Center for Vein Restoration

PATIENT INTAKE FORM

PATIENT INFORMATION - *Welcome to the Center for Vein Restoration - (Please complete all fields – Thank You)*				
NAME (Last, MI, First)		DATE OF BIRTH (MM/DD/YYYY)	SEX- M/F	
CURRENT ADDRESS		CITY	STATE	ZIP
CELL PHONE		EMAIL		
RACE / ETHNICITY	PREFERRED LANGUAGE	OCCUPATION		
REFERRING PHYSICIAN - NAME	PHONE NUMBER			
PRIMARY CARE PHYSICIAN - NAME	PHONE NUMBER			
EMERGENCY CONTACT NAME	RELATIONSHIP	CONTACT PHONE	EMAIL	

PRIMARY INSURANCE		
PRIMARY INSURANCE CARRIER' S NAME	POLICY/ MEMBER ID #	
POLICY HOLDER - NAME OF INSURED (Last, First)	GROUP#	
RELATIONSHIP TO PATIENT: □ SELF □ SPOUSE □ PARENT □ GUARDIAN □ OTHER:	POLICY HOLDER DOB	EFFECTIVE DATE

SECONDARY INSURANCE - (*If Applicable)*		
INSURANCE CARRIER' S NAME	POLICY/ MEMBER ID #	
POLICY HOLDER - NAME OF INSURED (Last, First)	GROUP#	
RELATIONSHIP TO PATIENT: □ SELF □ SPOUSE □ PARENT □ GUARDIAN □ OTHER:	POLICY HOLDER DOB	EFFECTIVE DATE

How often do you feel the following problem in your legs?

Varicose Vein Symptom Questionnaire- Select [x] all that applies						
SYMPTOM	**Always**	**Very Frequently**	**Frequently**	**Sometimes**	**Rarely**	**Never**
Heaviness						
Achiness						
Swelling						
Throbbing						
Itching						

Assignment and Release: I certify that the information provided is correct. I hereby authorize the assignment of insurance benefits for the insured are to be made payable to Center for Vein Restoration (CVR) for services rendered and that CVR may release medical information for treatment, payment and healthcare operations. Payments received for services rendered to me by CVR may be applied to unpaid bills for which I am liable, subject to coordination of benefit rules. I acknowledge that I am fully responsible for all non-covered services, co-payments, coinsurance, and deductibles. I further agree to be responsible for collection fees, court costs, and/or legal fees accrued in the event of default due to non-payment, and that a fee of $35.00 will be assessed for each returned check with insufficient funds.

SIGNATURE OF PATIENT / GUARDIAN _____ DATE _____ Rev 1/22

Center for Vein Restoration

HIPAA Privacy Notice, Access Designations and Communication Acknowledgement

Patient Name:	Date of Birth:

Maintaining the privacy of your information is paramount at the Center for Vein Restoration (CVR). Our staff are trained on Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security regulations, and follow our ***Notice of Privacy Practices ('Notice')***, which describes how CVR may use and disclose your medical information (called "Protected Health Information" or "PHI"), and to inform you of your rights with respect to PHI in our possession. A copy of the *Notice* is provided and displayed at registration, and can be requested anytime or viewed on CVR's website.

To ensure your understanding of CVR's Privacy *Notice*, please review the consents and authorizations below and acknowledge your understanding with your dated signature at the end – Thank you.

A) Consent for Disclosure of Protected Health Information:

I understand that CVR will use my PHI to carry out Treatment, Payment and Healthcare Operations. This may include sharing PHI with your insurance plan(s), other healthcare providers involved in your care, as well as other persons (i.e., caregivers, family, friends) you may designate below. You have the right to revoke this consent at any time by writing to: *CVR Privacy Officer, 7474 Greenway Center Drive, Suite 1000, Greenbelt, MD 20770*.

B) Acknowledgement of CVR Notice of Privacy Practices – *Review and/or Receipt*:

I acknowledge that I was provided the opportunity to receive and review the Practice's ***Notice of Privacy Practices*** ("*Notice*"). I understand the terms of the Practice *Notice* are subject to change and that I may request an updated copy of the *Notice* anytime from the CVR staff or by contacting the CVR Privacy Officer at privacy.officer@centerforvein.com.

C) Patient Care Communication Methods – *Mail, Email, Text, Phone and Online Portal*:

HIPAA allows CVR to communicate with patients related to their care through the mail, emails, text and phone. We also encourage patients to access secure ***Patient Portal*** to access your account information and send messages to CVR staff. If you would like to discontinue or "opt-out" of a specific method, please inform CVR staff of your preferences [1].

D) Designation of Others for Disclosure of PHI – *(Caregiver, Family, Friends or Personal Representative)*:

You may designate individuals that you want to have access or to share your information at CVR [2]. To protect your information, *please enter the names of the specific individuals that you want to grant access below*. CVR will use professional judgement and disclose the minimum amount of PHI necessary to fulfill the request.

If you do not want anyone other than yourself to have access to your PHI, please mark '☑ - *None*' →		**☐ - *NONE***
Access "Designee" - Print Name	*Relationship to Pt*	*Contact Phone*

I consent and authorize Center for Vein Restoration to contact healthcare providers to release information related to my care, and to use and disclosure of my PHI for treatment, payment and healthcare operations.

_____ _____

Patient *(Guardian / Representative)* Signature — Date

_____

Guardian / Representative Name and Relationship - (Printed)

CVR Staff: *I made a good faith effort to obtain a written patient Acknowledgement of Notice receipt but was unable due to:*

□ *Patient refused or unable to sign* □ *Other:* *Employee:* _____ *Date:* _____

[1] Patient ***Communication Preferences*** can be modified by completing CVR's *Pt Communication Preference Update Form*

[2] ***Specific PHI 'restrictions'*** requires the completion of CVR's *Patient HIPAA Privacy Rights Action Request Form*

Center for Vein Restoration

Patient Consent, Assignment of Benefits and Acknowledgement Form

Patient Name: _____ **DOB:** _____

Please read and acknowledge the following consents, assignment and authorizations.

Consent for Diagnostic, Medical and/or Surgical Treatment: I wish to be evaluated and treated by the Center for Vein Restoration (CVR). I hereby agree and give my consent to the providers/staff of CVR to order, prescribe and provide diagnostic, medical and surgical treatment to me that they judge is appropriate in diagnosing and/or treating my medical condition(s).

Assignment of Insurance Benefits and Authorization to Pay Insurance Benefits: I authorize CVR to apply for benefits for services rendered to me or the patient under my health insurance policies providing benefits. I assign and authorize payment of benefits from my insurance plan(s) to CVR and grant permission to contact my employer or health plan(s) regarding insurance information and coverage of my health benefits.

No Show / Cancellation Policy: To accommodate scheduling of patient care and provide timely appointments, our practice has a No Show/Cancellation Policy. Any missed or no show appointments for diagnostic scans, visits or treatments that are not canceled 48 hours prior to the appointment time may be charged a $50.00 fee. Our office reserves time for your care in good faith; please extend the courtesy by contacting our office at least 48 hours prior to your appointment time to cancel or rescheduled an appointment – Thank You.

Patient Financial Agreement and Payment Policy: I understand that CVR will bill my health insurance plan(s) for care I receive. I agree that payments from my health plan(s) will go directly to CVR. I understand that CVR can bill me directly when: (1) I choose to have care that my health plan covers but I do not secure needed referral or an approval for the care from my health plan; (2) I choose not to use my health coverage and agree to pay for the care myself; (3) CVR does not participate with my health plan and I agree to pay for 'out-of-network' care; or (4) I receive care for service(s) or supplies that are non-covered by my health plan(s). I further agree to pay for any and all related collection costs related to my financial responsibility.

Authorization for Use of Copies: I permit a copy of these authorizations and assignments defined with my signature below to be used in place of the original on all insurance claim submissions and for the release of specific medical or other protected health information, whether manual, electronic or telephonic.

I understand and agree to the above consents, assignments and authorizations: *(Please sign and date below:)*

_____ _____

Patient / Responsible Party Date

Medicare Beneficiary Lifetime "Signature on File": *(To be completed only if patient has Medicare coverage)*

I request that payment of authorized Medicare benefits be made on my behalf to CVR for services furnished me by CVR providers. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) information needed to determine these benefits. I understand my signature below requests that payment be made and authorizes release of medical information necessary to pay the claim. My signature below authorizes releasing of the information to any other insurer. For 'assigned' claims, CVR agrees to accept the Medicare defined allowance as the basis for payment and I will be responsible for payment of the deductible, co-insurance, and non-covered services based on Medicare's Explanation of Benefits.

_____ _____

Medicare Beneficiary / Authorized Representative Date

Center for Vein Restoration
www.centerforvein.com

CONSENT FOR COMPRESSION STOCKINGS AND PERIODIC RESUPPLY

I acknowledge that Center for Vein Restoration has advised compression therapy as a treatment for my symptoms, which could lead to a chronic condition requiring ongoing compression management. Given that compression stockings lose their therapeutic effectiveness after a certain number of uses and washes, I am aware that my insurance may provide coverage for multiple pairs of compression stockings each year to help manage my condition.

By signing below, I consent for Center for Vein Restoration to automatically send me new compression stockings as per my insurance plan's coverage limits. I understand that I may be responsible for any costs not covered by my insurance, including applicable deductibles or copayments. I also understand that I can cancel this automatic shipment service anytime by contacting Center for Vein Restoration at 855-436-2243, Option 3.

Patient Authorization for Recurrent Shipment of Compression Stockings

- ☐ I Accept
- ☐ I Decline

_____

Signature (Patient Name)

_____

Printed Patient's Full Name

_____

Date