Maryland Vein Professionals, LLC

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1838 Greene Tree Road, Suite 340, Baltimore, MD 21208

PATIENT REGISTRATION

Patient Last Name: First: MI:

Address:

City: State: ZIP:

Home Phone: Work Phone: Cell:

Email : ☐ **Please sign me up for the MVP E-Newsletter/Updates**

Sex: M F Marital Status: S M D W **Date of Birth: Social Security #:** ____-____- ___

Employer:_____ **Status – Full time - Part-time - Retired**

Family Physician: _____ **Phone #:** _____

Referring Physician:_____ **Phone #:** _____

Emergency Contact: _____
Name Phone # Relationship

☐ **FOR ANY FUTURE TREATMENTS PLEASE CALL ME TO FILL A CANCELLATION FOR THE SOONEST AVAILABLE BEST DAYTIME CONTACT NUMBER** _____

☐ **PLEASE LEAVE A DETAILED MESSAGE REGARDING MY HEALTH INSURANCE COVERAGE FOR TREATMENTS AT THIS NUMBER**_____

Is English your main language? ☐ Yes ☐ No
Do you have another language in which it is easier for you to communicate? ☐Yes_____ **☐ No**
Do you have any problems with your vision or hearing that might affect how we teach you? ☐Yes ☐ No
How would you prefer to receive information regarding your care? ☐Written ☐ Verbal☐ Demonstrate ☐Other_____
Do you have any beliefs or practices that might affect how we teach you (such as religious, cultural, spiritual)?
☐Yes ☐ No☐ N/A
Do you have any questions regarding the information you have been given? ☐Yes ☐ No

Primary Insurance:

Plan Name:_____

Policy holder's Name:_____

Policy holder's DOB: ___/___/__ Relationship_____

Is this an: HMO PPO CoPay amt:_____

ID # _____ **Group #** _____

Policyholder's Employer:_____

Secondary Insurance:

Plan Name _____

Policy holder's Name: _____

Policy holder's DOB: ___/__/___ Relationship

Is this an: HMO PPO Copay amt: _____

ID#: _____ **Group #:** _____

Policyholder's Employer _____

Authorization to Release Healthcare Information

Patient Name: _____ Date of Birth: _____

I authorize the following person/people access to my medical records and/or to call on my behalf for medical, account questions, and/or billing questions.

Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____

_____

Signature of Patient: **Date**

Patient Authorization to Bill Insurance

I hereby authorize Maryland Vein Professionals, LLC to apply for benefits on my behalf for services rendered. I request that payment from my insurance company to be made directly to Maryland Vein Professionals, LLC.

I understand that Maryland Vein Professionals, LLC will bill insurance where applicable for all clinical services. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

I understand that Maryland Vein Professionals, LLC will bill my insurance for the necessary compression stockings. I understand that compression stockings may not be a covered benefit under my policy, therefore I will be responsible for payment ($59/per pair). I understand that that follow up ultrasound imaging is not included as part of the surgery or the global period and will be billed to my insurance.

_____

Signature of Subscriber or Beneficiary **Date**

All information released is in compliance with HIPAA as stated in our Notice of Privacy Practices.

Late Policy

Time management in physician offices is often a frustration to patients, staff, and providers. We realize this and ask for your help and for your understanding. Patients who arrive on time for appointments help our providers stay on schedule. As a courtesy to other patients, if you are more than 10 minutes late, you may be asked to reschedule. If you do not keep a scheduled appointment, or cancel with less than 48 hours notice, a charge will be made.

We ask new patients to arrive at least 15 minutes prior to his or her scheduled appointment to allow additional time to gather all of the necessary information. If a new patient arrives after his or her scheduled appointment time, he or she may be asked to reschedule.

_____

Signature of Subscriber or Beneficiary **Date**

Notice of Privacy Practices and Patient Consent
For Use and Disclosure of Protected Health Information

Patient Name:_____ **Date:**_____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Maryland Vein Professionals, LLC may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Maryland Vein Professionals, LLC has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Maryland Vein Professionals, LLC will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Maryland Vein Professionals, LLC to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Maryland Vein Professionals, LLC has taken action relying on this consent.

_____

SIGNATURE (Patient or Legal Custodian/Authorized Representative) **DATE**

_____

Relationship to Patient if signed by another party **DATE**

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our 'Notice' at any time by contacting: Maryland Vein Professionals 410-964-8346.