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| --- | --- | --- | --- |
| **Patient Name:** | | **Sex:**  Male ¨ Female ¨ | **Date of Birth:** |
| **Mailing Address**: (Street City, State Zip) | | **Home Phone:**  **Cell Phone**: | **Email address:** |
| **Name of Employer:** | **Occupation:** | **Work Phone:** | **Social Security #:** |
| **Primary Care Physician:** | | **Referring Doctor:** | |

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| --- | --- | --- | --- | --- | --- |
| **Responsible Party** | | | | | |
| **Name of Responsible Party:** | | | **Date of Birth:** | **Social Security #:** | |
| **Responsible Party Address:** | | | **Phone:** | **Sex:**  Male ¨ Female ¨ | |
| **Relationship to patient:** | | | **Responsible Party Employer:** | | |
|  | | | | | |
| **Emergency Contact** | | | | | |
| **Emergency Contact:** | | **Relationship to patient:** | | | **Phone:** |
|  | | | | | |
| **Primary Insurance Coverage** | | | | | |
| **Primary Insurance Company:** | | | **Address:** | | |
| **Subscriber Name:** | **Subscriber DOB:** | | **Policy #:** | **Group #:** | |
| **Is this insurance through your employer?**  Yes ¨ No ¨ | | | **Patient’s relationship to insured:**  Self ¨ Spouse ¨ Child ¨ Other ¨ | | |
|  | | | | | |
| **Secondary Insurance Coverage** | | | | | |
| **Secondary Insurance Company:** | | | **Address:** | | |
| **Subscriber Name:** | **Subscriber DOB:** | | **Policy #:** | **Group #:** | |
| **Is this insurance through your employer?**  Yes ¨ No ¨ | | | **Patient’s relationship to insured:**  Self ¨ Spouse ¨ Child ¨ Other ¨ | | |



If this document is signed by someone other than the Patient, such as a person holding a Durable Power of Attorney for Healthcare, the signer must state his/her relationship to the Patient, describe his/her authority to act on the Patient’s behalf, and provide a copy of the Durable Power document:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legally Authorized Representative Date

**Please present all insurance cards and information to the receptionist for registration.**

**Insurance Authorization and Assignment**

I hereby authorize Vascular and Vein Institute of the South to provide any necessary medical or other information about me or my dependent to my insurance company, and/or its designated representatives, for the purpose of obtaining payment. This authorization is valid as long as I am a patient of Vascular and Vein Institute of the South

I hereby assign to the provider all payments for healthcare services, including behavioral and mental health treatment, rendered to myself or my dependent.

I understand that my insurance company may only cover a portion of my total bill, or may cover nothing at all. I understand I am responsible for all bills related to the provision of healthcare services and will be responsible for payment of any charges not covered under this assignment. If for any reason my or my dependent’s account becomes delinquent, I agree to pay for any and all charges related to re-billing, cost of collections, reasonable legal fees, and any other charges permitted by law.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legally Authorized Representative Date

**Medicare One Time Signature Authorization**

I hereby request that payment of authorized Medicare benefits be made on my behalf to Vascular and Vein Institute of the South or any healthcare services provided to me or my dependent. I hereby authorize Vascular and Vein Institute of the South to provide any necessary medical or other information about me or my dependent to the Health Care Financing Administration and its agents as needed to determine these benefits or the benefits payable for related services.

**Medigap Assignment Authorization**

I request that payment of authorized Medigap benefits be made to Vascular and Vein Institute of the South for any healthcare services provided to me or my dependent by Vascular and Vein Institute of the South I hereby authorize Vascular and Vein Institute of the South to provide any necessary medical or other information about me or my dependent to the Medigap carrier as needed to determine these benefits or the benefits payable for related services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Signature of Patient or Legally Authorized Representative Date

**Vascular and Vein Institute of the South, PLLC**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for your visit: ­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you to us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other physicians you see: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- |
| **SURGERIES** | | |
| Date | Type of Surgery | Doctor/Hospital |
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Have you ever smoked cigarettes? Yes ¨ No ¨ Year you started: \_\_\_\_\_\_ Packs/day: \_\_\_\_\_\_

Do you still smoke? Yes ¨ No ¨ Year you quit: \_\_\_\_\_\_\_\_

Do you use any other form of tobacco? Yes ¨ No ¨ Cigar Pipe Chewing Tobacco Snuff (circle)

Do you drink alcohol? Yes ¨ No ¨ How much/How often/What type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever used street drugs? Yes ¨ No ¨ Past ¨ Present ¨

Does Any of your immediate family (mother, father, brother sister) have/had any of the following:

¨ Heart Disease ¨ Bypass Surgery ¨ Stroke ¨ Aneurysm ¨ Diabetes ¨ Cancer

Have you ever had a blood transfusion? Yes ¨ No ¨ If yes, did you have a reaction? Yes ¨ No ¨

Describe an reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Will you accept a blood transfusion during surgery or hospitalization if necessary? Yes ¨ No ¨

**Vascular and Vein Institute of the South, PLLC**

**Patient Medication List**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

\*\*\****PLEASE LIST ALL OF YOUR MEDICATIONS – prescription, OTC, herbal supplements, vitamins, inhalers, and patches \*\*\****

**\*\*\* SOME MEDICATIONS CAN CAUSE SERIOUS BLEEDING DURING SURGERY. PLEASE LIST EVERYTHING! \*\*\***

|  |  |  |  |
| --- | --- | --- | --- |
| Medication Name | Strength | Directions | When was it started? |
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Do you have any allergies? Yes ¨ No ¨

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| --- | --- |
| Allergy | Reaction |
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**Acknowledgement of Receipt of Notice of Privacy Practices**

I have been made aware of VASCULAR AND VEIN INSTITUTE OF THE SOUTH’s “Notice of Privacy Practices” (“Notice”). I received a copy of this document on today’s date, and I have a right to request additional copies in the future. The Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of VASCULAR AND VEIN INSTITUTE OF THE SOUTH’s healthcare operations. The Notice also describes my rights and VASCULAR AND VEIN INSTITUTE OF THE SOUTH’s responsibilities with respect to my protected health information.

I understand that copies of the Notice are available in the registration areas of each facility and on VASCULAR AND VEIN INSTITUTE OF THE SOUTH’s system website at [www.vascularandveininstitute.com](http://www.vascularandveininstitute.com). I understand that I may request a copy of the Notice at any time. VASCULAR AND VEIN INSTITUTE F THE SOUTH reserves the right to change the privacy practices that are described in the Notice at any time and will make a revised Notice available for review. I may obtain a revised Notice of Privacy Practices by requesting a copy or by accessing VASCULAR AND VEIN INSTITUTE OF THE SOUTH’s website listed above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Authorized Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient (if not signed by the patient)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Date

**\*\* A COPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL\*\***

**Vascular and Vein Institute of the South, PLLC**

**Phone: (901) 390-2930 | Fax: (901) 390-2940**

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

(ALL SECTION MUST BE COMPLETED)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize VASCULAR AND VEIN INSTITUTE OF THE SOUTH to release or disclose to the below named recipient(s) all of my medical records including any specially protected records, such as those related to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection (unless otherwise indicated.

I hereby authorize the release of my records to:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The authorization will expire on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date or event may not exceed one year)

Purpose of release (i.e. evaluate for surgery, evaluate condition, second opinion, attorney, etc.)

This authorization applies to (initial all applicable)

\_\_\_\_\_ All medical records

\_\_\_\_\_ Healthcare information relating to the following treatment, condition, or dates of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Specific records to be released (i.e. labs, imaging, reports, other):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am aware that I have the right to inspect and receive a copy of the information I have authorized to be used and/or disclosed by this Authorization. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I am aware that I may revoke this Authorization at any time in writing; however, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; (2) as authorized by law. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law. I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I knowingly and voluntarily authorize the transfer of my health information in the manner described above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Authorized Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient (if not signed by the patient)

**Vascular and Vein Institute of the South, PLLC**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vascular and Vein Institute of the South is committed to providing high-quality healthcare to its patients. This includes the use of clinical photography for the purposes of diagnosis, treatment, and professional education. This policy establishes guidelines for managing multimedia imaging of patients. For the purpose of this policy, multimedia imaging includes photography, videotaping, and audiotaping.

Multimedia imaging of patients may be appropriate for the diagnosis of treatment of medical conditions, as well as professional education. Clinical photography can be accomplished through various technology to collect, analyze, and store multimedia images. These images will be taken and stored in compliance with Vascular and Vein Institute of the South’s policies and procedures, as well as relevant state and federal law.

Multimedia images taken and retained by Vascular and Vein Institute of the South will be of certain body parts to record their appearance at a particular moment in time. Multimedia images will not show any identifying features of the patient. The transmission of any multimedia image will be in accordance only with the treatment, payment, and healthcare operations of Vascular and Vein Institute of the South. Any additional use or transmission will be done only after obtaining written authorization from the patient.

**AUTHORIZATION FOR MULTIMEDIA IMAGING**

**I HAVE READ AND UNDERSTAND THE FOREGOING POLICY REGARDING THE USE OF MULTIMEDIA IMAGING IN CONNECTION WITH MY TREATMENT AT VASCULAR AND VEIN INSTITUTE OF THE DOUTH. I HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS REGARDING THE POLICY AND SUCH QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Authorized Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient (if not signed by the patient)