CENTRAL TEXAS VEIN CENTER

Patient Information

Last Name___________________________________ First Name__________________________

Address________________________________City_______________State_________Zip______

Date of Birth____________________________Age____________________________Sex_______

Social Security # __________________Home Phone_________________Cellular______________

Emergency Contact______________________Relationship______________Phone____________

Primary Care Physician___________________________________Phone____________________

Patient Employer____Phone____________________

E-mail Address____

INSURED PARTY (if other than self)

Last Name___________________________________First Name___________________________

Social Security Number______________________________Date of Birth___________________

Insurance Company_________________________________ Phone Number_________________

Policy Number_____________________________________Group_________________________

My signature on this form indicates my acknowledgement that I have been provided with the opportunity to read and receive a copy of Central Texas Vein Center's Privacy Notice, which explains how my protected health information may be used or disclosed by Central Texas Vein Center. Central Texas Vein Center may not discuss with anyone other than your doctor and members of your treatment team about your health information or medical care without your permission. Please provide name(s) of family members that you authorize release to: ____

MEDICAL RELEASE/ASSIGNMENT OF BENEFITS: I hereby authorize payment of all health insurance benefits to Central Texas Vein Center and allow assignee to release all information necessary to secure payment. I agree that a photocopy of this authorization shall be considered as effective and valid as the original. I understand that I am legally responsible for all charges incurred whether or not they are paid by my health insurance, and that any unpaid balance shall be due in full immediately if insurance proceeds are paid directly to me. I understand that if my account should be forwarded to a collection agency, a 20% charge will be added to my account balance. I hereby authorize release of my medical records, inclusive of all test results and pertinent information acquired during my treatment, to/from other physicians as deemed necessary.

HIV TESTING AFTER ACCIDENTAL EXPOSURE: I understand that in the event a healthcare worker is exposed to my blood or body fluids during my exam/procedure, my blood may be tested for the HIV antibody and other communicable diseases at no cost to me.

Signature____Date_____________________________

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