|  |
| --- |
| **DEMOGRAPHICS** |
| First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M. Initial: \_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex:\_\_\_\_\_\_ S.S#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_Marital Status: \_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Race\*:** 🞎Am. Indian 🞎Asian 🞎African American 🞎White 🞎Decline to Answer 🞎 Other**Ethnicity**: 🞎Hispanic or Latino 🞎 Not Hispanic or Latino 🞎Decline to Answer **Language:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **INSURANCE/PHYSICIAN/REFERAL** |
| Primary Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy Holder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy Holder Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you have a co-pay 🞎Yes 🞎No If yes, Co-pay Amount:\_\_\_\_\_\_\_\_\_\_\_\_\_Family Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How did you hear about us?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **RECEIPT OF NOTICE OF PRIVACY AND FINANCIAL PRACTICES ACKNOWLEDGEMENT** |

I hereby acknowledge that on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date) I have reviewed the Notice of Privacy Practice and Financial Policy of Vein Care Center which sets for the ways in which my personal health information may be used or disclosed by Vein Care Center and acknowledges that I am financially responsible for payment of any balances due.

You may disclose my health information to any of the following persons (Ex: Doctors, Family, Employer, etc.):

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

***The full copy of the Vein Care Center’s Privacy Notice and financial policy are kept in the office. You may ask to review the full policies at any time.***

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **PHOTO CONSENT** |

I hereby do \_\_\_\_do not \_\_\_\_ give permission to The Vein Care Center to photograph the areas I would like treated, both before and after treatment. I understand these photographs will be used to monitor the progress of my treatments. I understand that if used for marketing or medical research purposes these photographs will not contain my name or other identifying information. I understand that I will not be entitled to any payment or other form of renumeration as a result of any use of the photographs.

**I have read and fully understand and agree to the HIPAA, Financial and photography policies of this practice.**

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**