INTERNATIONAL VEIN AND SKIN INSTITUTE

Patient Information as of _____

(PLEASE PRINT LEGIBLY & FILL IN ALL FIELDS) ❒New patient ❒Update of Infromation

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Age _____ Date of Birth _____ SS# ___ - ___ - _____ Sex ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: _____ Date of Birth ___/___/___
❒ Other _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____
Street & Suite # City State Zip

IF Patient is a Minor(less than 18 years old) provide information about parents

Mother _____ Date of Birth ___/___/___ Cell Phone _____

Father _____ Date of Birth ___/___/___ Cell Phone _____

Emergency Contact
(Not in your household) _____ Relationship to Patient _____

Home Phone _____ Work Phone _____

Primary Health Insurance Company: _____

Insured: Name _____ Gender _____
Last First

Date of Birth _____ SS# _____

Address _____
Street & Apt # City State Zip

PATIENT relationship to insured to person _____ Employer _____

Secondary Health Insurance Company _____

Insured: Name _____ Date of Birth _____

Signature _____ **Date** _____

INTERNATIONAL VEIN AND SKIN INSTITUTE TEL 847-518-9999

Patient Name		Birthday	

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, hereby acknowledge that, I have received a copy of International Vein & Skin Institute's Notice of Privacy Practices. I have been given the opportunity to ask questions I may have regarding this Notice.

Signature _____ **Relationship** _____ **Date** _____
Patient or parent if minor

Designation of person with which we may share your Treatment/Procedure information with

You may designate a person or entity that we are able to share information (i.e. Treatment Plans, procedures, etc.) with. This access may be revoked at any time by you in writing. Please print each person/entity's name separately and state their relationship to you the patient.

Name: _____ Date of Birth _____ Relationship _____

Name: _____ Date of Birth _____ Relationship _____

Name: _____ Date of Birth _____ Relationship _____

I agree to pay for medical services provided to me, at the day of visit. I understand that delaying payment may result in additional administration charges.

I understand that I will be legally responsible for all collection costs involved with the collection of this account including all court costs, reasonable attorney fees and all other expenses incurred with collection if I default on this agreement. **I consent/ give permission to use automatic telephone dialing systems (ATDS), commonly known as autodialers that will be making call to cell phones, listed by my on my account, in order to collect past due balance on the account.**

I authorize the release of any information including the diagnosis and the records of any treatment or examination (including any record of Drug Abuse HIV AIDS STD and Abuse, Neglect and Domestic Violence) rendered to me or my child during the period of such care to third party payers required to file, adjudicate the claim and/or healthcare operations. I authorize and request my insurance company to pay directly to International Vein & Skin Institute SC insurance benefits otherwise payable to me. Your health insurance will only pay for services that it determines to be "reasonable and necessary". If your insurance determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary for the symptoms presented" under their program standards, they will deny payment for that service. This means that you will be held liable for the services mentioned above.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or of my depend. I further agree that a photocopy of this agreement shall be as valid as the original. This authorization is effective until revoked in writing. **By providing my signature below, I acknowledge that I have read and understood all of the information written above.**

Signature _____ **Relationship** _____ **Date** _____
Patient or parent if minor