The Vein Center

CHART #: _____ **PROVIDER:** ERIC E. WEGENER, MD

NEW PATIENT INFORMATION

PATIENT NAME: _____ **GENDER:** ☐MALE ☐FEMALE

ADDRESS: _____ **CITY**_____**ST**_____ **ZIP**_____

HOME PHONE #: ( ) _____ **WORK PHONE #:** ( ) _____

ALT PHONE #: ( ) _____ **EMAIL ADDRESS:** _____

DATE OF BIRTH: _____ **SOCIAL SECURITY NUMBER:** _____

MARITAL STATUS: ☐Single ☐ Married ☐Separated ☐Divorced ☐Widowed **LANGUAGE:** ☐English ☐Spanish ☐Other: _____

ETHNICITY: ☐Not Hispanic/Latino ☐Hispanic/Latino **RACE:** ☐ American Indian ☐Asian ☐African American ☐White ☐Other: _____

PATIENT'S EMPLOYER: _____

WHAT PROMPTED YOU TO CALL FOR AN APPOINTMENT? **(Please check all that apply):**
☐ **PHYSICIAN REFERRAL** ☐ **HOSPITAL** ☐**WEBSITE** ☐ **INTERNET SEARCH** ☐ **BILLBOARD** ☐ **NEWSPAPER** ☐ **TV**
☐ **YELLOW PAGES** ☐ **MAGAZINE** ☐ **RADIO** ☐ **FAMILY MEMBER** ☐ **FRIEND** ☐**OTHER:**

***IF FAMILY/FRIEND REFERRED, MAY WE CONTACT THEM TO SAY "THANK YOU"? YES NO**
WHO MAY WE CONTACT (FAMILY/FRIEND NAME): _____

REFERRING PHYSICIAN: _____**REASON FOR REFERRAL:** _____

RESP. PARTY INFORMATION
Please complete if patient is under 18 OR Insurance is under Parent/Guardian

RESP. PARTY NAME: _____ **GENDER:** MALE FEMALE

PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY: Self Spouse Child Other: _____

ADDRESS: _____ **CITY**_____**ST**_____ **ZIP**_____

HOME PHONE #: ( ) _____ **WORK PHONE #:** ( ) _____

ALT PHONE #: ( ) _____ **EMAIL ADDRESS:** _____

DATE OF BIRTH: _____ **SOCIAL SECURITY NUMBER:** _____

RESP. PARTY EMPLOYER: _____

INSURANCE INFORMATION

Please complete this section below accurately & bring your insurance cards/drivers license up with you for scanning.

PRIMARY INSURANCE COMPANY: _____**Copay $**_____

ADDRESS: _____

SUBSCRIBER'S NAME: _____**CONTRACT (ID#) NUMBER:** _____

SUBSCRIBER DOB: _____ **SUBSCRIBER SSN:** _____

GROUP NAME: _____ **GROUP NUMBER:**_____

PATIENT RELATIONSHIP TO SUBSCRIBER: Self Spouse Child Other: _____

SECONDARY INSURANCE COMPANY: _____**Copay $**_____

ADDRESS: _____

SUBSCRIBER'S NAME: _____**CONTRACT (ID#) NUMBER:** _____

SUBSCRIBER DOB: _____ **SUBSCRIBER SSN:** _____

GROUP NAME: _____**GROUP NUMBER:** _____

PATIENT RELATIONSHIP TO SUBSCRIBER: Self Spouse Child Other: _____

*****If you have Medicare***:**
*Are you covered under _____Regular Medicare or _____Medicare Replacement Plan (Managed Care Plan)

*If you are covered by a Medicare Replacement Plan, what is the name of the company? _____

Notice of Privacy Practices
I have received the Plastic & Hand Surgery Associates, PLLC Notice of Privacy Practices explaining the uses and disclosures of my health information.

***PATIENT/GUARANTOR SIGNATURE:** _____ **DATE:** _____

The Vein Center

Conditions of Service

Thank you for choosing The Vein Center of The Plastic & Hand Surgery Associates. This document represents our established *Conditions of Service* that will be used to resolve any issues or disputes pertaining to the vein care services rendered by The Vein Center of The Plastic & Hand Surgery Associates physicians and staff.

CONSENT TO TREATMENT

The patient identified below consents to therapeutic vein care evaluations and treatments which may be performed or assisted by our Vein Specialists and/or staff while under the care of Eric E. Wegener, MD. These evaluations and treatments may include, but are not limited to, initial evaluation and consultation, history and physical examination, lower extremity venous ultrasound study, infiltration of tumescent local anesthesia, endovenous laser ablation (EVLA), endovenous chemical ablation (EVCA) or sclerotherapy, ultrasound-guided sclerotherapy, ambulatory phlebectomy, vein light sclerotherapy, and/or conservative vein therapy.

PRIVATE PAY

For patients having no insurance, or choosing not to bill their insurance, it is expected that all vein care services will be paid in full prior to services, or at the time of service if arrangements for payment have been made acceptable to The Vein Center of The Plastic & Hand Surgery Associates. In all cases, accounts must be resolved in full within ninety (90) days. Accounts not resolved within ninety (90) days will be referred to an outside collection agency.

ASSIGNMENT OF BENEFITS

I, the undersigned, represent that I have insurance coverage with, and do here by authorize my insurance company to pay and assign directly to The Plastic & Hand Surgery Associates, all surgical and/or medical benefits. **[See Assignment of Benefit Form]**

PERSONAL VALUABLES

It is understood and agreed that The Vein Center of The Plastic & Hand Surgery Associates shall not be liable for the loss or damage to any money, jewelry, documents, garments, dentures, eye glasses, hearing aids, prosthetics, or articles of unusual value and small size. Also, The Vein Center of The Plastic & Hand Surgery Associates shall not be liable for the loss or damage to any other personal property.

CONSENT TO PHOTOGRAPH/VIDEOTAPING

The Vein Center of The Plastic & Hand Surgery Associates is permitted to take pictures of the medical or surgical progress involving vein care. The patient consents to photography and/or videotaping during medical or surgical procedures and the use of same for scientific, educational or medical research purposes. The patient further consents to routine photo-documentation related to patient care.

FINANCIAL OBLIGATIONS

I understand that I am responsible to The Vein Center of The Plastic & Hand Surgery Associates for all charges incurred by me and not paid by third party benefits. In the event that said bill, or any part thereof, is deemed delinquent by the practice, I understand that I will be responsible for all collection of expenses as well as reasonable attorney's fees and court costs if a suit is instituted. All delinquent accounts shall bear interest at the maximum rate allowed by law.

CANCELLING APPOINTMENTS

I understand that I am responsible for notifying The Vein Center of The Plastic & Hand Surgery Associates at least 48 hours before my scheduled appointment if I am unable to keep said appointment. Failure to do so may result in my account with The Vein Center of The Plastic & Hand Surgery Associates being assessed a $100 cancellation fee for breach of notification of each scheduled appointment.

RELEASE OF INFORMATION

The Vein Center of The Plastic & Hand Surgery Associates will obtain the patient's consent and authorization to release protected health information concerning the patient, in accordance with HIPAA regulations, except in those circumstances when The Vein Center is permitted or required by law to release the information. The Vein Center may disclose protected health information to the Intersocietal Accreditation Commission (IAC) for vascular lab accreditation purposes. The IAC is operated in accordance with strict HIPAA regulations. For further info, please see the 'Notice of Privacy Practices'.

SEVERABILITY

If any terms or conditions of this agreement are held by a court of law to be invalid or unenforceable, then this agreement, including all of the remaining terms and conditions, will remain in full force and effect as if such invalid or unenforceable term or condition had never been included. My signature below acknowledges that I have received a copy of this document and accept its terms.

_____	_____	_____
Patient's Printed Name	**Patient's Signature**	**Date Signed**

The Vein Center of The Plastic & Hand Surgery Associates

Assignment of Benefits Form

Included Facilities: Plastic Hand and Surgery Associates, The Plastic Surgical Center of MS, Rankin Laboratories

I, ***(responsible party)*** _____ with insurance benefits through ***(responsible party employer name)*** _____ (Medicare, Medicaid or Individual Plan) ***hereby authorize all entitled benefits under my governing Plan/Policy to be directly paid to the provider listed above for all services rendered.*** I understand that I am entitled to all benefits that my Health and Welfare Plan is legally obligated to provide. I understand that my Plan Sponsor and Insurance Company are both required to accept this HIPAA compliant agreement and provide all entitled benefits following all terms, conditions and requirements of the governing Plan for all services rendered, as well as comply with all applicable state and federal governing laws based on all protected rights. This authorization includes any and all rights permissible under my governing Health and Welfare Plan; applicable Social Security Act; Federal, City or State Government program; state and federal law in assuring all rights and entitled benefits are received for services rendered by the said provider. I understand this authorization also covers any other provider of service directly associated with services rendered and requested by the above provider, including but not limited to surgical related services, anesthesia, diagnostic testing, labs, pathology, radiology, implants, tissues, durable medical equipment or any other services as ordered by the provider above involving treatment.

I hereby certify that all insurance information provided is true and accurate and that I am responsible for keeping it updated. I hereby authorize the Provider listed above to submit claims, on my behalf, to the insurance company responsible for administering entitled benefits for all services rendered in good faith. I fully agree and understand that the submission of a claim does not absolve me of my responsibility to ensure the claim is paid in full and in full compliance of applicable state and federal laws***. I also understand I may be responsible for any and all amounts not payable by my insurance company including deductibles, co-pay, coinsurance amounts as well as any portion paid and not applied to in network benefits for any out of network services, non-covered services, services determined by the insurer as not medically necessary, or any failure by my insurer to comply with all applicable laws.***

I hereby irrevocably, designate, authorize and appoint Provider listed above as my true and lawful attorney-in-fact. This power of attorney is hereby provided for the limited purpose of receiving all payments, rights and remedies due under my Health and Welfare plan/Policy to include all medical services rendered or to be rendered as ordered by the provider listed above. This power of attorney shall automatically terminate, without formal action being taken, as soon as the above listed healthcare provider has received payment in full as entitled under my governing Plan, along with all rights and remedies under applicable governing law for all medical care and services provided. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein. I hereby authorize my insurer to assign and transfer any and all entitled plan benefits and rights to Provider listed above and any appointed business associates working with them for the sole purpose of making sure all protected rights and entitled benefits under my specific health and welfare plan or governing policy are administered accurately and not withheld for services rendered, including all protected rights under applicable law to receive a copy of all relevant documents or data, governing plan documents, remedies, disclosures, appeal, administrative reviews and litigation on my behalf. This is a direct assignment of my rights and benefits under the governing plan/policy. I understand this payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment where entitled benefits are not paid pursuant to applicable federal and /or state laws. ***I also authorize Provider to apply any refund that may be due to me on an account with one of the Included Facilities to an amount due from me on another account with one of the Included Facilities.***

I hereby instruct and direct my Insurance Company to pay all entitled plan benefits as required by the governing Plan/Policy directly to any applicable Provider(s) listed above and rendering services following all terms, conditions and requirements of the governing Health and Welfare Plan. I understand under applicable governing law that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the provider of service, I under my protected rights pursuant to applicable state, federal or ERSIA law hereby instruct and direct my Insurance Company to provide specific SPD documentation stating such non-assign ability clause to myself and the applicable Provider, along with the regulatory guideline that allows for such non-assignability. Upon proof of specified non-assignability documentation, I then instruct that the insurer make out the check to me and mail it directly to the Provider and address listed on the submitted claim for the professional or medical expense benefits, and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered. I agree and understand that any funds received by my insurance company due for services rendered by any and all healthcare providers listed in this assignment of benefits will be immediately signed over and sent directly to such provider. Upon receipt of said check, I authorize Provider listed above to receive any such checks, endorse them for deposit only, and to deposit and apply all the proceeds toward payment due on my account. I authorize the release of any information pertinent to my case including medical records to any business associate, insurance company, adjuster, Plan Sponsor, governmental agency or attorney involved in this case or responsible for making sure all protected rights and entitled benefits are provided pursuant to the governing Plan, state and federal laws. I authorize all applicable Providers listed providing medical services or appointed business associates to be my personal representative, which allows them as my legally binding authorized representative to: (1) submit any and all claims and appeals when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information, appeals, remedies and protected disclosures from my Plan or insurance company, and (3) initiate formal complaints to any State or Federal agency that has jurisdiction over my insurer and/or plan benefits. Should the account be referred to an attorney or outside agency for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. I understand that all delinquent accounts bear interest or administrative fees at the legal rate. I also agree that any penalties or fines levied against my insurance company will be paid to Provider acting as my personal representative. I understand this assignment will remain in effect until revoked by me in writing.

I authorize all providers included in this agreement to provide medical care reasonable and at the standard of care as required by state law.
A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ _____

Signature of Patient/Responsible Party (if under age 18) ***Date***

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