Revised 4/14/22

Nevada Vein and Vascular

PATIENT REGISTRATION

DATE:

PLEASE PRINT AND COMPLETE ALL ENTRIES

FIRST NAME:	MI:	LAST NAME:		
ADDRESS:		CITY:	STATE:	ZIP CODE:
❑ FEMALE ❑ MALE ❑ OTHER	SSN (last 4 digits):		DOB:	
PRIMARY PHONE: ❑ HOME ❑ CELL		SECONDARY PHONE: ❑ CELL ❑ WORK ❑ FAMILY/FRIEND		
MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ DOMESTIC PARTNER ❑ DIVORCED ❑ WIDOW				
EMAIL:		REMINDER PREFERENCE: ❑ EMAIL ❑ PHONE ❑ TEXT		
PRIMARY CARE PROVIDER: (LAST, FIRST)		REFERRING PHYSICIAN: (LAST, FIRST)		
PHARMACY:	LOCATION:	PHONE NUMBER:		

RACE: ❑ AMERICAN INDIAN OR ALASKA NATIVE ❑ HISPANIC ❑ ASIAN ❑ BLACK OR AFRICAN AMERICAN
❑ NATIVE HAWAIIAN OR PACIFIC ISLANDER ❑ WHITE

PREFERRED PRIMARY LANGUAGE: ❑ ENGLISH ❑ SPANISH ❑ OTHER (PLEASE LIST):_____
ETHNICITY: ❑ HISPANIC OR LATINO ❑ NOT HISPANIC OR LATINO ❑ REFUSED TO REPORT

OTHER TREATING PHYSICIANS YOU WOULD LIKE INFORMATION SHARED WITH: (WITH FIRST AND LAST NAME)

1)	2)
3)	4)

INSURED/RESPONSIBLE PARTY

PRIMARY INSURANCE NAME:

SUBSCRIBER FIRST NAME:	MI:	LAST NAME:
SUBSCRIBER RELATIONSHIP: ❑ SELF ❑ CHILD ❑ SPOUSE ❑ PARENT ❑ GUARDIAN ❑ PARTNER		
MEMBER ID NUMBER:	GROUP NUMBER:	EFFECTIVE DATE:
PLAN TYPE:		

SECONDARY INSURANCE NAME:

SUBSCRIBER FIRST NAME:	MI:	LAST NAME:
SUBSCRIBER RELATIONSHIP: ❑ SELF ❑ CHILD ❑ SPOUSE ❑ PARENT ❑ GUARDIAN ❑ PARTNER		
MEMBER ID NUMBER:	GROUP NUMBER:	EFFECTIVE DATE:
PLAN TYPE:		

ASSIGNMENT AND RELEASE INSURANCE

I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. I understand that the physician has a right to change their privacy practices and that I may obtain any revised notices at the clinic. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

PATIENT FINANCIAL POLICY

By signing below, I acknowledge that I have received, reviewed, understand, and will comply with the policies explained in the Nevada Vein and Vascular Patient Financial Policy Form. There is a detailed form available upon request.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional):

Nevada
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FINANCIAL POLICY

Thank you for choosing Nevada Vein and Vascular to participate in your medical care. To provide you with a full understanding of your financial obligations, an important aspect of your medical care, we have developed the following policies:

ALL PATIENTS ARE FINANCIALLY RESPONSIBLE FOR SERVICES PROVIDED.

- Nevada Vein requires that you provide a copy of your current insurance card and photo ID at every visit.
- Nevada Vein will bill your primary and secondary insurance on your behalf. You will be responsible for services rendered that are not covered by your Insurance or the amount that the Insurance deems is patient responsibility.
- A requirement of both NVV and your insurance company; co-payments are due at the time of service.
- Payment of co-insurance or any charges not covered by your plan is required at the time of service.
- Medicare recipients must update the National File with any changes by calling 1-800- MEDICARE.
- Payment is required in full at the time of service from uninsured patients unless arrangements have been made in advance.
- Unless previous arrangements made, account balance over 90 days will be sent to a collection agency.
- A fee of $25 will be charged to you for returned checks, plus any bank fees incurred.

APPOINTMENTS

- A $35 fee will be assessed for canceled appointments without 24 hours' notice.
- Patients who accumulate a total of three "No Shows" in a calendar year may be terminated from the practice.

OUTSIDE DOCUMENT COMPLETION

- FMLA/Disability/Insurance forms requiring the Physician's office to fill out will be charged as follows

1 Document	$25.00	***This fee must be paid at the time of dropping off the document(s).***
2 Document	$40.00	
3 or more Documents	$50.00	

REFERRALS/AUTHORIZATIONS

- It is the patient's responsibility to ensure that any referrals or authorization for treatment are provided to the office the office prior to your appointment. If the authorization or referral is not obtained prior to your visit, you will be expected to pay for all charges at the time of your visit.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Questions about our Financial Policy should be directed to the front desk personnel.

I have read and understand the Financial Policy, I accept responsibility for services provided by Nevada Vein and Vascular

Signature of Financially Responsible Party_____ Date _____

Printed Name _____

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HIPAA PATIENT ACKNOWLEDGMENT FORM

Our electronic Notice of Privacy Practices (NPP) provides information about how Nevada Vein and Vascular may use and disclose protected Health information (PHI) about you. The practice provides this form to further comply with the Health Insurance Portability and Accountability Act (HIPAA). The NPP contains a Patients' Rights section describing your rights under the law. Please review the Notice of Privacy Practices thoroughly before signing this acknowledgment form. If you would like a written copy of our NPP, please request this from the front desk.

By signing this form, you acknowledge that our Practice may use and disclose PHI about you for treatment, payment and healthcare operations. Please review the following for further delineation of your wishes.

I give permission for Nevada Vein and Vascular Services to: (check below)

Leave a message regarding ❑ appointment and/ ❑ test results.

❑ At _____ Home phone number and/or

❑ At _____ Cell phone number and/or

❑ At _____ Work phone number

Please list authorized persons we may communicate with:

Name _____Authorized Person's DOB_____

Relationship _____ Phone Number_____

❑ Emergency Contact ❑ May share medical information with this person ❑ Do not share my medical information

Name _____Authorized Person's DOB_____

Relationship _____ Phone Number_____

❑ Emergency Contact ❑ May share medical information with this person ❑ Do not share my medical information

I assume responsibility to inform the practice of any changes in the above information.

Print Patient's Name / Responsible Party_____Patient DOB_____

Signature _____Today's Date_____

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ePrescribe Program

CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribing is 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 Nevada Vein and Vascular 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 Nevada Vein and Vascular 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 Nevada Vein and Vascular 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 DOB_____

Signature of Patient or Guardian _____Today's Date _____

Relationship to Patient _____