Welcome!

VARICOSITY VEIN CENTER
live your best life

Please take a moment to fill out this form as thoroughly as possible. If you have any questions, we are happy to help.

Date:_____

YOUR INFORMATION

Full Name:_____

Date of Birth:_____

Gender:_____Race:_____

Ethnicity: ☐ Prefer not to answer ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Social Security Number:_____

Address:_____

_____

City:_____

State:_____

Zip Code:_____

Home Phone:_____

Cell Phone:_____

Work Phone:_____

E-mail:_____

Driver's License #/State:_____

Employer:_____

Primary care physician:_____

Referring physician:_____

Responsible party:_____

Relationship to patient :_____

Do you have any drug allergies? _____

_____

_____

EMERGENCY CONTACT INFORMATION

Contact Name:_____

Contact Phone:_____

Contact Home Phone:_____

Relationship to patient:_____

SPOUSE INFORMATION

Spouse Name:_____

Spouse Date of Birth:_____

Spouse Phone:_____

PRIMARY INSURANCE
Plan:
Subscriber:
Relationship to Patient:
Member ID:
Group No.:

SECONDARY INSURANCE
Plan:
Subscriber:
Relationship to Patient:
Member ID:
Group No.:

[see reverse side]

- **How did you hear about us?**

☐ Physician_____

☐ Radio _____

☐ TV _____

☐ Print/Newspaper _____

☐ Website_____

☐ Facebook_____

☐ Friend_____

☐ Other_____

Preferred Contact Method

☐ Cell phone

☐ Home phone

☐ Work phone

☐ E-mail

☐ Online Patient Portal

☐ Other_____

Varicosity Financial Policy

AUTHORIZATION TO RELEASE INFORMATION: The undersigned authorizes Varicosity, LLC to release any medical or other information about the patient which may be necessary for the proper filing of all insurance claims, review of services, or receipt of benefits.

ASSIGNMENT OF BENEFITS: The undersigned will furnish necessary health insurance information to Varicosity, LLC and agrees to assist in processing all claims for benefits. The undersigned also assigns to and authorizes direct payment of benefits to Varicosity, LLC

FINANCIAL RESPONSIBILITY: Varicosity, LLC strives to provide the best possible medical care for its patients. We expect that we will be paid for services rendered. The undersigned agrees to be totally responsible for all charges for services rendered to the patient including any non-covered charges. The undersigned also agrees that if the unpaid account is referred to an attorney for collection, to pay all costs of collection including reasonable attorney fees.

Signature of Patient/Representative (agreement to pay):_____

Privacy Notice
Acknowledgement/Good Faith Effort

We will provide you with a privacy notice when you come in for your appointment. Sign below once you've received a copy.

I acknowledge that I have received a copy of Varicosity, LLC's Privacy Notice.

Signature of Patient or Representative: _____

FOR OFFICE USE ONLY

☐ Patient refused to sign.

☐ Patient was unable to sign for the following reason: _____

_____

Employee Signature:_____Date:_____

Witness Signature:_____Date:_____

Varicosity Vein Center

Records Release Authorization

Name: Date of Birth:

Can we leave messages on your voicemail in regards to your care at Varicosity Vein Center? ☐ **Yes** ☐ **No**
This can include messages about your appointment time, your treatments, or your balance.

Can we release your medical information to your primary care doctor or other physician? ☐ **Yes** ☐ **No**

Name of physician(s):_____

_____

Please specify any person allowed to receive your medical information.
INCLUDE YOUR SPOUSE OR OTHER FAMILY MEMBERS WHO ROUTINELY ACT ON YOUR BEHALF - THIS INCLUDES SCHEDULING APPOINTMENTS, CONFIRMING APPOINTMENTS, AND CALLING ABOUT YOUR BILL

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I authorize Varicosity, LLC to disclose medical records originating from Varicosity, LLC. This authorization is valid for the release of medical records dated prior the date on this form and future dates where care is given at Varicosity, LLC

I may revoke this authorization at any time. If I do so, it must be in writing and presented to the Office Manager of Varicosity, LLC. A revocation does not apply to information that has already been released due to this authorization form or when my insurer has the lawful right to contest a claim under my policy.

Signing this form is voluntary. I DO NOT HAVE TO SIGN THIS DOCUMENT TO RECEIVE TREATMENT. I can request a copy of disclosed information at any time and if I have any questions, I can contact the office manager. I have read the above records release authorization and acknowledge that I fully understand the terms.

Do you have any other instructions regarding the release of your medical records?_____

_____

_____

_____

_____

Signature of Patient or Authorized Representative:_____ **Date:**_____

Printed Name of Authorized Representative:_____ Relationship:_____

Please let us know if you have any questions regarding this form. We are happy to assist you.