PATIENT REGISTRATION FORM

Name: ______________________ Preferred Name: ______________
SSN: ________________ SEX: __________ DOB: ______________
Street Address: ____
City: ________________ State: __________ Zip Code: __________
Home Phone #: ________________ Work Phone #: ______________
Mobile Phone #: ________________ Preferred Contact #: Home / Work / Mobile
Email Address: ____
Preferred Language: ____________________ Needs Interpreter: Y / N
Marital Status: ______________ If Married, Spouse's Name: ______________
Ethnicity: ____________________ Race: ____________________

Employer: ______________________ Employment Status: ______________
Employer Address: ______________________________________
City: ____________________ State: __________ Zip Code: __________

Emergency Contacts:
Name: ______________ Relationship: __________ Phone #: __________
Name: ______________ Relationship: __________ Phone #: __________

Referring Physician's Name: ____________________ Phone #: __________
Primary Care Physician's Name: __________________ Phone #: __________
Preferred Pharmacy: ______________________ Phone #: __________

Primary Insurance: ____________ Policy ID #: __________ Group #: __________
Policy Holder: ________________ Relationship to Policy Holder: ______________

Secondary Insurance:____________ Policy ID #: __________ Group #: __________
Policy Holder: ________________ Relationship to Policy Holder: ______________

(If different from patient please provide the following information)
Policy Holder Employer: __________________ Employment Status: __________
Policy Holder Employer Address: ______________________________
City: ____________________ State: __________ Zip Code: __________

Patient Signature: ______________________ Date: ______________

ASSIGNMENT AND RELEASE

I, the undersigned, authorize and assign the payment of my medical payments and benefits to Southern Vein Care otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not covered by insurance for services rendered on my behalf or my dependents. I authorize Southern Vein Care to release any information to complete and process my insurance claims and to secure payment of benefits. I further agree to pay all collection costs, attorney fees, and other collection costs that may be incurred to enforce the collection of any amounts that are outstanding and unpaid. I authorize the use of this signature on all insurance submissions.

Patient Signature: ________________________________ Date: ________________

MEDICARE AUTHORIZATION

I, the undersigned, request that payment of authorized Medicare benefits be made to Southern vein Care for any services rendered. I authorize the 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 to related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “the other health insurance” is indicated in box 9 of the HCFA-1500 form, or elsewhere on the approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient Signature: ________________________________ Date: ________________

Privacy Consent - For the Use and Disclosure of Protected Health Information

This consent is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to inform you of your rights for privacy with respect to your health care information.

I hereby give my consent to **Southern Vein Care** to use and disclose my protected health information for the purpose of treatment, payment, and operations of my healthcare and this practice.

Consent for treatment: I, with my signature, authorize **Southern Vein Care** and any employee working under the direction of the physician, for the purpose of evaluating my health, diagnosing medical conditions, and providing treatment.

Authorization to Pay Benefits to Physician: I hereby authorize payment of medical benefits directly to **Southern Vein Care** . I understand that co-pays, deductibles, out of pocket expenses and non-covered services are due at the time of service, unless prior arrangements have been made with the office administrator. **Southern Vein Care** will bill my insurance for services rendered. If my insurance does not pay within 30 days, I understand I am responsible for payment of the bill and/or contacting the insurance company to secure payment.

Authorization to Release Information: I hereby authorize **Southern Vein Care** to release any medical information necessary to process any insurance claim. This may be in the form of a copy of medical records or information conveyed via telephone or fax to my insurance company and/or any other necessary third party and/or its agents (collectively referred to as “the Plan”). I also authorize **Southern Vein Care** to disclose any medical information necessary to the Plan to verify services, conduct quality, chart site, or utilization reviews, investigate grievances. The Plan may review my medical chart in your office for proper documentation or for their studies as a measure of quality. My referring physician will receive a copy of your chart notes regarding my visit. This authorization also releases to the Health Care Financing Administration (HCFA) or its medical claims agencies any information referred to as “the Plan”. I hereby authorize **Southern Vein Care** to release any medical information needed to administer Title XVII (the Medicare Program) of the Social Security Act. This authorization is valid until revoked by me in writing.

Consent related to the Privacy Notice: I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand the terms of the Practice Notice may change and I may obtain these revised notes by contacting the Practice Privacy Officer by phone or writing. I understand I have the right to restrict how this information is disclosed, but **Southern Vein Care** is not required to agree to my restrictions.

Patient Name Printed: ____ DOB: _____________

Guardian Name Printed: ____________________________________ Relationship to Patient: _________________

Patient/Guardian Signature: ____ Date: ______________

Billing and Financial Policy

The following sets forth the general Billing and Financial Policy of **Southern Vein Care**. Please review and sign below where indicated:

- I understand that it is my responsibility to provide the office of **Southern Vein Care** with current and accurate billing information at the time of check-in.
- I understand that my account balance should be paid, including my co-pay amount prior to services being rendered.
- I understand that this is a contractual agreement that I have with my health plan and that the practice rendering services also has a contractual agreement with my health plan to collect co-pays at the time of services, and they are required to report to the carrier any enrollees failing to make co-pay.
- I understand that if I present an insufficient check (NSF) for payment associated with my care, I will be charged a **$35** NSF fee. I further understand that to rectify my account, I will be required to pay with cash, money order, cashier's check, or credit card.
- I understand that there is a **$30** fee to complete disability paperwork associated with my care. I will be provided a standard form free of charge; however, if additional disability forms (such as FMLA) requires completion, I understand that the **$30** fee is required and must be paid prior to completion.
- I understand that the clinic will verify my insurance eligibility, deductible amounts, and coinsurance amounts prior to any elective surgery that I may have. I further understand that it is the policy to collect the deductible and/or coinsurance prior to scheduling my elective surgery. I further understand that the **FEE** that I am **QUOTED** is only an **ESTIMATE** that is based on: First, the anticipated surgery to be performed and second, the current information provided to the clinic by my insurance carrier.
- I understand that I will be billed for any amounts due by me and that I have a financial responsibility to pay these amounts in **FULL**. I understand that I will be provided with two statements for any balance due after the insurance payment is received. I further understand that if I have not made payment prior to the second statement being mailed, that the next statement will be marked **FINAL NOTICE** and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with collection efforts.
- I understand that the practice will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is **NOT** a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.
- I understand that the practice may also take a verbal request to use my credit card for payment on my account or they may also use the same listed credit card on my account should my account become delinquent or to cover an NSF check and the fee.

My signature below confirms that I have read these billing policies and my obligation as pertains to the physicians of **Southern Vein Care.**

____________________________________ __________________

Signature of Patient Date

HIPAA Privacy Act Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO
May we leave a message on your answering machine at home or on your cell phone? YES NO
May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

1. Individual Name: ______________________________ Relationship to Patient: _______________
2. Individual Name: ______________________________ Relationship to Patient: _______________

Patient Name Printed: ____ DOB: _____________

Guardian Name Printed: ______________________________________ Relationship to Patient: ________________

Patient/Guardian Signature: ____ Date: ______________