



**Reaction or Allergy to medications:** \_\_\_\_\_

\_\_\_\_\_

**Medications currently taking including any diet pills** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I hereby authorize Dr. KYLE HRDLICKA to release to your company or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical or Surgical care.

I also authorize and request your company to pay directly to the above named doctor, the amount due me in my pending claim for Basic Medical, Major Medical and/or Surgical treatment or services, by reason of such treatment or services rendered, upon presentation of the original or photocopy of this signed authorization.

I understand that today's Vascular consultation for the evaluation of my lower extremities for varicose veins is free of charge.

However, if Dr. Hrdlicka feels the need for a Duplex examination of my lower extremities to diagnose the source of my Varicosities, there will be a charge and will be billed to my insurance company and subject to my deductible, and or co-insurance.

**I AGREE TO ACCEPT RESPONSIBILITY FOR PAYMENT OF ANY SERVICES WHICH MAY NOT BE COVERED UNDER THE TERMS OF MEDICARE AND/OR MY HEALTH INSURANCE BENEFIT PLAN. Signature of Insured/and or Responsible Party:**

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

CLAREMORE SURGEONS, INC & THE VASCULAR & VEIN LASER CENTER, INC

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have read a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
{Signature}

Date: \_\_\_\_\_ Patient refused to sign: \_\_\_\_\_

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**PLEASE LIST ANYONE YOU WANT US TO DISCUSS YOUR**

**DIAGNOSIS/TREATMENT WITH:**

_____	_____
_____	_____
_____	_____

Vascular & Vein Laser Center, Inc.  
1220 N. Florence Ave.  
Claremore, OK 74017  
(918)341-5311

I understand that today I am here for a free consultation on Varicose Veins, but my insurance and I will be billed for an UltraSound Examination that will be subject to my insurance co-pay or co-insurance and on my annual deductible. The charge for this will be approximately \$150.00 to \$600.00 depending on your insurance benefit(s).

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Please Print Full Name

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Signature

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Date

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Witness