

Thomas R. Bernik, M.D.
Vascular and Endovascular Surgery
Interventional Radiology and
Cosmetic Vein Surgery

CONSENT - AUTHORIZATION FORM

CONSENT FOR TREATMENT: I, _____ authorize the above-named doctor(s) et al. to perform the treatment/procedure(s) described bellow. I have been informed of the treatment/procedure(s) along with the expected benefits, risks, possible alternative methods of treatment, and possible consequences involved in the following.

Ablation/Interruption of Greater Saphenous vein, Lesser Saphenous vein, Plebectomy and all other indicated procedures.

The treatment/procedure(s) was, explained to me in detail and all my questions were fully answered. Understanding this, I authorize the above-named doctor(s) to perform such examinations, treatments, laboratory tests, and to administer such medications as, in his or her opinion, are necessary or advisable for me (or _____).
name of parent, if minor

I also certify that no guarantee or assurance has been made as to the results may be obtained.

This office is a doctor's office regulated pursuant to the rules of the Board of Medicine as set forth in Rule Chapter 64B8, F.A.C.

RELEASE OF MEDICAL RECORD: In order to ensure proper follow-up and continuity of care. I agree that a copy of my medical record be released to my physician, a designated referral physician, and/or the provider, if any, who referred me here.

INSURANCE AUTHORIZATION: I request that the payment of authorized bene fits be made to the above named doctor on my behalf, for any services provided to me. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company or third party pay or, state medical assistance agency, or any other governmental or private payer responsible of paying such benefits, any information needed to determine these benefits for related services. I agree to pay for all charges not covered by a third party payer. I authorize a copy of this authorization to be used in place of the original.

Patient Signature

Thomas R. Bernik, M.D.

Date: _____

20 West 13th Street ♦ New York, NY 10011
Tel (212) 838-3055 ♦ Fax (212) 691-0568