Vein Care Center
Laser Specialists

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:**_____

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?:_____

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: _____

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.

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Patient Signature: _____ **Date:** _____