) Submit any and all requests for benefit information from my insurance company, and (3) Initiate formal complaints to any state or federal agency that has jurisdiction over my benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100% of my benefits within 90 days of any appeals or request for information. I also agree that any fines levied against my insurance company will be paid to **Symmetry Laser Vein Center** for acting as my personal representative.

\_\_\_\_\_  
**Signature of Patient or Personal Representative**

\_\_\_\_\_  
**Printed Name of Patient or Personal Representative**

\_\_\_\_\_  
**Date**