



Today's Date: \_\_\_\_\_  
 Name: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Sex: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
 Primary phone: \_\_\_\_\_ Secondary phone: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_  
 E-mail: \_\_\_\_\_

I do not wish messages and/or appointment reminders left on my answering machine/voicemail or with persons other than myself. I understand I am responsible to cover costs of missed appointments if such reminders are not made.

Job Description: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Work Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
 Business Phone: \_\_\_\_\_

Name and contact information of person to notify in case of emergency	Name: _____ Relationship: _____ Phone: _____ Address: _____ City: _____ State: _____ Zip code: _____
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**Primary Insurance Information**

Company \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_  
 Cardholder's Name \_\_\_\_\_ Cardholder's Date of Birth \_\_\_\_\_  
 Relationship to Cardholder \_\_\_\_\_  Check here if cardholder's address is the same as above  
 Cardholder's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

**Secondary Insurance Information**

Company \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_  
 Cardholder's Name \_\_\_\_\_ Cardholder's Date of Birth \_\_\_\_\_  
 Relationship to Cardholder \_\_\_\_\_  Check here if cardholder's address is the same as above  
 Cardholder's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

**Where did you hear about our clinic?**

- |   |  |
|---|--|
| <input type="checkbox"/> Internet                               | <input type="checkbox"/> Newspaper (specify) _____                 |
| <input type="checkbox"/> Walked/Drove-by                        | <input type="checkbox"/> Friend Referral (specify) _____           |
| <input type="checkbox"/> Hoy                                    | <input type="checkbox"/> Physician Referral (specify) _____        |
| <input type="checkbox"/> Radio                                  | <input type="checkbox"/> Medical insurance carrier (specify) _____ |
| <input type="checkbox"/> American College of Phlebology website | <input type="checkbox"/> Other (specify) _____                     |



**Payment Policy:** Payment for services are due in full at time services are rendered, for self pay patients, unless otherwise agreed upon. We accept cash, checks and credit cards. If you are interested in financing your treatment, we will be happy to discuss this all available options with you.

- I authorize any third party payer to pay directly to Chicago Uptown Medical Center (DBA: Chicago Vein Institute), all benefits due as a result of services rendered. It is understood that this authorization does not relieve me from responsibility of charges incurred, and any balance not paid by third party shall be paid by me upon receipt of billing.
- I understand that I am responsible for meeting my individual deductible and coinsurance. I am aware that it is my responsibility to pay any copayment as determined by my insurance benefits.
- I understand that my insurance company may mistakenly send the check to the wrong party. In the event that the reimbursement is sent to me or someone related to me for the services that were rendered, I will endorse the check to Chicago Vein Institute within 1 month of said payment.
- In the case that I default on my account and my account is transferred to a collection agency, I am aware that any fees incurred as a result will be my responsibility.

After my account is sent to collections, Chicago Vein Institute will not be able to assist with payments or inquiries between myself and the collection agency. Once the account is transferred, it is no longer an account with the Chicago Vein Institute.

**General Consent to Treatment:** I agree and consent to the performance of diagnostic and therapeutic procedures deemed necessary by the physician. I acknowledge that there are no guarantees, expressed or implied, as the result of any procedure or treatment.

**Release of Information:** I authorize that my health information be used and disclosed by the physician, office staff and others outside of our office that are involved in my care and treatment for the purposes of providing health care services; insurance payment purposes; insurance treatment approval purposes; or any other use required by law. I understand that this authorization will remain in effect unless revoked by me in writing and delivered to the physician's office, Chicago Vein Institute.

**I have read the *Notice of Privacy Practices* on (date)\_\_\_\_\_.**

I have requested and received a copy. I do not wish to receive a copy. (CIRCLE APPLICABLE)

**I certify that the information listed above is true and correct to the best of my knowledge and that I have read and understand all of the above.**

Signature of patient/guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Print name: \_\_\_\_\_