REGISTRATION FORM

***PATIENT EMAIL ADDRESS:**_____
(TO BE USED BY DVVC FOR CORRESPONDENCE ONLY)

PRIMARY CARE PROVIDER: _____ **PHONE #:** _____

PHARMACY NAME (CROSS STREETS): _____ **PHONE #:**_____

Today's date:	Referred By:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

Message phone no.: ( )	City:	State:	ZIP Code:

INSURANCE INFORMATION

(Please give your insurance card(s) to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Parent	❑ Legal Guardian	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Parent	❑ Legal Guardian	❑ Other

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Discover Vein and Vascular. I understand that I am financially responsible for any balance. I also authorize Discover Vein and Vascular PLLC or my insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

NOTICE OF PRIVACY PRACTICES

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Discover Vein and Vascular. The Notice of Privacy Practices also describes my rights and Discover Vein and Vascular PLLC's duties with respect to my protected health information. The Notice of Privacy Practices can also be found on the Discover Vein and Vascular PLLC website.

Discover Vein and Vascular PLLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment, or accessing the Discover Vein and Vascular PLLC website.

Patient/Guardian signature *Date*

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Patient Consent(s)

Consent to Leave Messages

☐ **I authorize** DVVC to leave voice mail messages for me regarding medical and/or billing information at the following number (s):

(_____) _____ (_____) _____

☐ **I authorize** DVVC to leave messages, speak with, or respond to inquiries from the following individuals:

Name	Relationship	Phone Number
Name	Relationship	Phone Number

☐ **I do not authorize** DVVC to leave voice mail messages containing medical / billing information.

Patient Signature **Date**

Notice Of Appointment Fees

I have been informed and understand that a Fee will be applied to all appointments that I have not cancelled and /or rescheduled 48 hours in advance. I understand I will be charged $35 per office visit, $50 per ultrasound and $150 per In-Office Vein Procedure.

Patient Signature **Date**

Consent For The Use And Disclosure of Protected Health Information

I understand that Discover Vein and Vascular Center (DVVC) originates, collects and maintains Electronic Medical Records describing my Protected Health Information (PHI) such as health history, diagnosis, symptoms, test results etc. **I consent** to the use and disclosure of my PHI by DVVC, its staff and its business associates for treatment, payment and health care operations.

I certify that I have received a copy of Notice of Privacy Practices (NPP). I understand I have a right to request restrictions or revoke any use and/or disclosure of my PHI by DVVC. A detailed description of my rights was provided to me in the Notice of Privacy Practices.

DVVC reserves the right to change the privacy practices that have been described in the NPP. I understand that in the event of any changes, I will be notified and may obtain a revised Notice either by mail, accessing the DVVC website, or requesting a copy at my next appointment.

Patient Signature **Date**

Medical Records Release

I consent to the release of PHI by DVVC to my health care providers and insurance company (ies). **I authorize and consent** to the release by my healthcare providers to DVVC and any insurance company (ies) all PHI necessary for treatment, payment and/or continuation of care.

I,_____, hereby give Discover Vein and Vascular Center PLLC permission to obtain my medical records from_____for the purpose of continuing my medical care. Please send _____to Fax: 480-745-8677 ATTN: MEDICAL RECORDS.

Patient Signature **Date**

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Patient Financial Policies / Responsibilities

1. **Patient Information / Proof of Insurance**: At each visit, all Patients must complete / verify patient information before seeing provider. DVVC must obtain a copy of your driver's license or legal identification and current valid insurance card as proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for payment of services rendered.

2. **Insurance**: DVVC participates in most insurance plans, including Medicare. If you are not insured by a plan with which we are contracted, payment in full is expected at each visit. If we are a participating provider with your plan, but you have not provided us with the most up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits and rules is your responsibility. Please contact your insurance plan with any questions you may have regarding your coverage.

3. **Referrals**: Your insurance may require a referral form from your primary care physician for procedure/service (s) provided by DVVC. **It is the patient's responsibility to obtain the appropriate referral(s) prior to be seen**. If you are unable to produce a referral at the time of your visit, you will be given the option to reschedule your appointment or sign a waiver of insurance and pay for the visit in full.

4. **Co-Payments and Deductibles**: All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-pays and deductibles from patients are considered fraud. Deductibles are due at the time of notification by your insurance company. Such notification may be a verbal notice at the time of insurance verification, or benefit verification.

5. **Coverage Changes**: If your insurance changes, please notify DVVC prior to your next visit to help you receive your maximum benefits. Failure to notify us could result in denial of claim(s) which then you the patient, would be responsible for full payment of such claim(s).

6. **Missed Appointments**: DVVC's policy is to charge for missed appointments not canceled / rescheduled 48 hrs in advance. You, the patient, will be charged $35.00 per office visit, $50.00 per ultrasound, and $150.00 per In- Office Vein Procedure. These charges will be your responsibility and will be billed directly to you. Patients that continue to miss appointments will not be allowed to reschedule any appointments until such fees are paid in full.

7. **Non-Covered Services**: DVVC provider(s) follow appropriate medical guidelines for standard of care based on your medical condition. Please be aware that some of the services you receive may be determined to be non-covered or not considered reasonable or necessary based on the benefits of your specific plan. You, the patient, will be financially responsible for the cost of any/all services that are not paid.

8. **Claims Submission**: Your insurance benefit is a contract between you and your insurance company. DVVC will submit your claim(s) for the services which have been provided. Please be aware that you are responsible for any balance of your claim.

9. **Nonpayment / Delinquent Accounts**: If the patient responsibility portion of your account is over 60 days past due, you will receive a letter stating you have 10 days to pay your account in full to halt collection activity. In the event your account becomes delinquent, you will be liable for all reasonable collection/attorney fees plus any filing / processing costs.

10. **Refunds**: In the event that you have overpaid on your account, a refund check will be mailed to you.

By signing this, I certify I have received a copy of Discover Vein and Vascular Centers Patients Financial Responsibilities and agree to all the terms and conditions listed.

Patient Name (Please Print) Date

Patient Signature Date

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NAME_____ **Date of Birth**_____

Past Medical History

☐ No Significant past history

☐ High Blood Pressure	☐ Stroke	☐ Kidney Disease
☐ Diabetes	☐ Blood Clot(s)	☐ Thyroid Disease
☐ Neuropathy	☐ Cancer	☐ Emphysema
☐ Heart Problems	☐ Heart Attack	☐ Aneurysm
☐ High Cholesterol	☐ CHF	☐ Bleeding Ulcers

☐ Other_____

Tobacco Assessment

☐ Non-Smoker ☐ Former Smoker: Date Quit_____

☐ Active Smoker: Packs Per Day_____ ☐ Pipe/Cigar/ Chew

Social History

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Race: ☐African-American ☐Asian ☐Caucasian ☐Hispanic or Latino
☐American Indian ☐ Pacific Islander

Native Language: ☐English ☐Spanish ☐Other_____

Alcohol Use: ☐Non-Drinker ☐ Occasional ☐ Socially ☐ Quit
☐ Daily: Drinks Per Day_____

Surgical History ☐ No prior surgical history

☐ Heart Bypass	☐ Leg Bypass	☐ Breast Surgery
☐ Cardiac Stents	☐ Peripheral Stents	☐ Hysterectomy
☐ Appendectomy	☐ Aneurysm	☐ Gallbladder
☐ Hernia	☐ Carotid	☐ Cataract(s)

☐ Other_____

Family History :

☐ Adopted ☐ Denial of any Significant Family History

Mother: ☐Heart ☐Stroke ☐Diabetes ☐Aneurysm ☐Kidney ☐HTN

Father: ☐Heart ☐Stroke ☐Diabetes ☐Aneurysm ☐Kidney ☐HTN

Nutrition Introductory Questionnaire

Name: _____ DOB: _____

Sex (circle): M / F Age: _____ Occupation: _____

Address: _____

Marital Status: ☐ Married ☐ Never Married ☐ Separated ☐ Divorced ☐ Widowed

Medical Conditions: _____

Do you have any food allergies, sensitivities, or dietary restrictions?

_____

What medications, vitamins, or other supplements do you take?

_____

_____

What is your usual eating pattern? (check all that apply): ☐ 3 meals + snacks ☐ 3 meals/no snacks ☐ Grazer ☐ Skip meals ☐ Night-time eating ☐ Varies weekday vs. weekend

Record what you eat and drink on a typical day with as much detail as possible.

Meal/Time	Typical Intake: food/beverages/supplements/amounts

Do you participate in regular physical activity? (circle) Yes / No

If yes, what activities and how often? _____

What is most important to you to get out of today's visit?

_____

Patient Name: _____ Date of Birth: _____/_____/_____

Primary Care Physician: _____ Person Filling Form: _____

Referring Physician: _____ Relationship to Patient: _____

CURRENT MEDICATIONS AND ALLERGIES

Are you currently taking Aspirin?

DRUG	DOSAGE (MG)	TIMES DAILY?

MEDICATION ALLERGIES:

_____

_____

OTHER ALLERGIES:

_____

_____