CONSENT TO TREATMENT, ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

This CONSENT TO TREATMENT, ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE HEALTH INFORMATION (this "Agreement") pertains to the diagnosis and treatment of the patient identified below (the "Patient") by **Center for Vein Disease** - Chevy Chase ("Clinic"), Dr. Mehru Sonde MD ("My Doctor"), other doctors employed or under contract with the Clinic ("Clinic Doctors) and Clinic nurses and other care providers ("Care Providers"). The Patient and/or the individual signing this Agreement on the Patient's behalf (the "Legal Representative") hereby agree to comply with all requirements of this Agreement. For purposes of this Agreement, "I," "my" and "myself" refer to the Patient and/or the Patient's Legal Representative, as appropriate.

Consent to Treatment:

As part of the course of the diagnosis and treatment of my medical condition, I voluntarily consent to the provision of all diagnostic tests, physical examinations, medical procedures, medications and other items and services (collectively, "Services") that Clinic, My Doctor, Other Clinic Doctors and Care Providers deem appropriate to diagnose and treat the conditions that I discuss with Clinic Doctors or Care Providers. I acknowledge that no guarantees have been made to me about the outcome of any Services provided by Clinic, My Doctor, other Clinic Doctors or Care Providers.

Assignment of Benefits, Agreement to Pay for Services and Designation of Authorized Representatives:

I acknowledge that I may be entitled to receive payment for Services that I receive from Clinic, My Doctor, Other Clinic Doctors and Care Providers under (i) any employee health benefit plan, any insurance plan, the Medicare program or any other governmental or private third-party source of payment ("Third-Party Coverage") or (ii) any judgment, settlement, cause of action or other claim I might assert against a third party because of my injuries or illness ("Claim"). In considerate f Services, I hereby assign, authorize and transfer to the Clinic [and My Doctor] all right, title and interest in any insurance benefits, judgments, settlements and other monies otherwise payable to me under Third-Party Coverage of a Claim as a result of Services that I receive from Clinic, Clinic Doctors and Care Providers, and I authorize payment directly to Clinic [and My Doctor] of such payments. Further, I authorize the Clinic and My Doctor to exercise any applicable remedies that I may have under my employee health plan or other source of Third-Party Coverage. I agree to execute all forms that Clinic [and My Doctor] deems necessary or beneficial in order to enable Clinic [and My Doctor] to apply for and obtain such payments. I agree to cooperate with the Clinic [and My Doctor] regarding the foregoing.

I designate the Clinic [and My Doctor] as an authorized representative to act on my behalf in regard to claims submitted to any employee health plan or other source of Third-Party Coverage for Services rendered by Clinic [and My Doctor, respectively]. This designation includes, but is not limited to, initial determinations, request for documents, requests for additional information and appeals. I further authorize the Clinic [and My Doctor] to execute any documents necessary to process claims for reimbursement of charges for services received by patients.

I hereby authorize my plan administrator (or party to whom the plan administrator has designated its health plan responsibilities), employer, insurer, other source of Third-Party Coverage and my attorney to release to Clinic, My Doctor and any other Clinic Doctors, any and all Protected Health Information (as defined by the privacy regulations adopted pursuant to the Health Insurance Portability and Accountability Act of 1996), plan documents, insurance policies, claim denial information and/or settlement information upon written request form Clinic [and My Doctor] in order for Clinic [and My Doctor] to act as my authorized representative in claiming such medical benefits, reimbursement, authorizing an appeal of my benefit claim or exercising any applicable remedies I may have under my employee health plan or other source of Third-Party Coverage.

I understand that I am financially responsible for Clinic's [and My Doctor's] charges for Services regardless of the existence of any source of Third-Party Coverage or Claim and understand that payment of charges for Services is due within forty-five (45) days from the date on which Patient incurred the charges. In consideration of Services that Patient will receive from Clinic, My Doctor, Other Clinic Doctors and Care Providers, I hereby agree to pay Clinic [and My Doctor] for any charges incurred for Services, which are not paid by a source of Third-Party.

Coverage or as a result of a Claim, at Clinic's [and My Doctor's] regular rates, except where a law or an applicable contract with a source of Third-Party Coverage establishes a different payment rate and/or patient cost-sharing obligation. The amount due for Services is referred to as an "Account" in this Agreement. I agree to pay reasonable attorney's fees and all cost of collection in the event my Account is turned over to an attorney or collection agency.

I agree that if payment for Services under this Agreement results in a credit balance, the credit amount will be applied to amounts due on any other outstanding Accounts I have with Clinic [or My Doctor, as applicable], whether current or delinquent Accounts. If there are any credit balances related to prior agreements between me and Clinic [or My Doctor, as applicable] I authorize Clinic [and My Doctor, as applicable], to transfer such credit balances to this Account. If there is an overpayment in my Accounts, after the completion of treatment, I understand that I will receive a refund check in that amount from Clinic [and My Doctor, as applicable].

Use and Disclosure of Health Information:

I understand that Clinic's, Clinic Doctors' and Care Providers' uses and disclosures of information about the Patient for treatment, billing and collection, and other purposes are described in Clinic's "Notice of Privacy Practices." By this authorization, I specifically authorize Clinic [and My Doctor] to disclose medical and financial information about the Patient for billing and collection purposes to sources of Third-Party Coverage and other third-parties that Clinic [and My Doctor] believes to be responsible for the payment of the charges for Services received by patient.

In the unlikely event that I need to be admitted to a hospital or seen in an emergency room, I give permission for My Doctor to request a copy of my discharge summary records for collaborative health care purposes and the provision of appropriate follow-up care, as needed.

I authorize Center for Vein Disease to obtain my health information, including external prescription history, from all available databases. This includes medication that can be used to treat sexually transmitted diseases (including HIV/AIDS), mental health conditions, or other sensitive medical conditions. I understand that my prescription history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers will be viewable by Center for Vein Disease providers and staff, and the information may include prescriptions I had filled over the past several years.

My signature below certifies that I have read and understand the scope of my consent and that I authorize the access.

General Provisions:

1. I certify that all information given to Clinic is complete and accurate to the best of my knowledge
2. I agree that an electronic or paper copy of this Agreement is as valid as the original bearing my signature.
3. I have read and fully understand this assignment.

Name of Patient: _____

Signature of Patient/Legal Representative: _____

Print Name: _____ Date: _____

Relationship of Legal Representative to Patient: _____