Patient Responsibility for Payment of Charges

Patient Name: _____ DOB: _____

This is an evaluation, **not a free screening.** Your evaluation will include a complete ultrasound of the symptomatic leg(s). Following the ultrasound, you will speak with one of our clinic providers regarding results of the ultrasound and treatment for venous reflux, if needed. This appointment will take one and a half to three hours. Following your discussion with the provider, you will speak to our insurance expert regarding payment for any treatments needed going forward.

Your insurance **will be billed** for this evaluation and you will be responsible for insurance deductible and co-pay amounts. If your insurance company determines that the procedure is not covered for any reason, you will be responsible for the remaining charges.

For those patients who do not have insurance, payment is due at the time of service via cash, check or charge (All major credit cards accepted. CareCredit financing options are also available).

I hereby authorize the Ozark Regional Vein Center (ORVC) to release any medical information to process a medical claim. I understand that the ORVC has the right to charge for a consultation and any necessary studies once I am an established patient. I understand that I am financially responsible for any and all charges rendered at the time of office visit.

If, for any reason, it becomes necessary to initiate collections proceedings, I understand I am responsible for the cost of all treatments received, as well as any and all legal or collection fees that ORVC incurs.

I _____ understand & agree to the terms for payment of my account. (Printed Name)

Signature: _____ Date: _____

Ozark Regional Vein Center
5433 Walsh Lane
Rogers, AR 72758

Tel: 479-464-VEIN (8346)
Fax: 479-464-9046
www.OzarkRegionalVeinCenter.com

Ozark Regional VEIN CENTER

PATIENT REGISTRATION

www.ozarkregionalveincenter.com

Internal Use Only

_____

PATIENT INFORMATION – Please Print

Patient Name _____
Last First Middle

Sex: ☐ M ☐ F Date of Birth _____ Social Security # _____

Address _____ Apt. _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Please check one: ☐ Married ☐ Single ☐ Partner ☐ Divorced ☐ Widowed ☐ Separated

Race: ☐ White ☐ African American ☐ Asian ☐ Native Hawaiian/Other Pacific Islander
☐ Native American Indian/ Alaskan ☐ Other Race _____

Ethnicity (Origin): ☐ Not Hispanic or Latino ☐ Hispanic or Latino Preferred (Primary) Language: _____

Primary Physician _____

Preferred Pharmacy _____ Street _____

EMAIL AUTHORIZATION

Email Address _____

By providing my email address above, I hereby agree to allow ORVC to contact me by email with e-newsletters, wellness reminders, health news and updates regarding health-related services provided by ORVC. I understand that ORVC will not share the information provided above with outside marketing companies.

SPOUSE or PARENT (if minor) INFORMATION

Name _____ Date of Birth _____ Social Security _____

Employer _____ Address _____ Phone _____

EMERGENCY CONTACT INFORMATION

Relative or Friend not in the home

Emergency Contact _____ Relationship _____

Phone _____ Address _____ City _____ State _____ Zip _____

REFERRAL

If you are a new patient, how did you hear about the clinic or physician?

01 ☐ Recommended by a friend or family member
02 ☐ Washington Regional Medical Center
03 ☐ Phone Directory / Yellow Pages
04 ☐ Referred by a Physician _____
05 ☐ Insurance Plan Directory
06 ☐ Newcomers Group or Chamber of Commerce
07 ☐ Community or Company Health Fair
08 ☐ Newspaper or Magazine
09 ☐ Employer
10 ☐ Internet or clinic web site
11 ☐ Drove by clinic / Location of clinic
12 ☐ Other Source: Please list _____
13 ☐ Treated by physician in the hospital
14 ☐ Return Patient/ Not applicable

➔➔ **Please complete the back of the form** ➔➔

PERSON RESPONSIBLE FOR PAYMENT

☐ My self/ My spouse (skip to the next section) OR: (List Father, Mother, Guardian or other)

Responsible Party _____ DOB _____

Relationship to Patient _____ SS# _____

Phone _____ Address _____ City _____ State ____ Zip _____

HEALTH INSURANCE INFORMATION

Please provide a copy of your insurance card to the receptionist.

MEDICARE ☐ Medicare No. _____ - _____ - _____ - _____ Effective Date _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Ozark Regional Vein Center for any services furnished to me by the provider. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid and its agents any information needed to determine these benefits payable for related services.

PRIMARY INSURANCE _____

ID# _____ GP# _____ Phone# _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ DOB _____ SS# _____

Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐ Other

SECONDARY INSURANCE _____

ID# _____ GP# _____ Phone# _____

Address _____ City _____ State _____ Zip _____

Policy Holder's Name _____ DOB _____ SS# _____

Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐ Other

INSURANCE AUTHORIZATION & FINANCIAL AGREEMENT

I hereby authorize Ozark Regional Vein Center (ORVC) to give my insurance company or companies all information they require concerning my case, and hereby assign to the physicians(s) all payments for medical services rendered.

I understand that I am responsible for any amount not covered by insurance. I agree to pay any co-pay and amount due at the time of service.

Signed _____ Date _____

PATIENT NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received a copy of the Patient Notice of Privacy Practices from Ozark Regional Vein Center (ORVC).

SIGNATURE _____ **DATE** _____

In the event this Acknowledgement form is being executed by a personal representative, guardian or parent, please print your name, date of birth, social security number and relationship to the patient here:

_____

If you would like to authorize ORVC clinic to release information to a **family member, spouse, or personal representative**, please complete an **Individual Authorization Form** provided by the receptionist.

Universal Consent Form

HIPPA Consent

In April of 2003, new federal requirements regarding privacy of information for health care patients take effect. The Health Insurance Portability and Protection Act (HIPPA) requires that all medical providers, insurance companies and others put in place controls to ensure that your personal medical information is safe. The Ozark Regional Vein Center (ORVC) requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request the results of tests and procedures. Under the requirements for HIPPA we are not allowed to give this information to anyone without the patient's consent. This consent form will allow ORVC to release your medical and billing information to family members listed in your chart.

Authorization to Leave Messages with Household Members/Answering Machine

From time to time it is necessary for representatives of ORVC to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss ultrasound or procedure results, or to ask a patient to call regarding an issue or concern. At no time will a representative discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

Authorization to Release Health Information

As needed, we may request relevant medical records from any of your existing healthcare providers that may assist us in your evaluation and treatment.

Photography Consent

I understand that photographs or other digital other images may be recorded to document my care. I agree to have photographs taken for my records, as well as for use in medical, scientific, educational, and promotional purposes. I understand that ORVC will retain the ownership rights to these photographs or digital images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy. I waive all my rights to any claims for payment or royalties.

Email and Demographics Consent

I understand that my email and demographic information (Name, Address and contact information) will be entered into our database of contacts for notification of special offers from our aesthetic division, Renew Aesthetics at Pinnacle Point. I understand that my information will never be sold or given to an outside entity. I can withdraw my consent at any time by notifying Ozark Regional Vein Center.

☐ Please check here if you agree to all of the above consents ☐ Please check here if you refuse any of the above consents

If you refuse, please list here: _____

You have the right to revoke any of these consents, in writing, except where we have already made disclosures in reliance on your prior consent.

Print Name: _____ **Date:** _____

Signature: _____ **Date of Birth:** _____

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Health History

Occupation:_____

Height:_____

Weight:_____

Leg Symptoms, please check all that apply:

leg pain

itching

leg cramps

night cramps

tired/heavy legs

aching/throbbing

burning/stinging

open sore/ulcer

tenderness

red warm areas

restless legs

spider veins

varicose veins

worse with heat

bleeding from a vein in my leg,ankle or foot

Involving which leg:

RT

LT

BOTH

List any symptoms that affect your workday and how:

List any symptoms that affect your daily routine, leisure time and how:

Have you worn compression stockings in the past? If so, how long:

Do you take medication for your leg symptoms:
yes
no

If so, please list (including over the counter medication):

Patient Medical History (Please check all that apply):

Hypertension

Coronary Artery Disease

Congestive Heart Failure

Hepatitis

Deep Vein Blood Clot

Factor V

Diabetes

Asthma

Phlebitis

Arthritis

HIV/AIDS

Lung Disease/COPD

Pulmonary Embolus (clots in the lungs)

Cancer

Other:

Total number of pregnancies:

Number of live births:

Number of miscarriages:

Do you take hormones:

Have you ever been diagnosed with phlebitis/superficial blood clots?

Have you ever been diagnosed with deep vein thrombosis?

Have you ever been diagnosed with Factor V or any genetic clotting disorders?

Are you currently taking any blood thinners or have you in the past?

Do you have a family history of varicose veins, if so, who?

Do you have a family history of deep vein blood clots, if so, who?

Do you have family history of Factor V or any genetic clotting disorders, if so, who?

Please list your past surgeries:

Are you a current or former smoker, if so when did you quit?

Do you drink alcohol? If so, how many drinks per week?

Please list all your current medications:

_____

_____

_____

_____

_____

Please list all allergies:

_____

_____

_____

Ozark Regional
VEIN CENTER

AUTHORIZATION FOR RELEASE OF MEDICATION HISTORY

Patient Name: _____ Date of Birth: _____
Patient Address:

_____

I, or my authorized representative, consent to allow Ozark Regional Vein Center to download a list of medications purchased through my insurance in the last two years, as set forth on this form.
In accordance the DC Law and the Privacy Rule of the Health Insurance Portability and Accountability act of 1996 (HIPAA), I understand that:

1. Ozark Regional Vein Center uses SureScripts, Inc. a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized by Ozark Regional Vein Center.

2. This Authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to Ozark Regional Vein Center.

3. I have the right to revoke this authorization at any time by notifying Ozark Regional Vein Center. I understand that I may revoke the authorization except to the extent that action has already been taken based on this authorization.

4. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan. or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

This authorization does not authorize Ozark Regional Vein Center to discuss my health information or medical care with anyone other than those permitted under applicable law.

Signature of patient or representative: _____ Date: _____

Ozark Regional VEIN CENTER

CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribe Program

ePrescribing is a way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Formulary and benefit transactions** - Gives the health care provider information about which drugs are covered by your drug benefit plan.

- **Fill status notification** - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.

- **Medication history transactions** - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your health care provider at Ozark Regional Vein Center as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. ***As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.***

Consent

By signing this consent form you are agreeing that your provider at Ozark Regional Vein Center may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Ozark Regional Vein Center to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name: _____

Patient's date of birth: _____/_____/_____

Signature of patient or guardian: _____

Relationship with the patient: _____

Today's date: _____/_____/_____