Western Vascular Institute, PLLC

7165 E UNIVERSITY DR. SUITE 183
MESA, AZ 85207
480-668-5000
Fax: 480-668-5065

Please Print Your Name: ____

Payment Policy

Payment of Insurance and/or Medicare Benefits to Western Vascular Institute:
7165 E University Dr., Suite 183 Mesa, AZ 85207
Mitar Vranic, DO, and Henry Tarlian, MD

I request payment under the above listed insurance program be made directly to me or the provider listed on any claim for services furnished to me during the effective period of this authorization. I authorize the above listed provider to release to the Social Security Administration, its intermediaries or carriers any information required for this claim or any related Medicare claim. I authorize the release of any information necessary to determine these benefits or the benefits payable for related services.

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Signature of Patient or Patients Representative Date

Cancellation Policy

If you are unable to keep your appointment, you are obligated to inform our office within 24 business hours of your scheduled office visit or ultrasound appointment and 48 business hours for an in-office surgery or hospital surgery. If you do not cancel your appointment within that time frame, you will be subject to a non-cancellation fee as follows:
Office visits $35.00, Ultrasounds $50.00, In-office surgery $150.00 and Hospital surgery $200.00.
By signing below, you agree that you have read and understand our non-cancellation policy.

_______________________________ _______________________________

Signature of Patient or Patients Representative Date

Consent for Treatment & Insurance Authorization/Assignment

1. The patient or authorized representative recognizes the need for care and consents to ANY and ALL medically necessary services as ordered by the physician and at the discretion of the patient. These services may include lab procedures, medical treatment, minor or emergency surgical treatment, exam or other services rendered under the specific instructions of the physician.
2. I hereby authorize WESTERN VASCULAR INSTITUTE, PLLC to furnish information to carriers concerning myself or my illness and treatment. I hereby assign to the physicians ALL payments for medical services rendered to myself or my dependents. I understand that I am responsible for ANY amount NOT covered by insurance. I am including attorney's fees.

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Signature of Patient or Patients Representative Date

Acknowledgement of Receipt
Notice of Privacy Practices

By signing below, I acknowledge that I have received the Notice of Privacy Practices of Western Vascular Institute, which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this acknowledgement.

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Signature of Patient or Patients Representative Date