PATIENT REGISTRATION FORM

VEIN INSTITUTE OF UTAH

PATIENT INFORMATION

Patient name: _____ Date of birth: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Home phone: _____

Cell phone: _____ E-mail: _____

Preferred language: _____ Ethnicity (circle): Hispanic or Latino NOT Hispanic or Latino Race: _____

Spouse's Name (if applicable): _____ Marital Status (circle): S M D W Other: _____

Patient Relationship to Responsible Party (circle): Self Spouse Child Other: _____

Primary Care Physician: _____ Referring Physician: _____

How did you hear about our clinic? _____

Patient's Employer Name: _____ Work / Employer phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Accident Information (if applicable): Date of injury? _____ Work Related? _____ (Y / N) Auto? _____ (Y / N) Other? _____ (School, business etc.)

Emergency Contact Name: _____ Relationship: _____

Home phone: _____ Cell phone: _____

RESPONSIBLE PARTY INFORMATION (If other than the patient)

Name of Responsible Party: _____
(Last) (First) (Middle)

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Date of Birth: _____ Gender: (circle): Female Male

Cell phone: _____ E-mail: _____

Resp. Party Employer Name: _____ Work / Employer phone: _____

Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____ (Zip + 4)

Subscriber's Name: _____ Date of Birth: _____ Gender: (circle): Female Male

ID Number: _____ Group Name and # (if applicable): _____ Co-pay amount: $ _____

Patient Relationship to Subscriber (circle): Self Spouse Child Other: _____

Secondary Insurance Company: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____ (Zip + 4)

Subscriber's Name: _____ Date of Birth: _____ Gender: (circle): Female Male

ID Number: _____ Group Name and # (if applicable): _____ Co-pay amount: $ _____

Patient Relationship to Subscriber (circle): Self Spouse Child Other: _____

Patient name: _____ Date of birth: _____

CONSENT AND CONDITIONS OF SERVICE

As either the patient or the legally authorized representative of the patient, the following consents, understandings, and agreements are made on my own behalf or on the behalf of the patient in partial consideration of the health care services to be provided to the patient by the ***Vein Institute of Utah, Inc***. to provide health care services to the patient and to administer physician orders for the benefit of the patient for this visit and any other subsequent visits, and it is understood that this consent may be revoked, in writing, at any time. It is understood that there is a risk of substantial and serious harm involved in such health care services, and such risk is accepted in the hope of obtaining beneficial results from such services.
No promises of any particular outcome or successful result have been made, it being understood and accepted that there is some uncertainty involved in the outcome of health care services for which this consent is given. It is understood that physicians are separately responsible to explain what they do.

Patient and the undersigned, if other than the patient, each jointly and severally agree to pay for all the health care services rendered to the patient from the ***Vein Institute of Utah, Inc***. including but not limited to any amounts not paid by any insurance company or other third party payor. Patient and the undersigned, if other than the patient, remains responsible for all co-payments, deductibles, co-insurance, and/or non-covered services regardless of amount paid by insurance or third party payor. It is understood ant agreed that charges not paid in full within 60 days of the date of service may be placed with a collection agency or attorney for purposes of collection. It is further understood and agreed by patient and the undersigned, if other than the patient, that all late payments are subject to interest charges of 1.5% per month. It is further understood and agreed by the patient and the undersigned, if other than the patient, each jointly and severally agree to pay costs and reasonable attorney fees in connection with the collection process. A service charge may be collected in connection with any check or other instrument tendered by the patient or the undersigned, if other than the patient, but returned, unpaid, to the ***Vein Institute of Utah, Inc.***

Payment Options:

☐ Self-Pay – I agree to pay my balance in full at the time of service.

☐ Private Insurance – ***Vein Institute of Utah, Inc.*** will bill your insurance.

I have read and understand this document and intend that it be legally binding.

I, the undersigned, grant permission to Ehsan Hadjbian, M.D. to disclose medical information to other treating physicians regarding my care. I authorize the release to Centers for Medicare and/or Medicaid or said insurance company and its agents any medical information about me to determine benefits payable for related services.

I request that payment of authorized Medicare of health insurance benefits are to be made to the ***Vein Institute of Utah, Inc***. or Ehsan Hadjbian, M.D. for services furnished to me.

Patient's Signature: _____ Date: _____

ACKNOWLEDGEMENT OF REVIEW AND RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have been given the opportunity to read the *Privacy Practices*. I understand that Dr. Ehsan Hadjbian takes every precaution to safeguard any "Protected Health Information" (PHI). By signing this acknowledgement I am consenting to Dr. Ehsan Hadjbian's use and disclosure of my PHI to carry out treatments, payment, and health care operations. If I do not sign this consent, or later revoke it, Dr, Ehsan Hadjbian may decline to provide treatment to me.

Patient's Signature: _____ Date: _____