



Deak Vein NJ Clinic

In Office Laser Vein Treatment
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INFORMATION

Patient's Name: _____

Today's Date: _____

First

Middle

Last

[Primary Insurance]

Name of Insurance Company:

Address:

City: _____

State:

Zip: _____

Insured's Name:

Group Number: _____

Policy ID Number:

[Secondary Insurance]

Name of Insurance Company:

Address:

City: _____

State:

Zip: _____

Insured's Name:

Group Number: _____

Policy ID Number:

Did your injury happen on the job?

Yes No

If yes, on what date did the injury occur?

Did you report the accident to your employer?

Yes No

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts. See our complete financial policy for details.

Method of Payment for Today's Visit: ___ Cash

___ Check ___ Visa/MC

Signature of Patient or Responsible Party:

Date: _____

I authorize the release of any medical information necessary to process my claim.

Signed: _____

Date: _____

(Patient or responsible party)

I authorize payment of medical benefits to Steven T. Deak, M.D., Ph.D.

Signed: _____

(Patient or responsible party)

Date: _____