UNIVERSITY MEDICINE & CARDIOLOGY

Vein Center at UMC

Dr. Stamatis (Tom) **Dimitropoulos**
Board Certified Cardiology & Vein Diseases
Board Certified Interventional Cardiology

Billing Authorization

Date: _____

WELCOME TO OUR OFFICE! Filling out this sheet provides us with information vital to your health and will aid us in accurately filing your insurance forms. Be assured that this information will remain strictly confidential. Please note this form is two-sided. We ask that you complete each section as fully as possible.

PATIENT INFORMATION

Patient's Full Name: _____ Marital Status: S: _____ M: _____ W: _____ D: _____

Social Security Number (SS): _____ Date of Birth (DOB): _____ Age: _____ Sex: M: _____ F: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Patient's Home Phone: _____ Work Phone: _____

Employer: _____ Cell Phone: _____

Email Address: _____

SPOUSE / SIGNIFICANT OTHER INFORMATION

Full Name: _____ Social Secuity Number: _____

Employer: _____ Work Phone: _____

Email Address: _____

STUDENTS & MINORS

Mother's Name: _____ Father's Name: _____

Address: _____ Address: _____

Employer: _____ Employer: _____

Home Phone: _____ Work Phone: _____ Home Phone: _____ Work Phone: _____

MEDICAL INSURANCE

☐ HMO ☐ PPO ☐ COPAY $ _____ Insured by Employer: ☐ YES ☐ NO

Primary Company: _____ Primary Company: _____

Insured: _____ Insured: _____

Insured SS: _____ Insured DOB: _____ Insured SS: _____ Insured DOB: _____

Certificate or ID#: _____ Certificate or ID#: _____

Group or Policy #: _____ Group or Policy #: _____

Effective Date (coverage began): _____ Effective Date (coverage began): _____

PHYSICIAN INFORMATION

Primary Physician: _____ Referring Physician: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

PLEASE READ AND SIGN THE OTHER SIDE OF THIS FORM

8110 South Cass Avenue
Darien, Illinois 60561
T: (630) 963-4000
F: (630) 963-4000

4605 West Golf Road
Skokie, Illinois 60076
T: (630) 963-4000
F: (630) 963-4000

frontdesk@mygreatveins.com
www.mygreatveins.com

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Patient's Name: _____ Date of Birth (DOB): _____

AUTHORIZATION TO RELEASE MEDICAL BENEFITS

I authorize release of all medical information necessary to process insurance claim(s) and I hereby assign and authorize direct payment of all medical and/or surgical benefits, including major -medical, private insurance and other health plans to the undersigned:

Dr. Stamatis Dimitropoulos, M.D.

8110 S. Cass Ave., Darien, IL 60561 or 4605 W. Golf Road, Skokie, IL 60076

Please remember that medical insurance is considered a method of deferred payment and is not a substitution for payment. It is your responsibility to pay any deductible amount, co-insurance or any other balance deemed patient responsibility by the insurance company. It is your responsibility to pay the balance in full if the insurance information you provide us proves false or otherwise ineffective. It is your responsibility to follow all guidelines of your insurance company, including the obtaining of referrals as necessary if your coverage is through an HMO. You must inform our office prior to receiving service if your insurance coverage is through an HMO. Information regarding any change in your insurance coverage must be provided prior to receiving service.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fee and cost of collection.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record. This assignment will remain in effect until revoked by me in writing. A signed photocopy of this Assignment is to be considered as valid as an original.

Signature of Patient: _____ Date: _____

Signature of Responsible Party: _____ Date: _____

MEDICARE PATIENTS ONLY

MEDICARE LIFETIME SIGNATURE ON FILE:
I request that payment of authorized Medicare benefits be made on my behalf to Doctors Dimitropoulos and Laniosz or their associates for any services furnished me by that physician. lauthorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services.

Signature of Beneficiary: _____ Date: _____

LIFETIME CONSENT TO BILL SECONDARY INSURANCE:
I request that payment of authorized Medigap benefits be made on my behalf to Doctors Dimitropoulos and Laniosz or their associates for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Responsible Party: _____ Date: _____

Signature of Responsible Party: _____ Date: _____