Nelson Vein & Surgical Services

ACCREDITED FACILITY · IAC INTERSOCIETAL ACCREDITATION COMMISSION · VASCULAR TESTING

Name:_____ Birthday:_____

Address:_____ Social Security No.:_____

City:_____ Marital Status: S M D W

State:_____ Zip Code:_____ Sex: M F

Home Phone:_____ Okay to leave message: Yes or No

Cell Phone:_____ Okay to leave message: Yes or No

E-mail:_____ Access to your Electronic Records: Yes or No

How did you hear about our practice:_____

Employer:_____ Business Phone:_____

Emergency Contact:_____ Relation to patient:_____

Phone:_____ Okay to leave message? Yes or No

Primary Care Physician:_____ Phone:_____

Referring Physician:_____ Phone:_____

Pharmacy:_____ Phone:_____

Primary Insurance:_____ Subscriber Name:_____

ID/Certificate No.:_____ Group No.:_____

Secondary Insurance:_____ Subscriber Name:_____

ID/Certificate No.:_____ Group No.:_____

Authorization for Release of Medical information:

I hereby authorize Nelson Vein & Surgical Services to release any medical information including that, which may be required in the processing of insurance forms for services rendered.

Signature: _____ Date:_____

Consent for Medical Examination & Evaluation:

I authorize Nelson Vein & Surgical Services to a Physical Examination and Evaluation

Signature: _____ Date:_____

Assignments of Insurance Benefits:

I authorize direct payments for surgical and medical benefits by my insurance company to Nelson Vein & Surgical Services rendered. I am responsible for any balance remaining after treatments are rendered. I am responsible for any and all Co-payments, Coinsurance, and deductibles. Precertification/ Predetermination is not a guarantee of payment.

Signature: _____ Date:_____

30915 Lorain Road Suite 100 North Olmsted, Ohio 44070
Phone 440-617-6061 Fax 440-617-6065

AUTHORIZATION TO RELEASE

MEDICAL INFORMATION TO INDIVIDUALS/ FAMILY MEMBERS

In accordance with Federal Government Privacy Rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for Nelson Vein & Surgical Services to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so.

_____ I authorize Nelson Vein & Surgical Services to take photos & publish them while maintaining my patient confidentiality.

_____ I do not authorize my pictures to be published

_____ I authorize Nelson Vein & Surgical Services to release any or all information concerning my medical care to anyone listed below.

_____ I do not authorize anyone to obtain my medical information

_____ Name

_____ Relationship to Patient

_____ Name

_____ Relationship to Patient

_____ Patients Name (Print)

_____ Date of Birth

_____ Patients Signature

_____ Date

REVISED 12/6/11

HIPPA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____ (Patient's Name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- that this facility reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this facility is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this facility has already taken action in reliance thereon.

Signature of Patient or Legal Representative Witness: _____

Printed Name of Patient or Legal Representative Witness: _____

Date: _____

HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement Form

Acknowledgement of Receipt of Information Practices Notice (§164.520(a))

I, _____ (Patient's Name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I acknowledge that I have been provided with and understand this facility's **Notice of Privacy Practices** provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review this facility's ***Notice of Privacy Practices*** prior to signing this acknowledgment;
- this facility reserves the right to change their ***Notice of Privacy Practices*** and prior to implementation of this will mail a copy of any revised notice to the address I've provided, if requested.

Signature of Individual or Legal Representative Witness: _____

Printed Name of Individual or Legal Representative Witness: _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our ***Notice of Privacy Practices***, but it could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

_____

_____

Privacy Official: _____

Date: _____