ALBERT VEIN INSTITUTE
Colorado's Vein Specialist

# Patient Registration

**Please fill out completely**

Today's Date _____

## Patient Information

Last Name_____ First Name _____ MI_____

Gender _____ DOB ____/____/____ Age _____ SS# _____

Married Single Divorced Widowed (Circle One) Driver's License #_____

Address _____
City State Zip

Home Phone _____ Mobile_____ E-mail _____

Employer_____ Employer Phone_____

Primary Physician _____ Address _____ Phone_____

Referring Physician_____ Address _____ Phone_____

How did you hear about The Albert Vein Institute?
Referred to by my Doctor ☐ From a family member/friend ☐ Web ☐ Other _____

Is this a work related injury or illness? Y / N Is this an injury or illness related to an auto accident? Y / N

## Insurance

**FINANCIAL GUARANTOR** (POLICY HOLDER OR PERSON OTHER THAN PATIENT GUARANTEEING PAYMENT)

Last Name_____ First Name _____ MI_____

Gender _____ DOB ____/____/____ Age _____ SS# _____

Relationship to Patient _____ Driver's License #_____

Address _____
City State Zip

Home Phone _____ Mobile_____ E-mail _____

Employer_____ Employer Phone_____

**PRIMARY INSURANCE**

Insurance _____ Member/Policy #_____ Group # _____

Policy Holder's Name _____ Employer _____ Phone_____

**SECONDARY INSURANCE**

Insurance _____ Member/Policy #_____ Group # _____

Policy Holder's Name _____ Employer _____ Phone_____

**EMERGENCY CONTACT** (CLOSE FRIEND OR RELATIVE THAT WE CAN CONTACT IN AN EMERGENCY)

Name_____ Phone_____ Relationship _____

Self pay and previous balance amounts are due and payable at the time of service. Insurance co-payments are mandated by your insurance company and MUST be paid at each visit. Patients with insurance claims pending will be sent statements for full amount due until the account is satisfied. I agree that if the insurance company denies benefits for any reason, I am responsible for the full amount owed for services provided.

I request that payment of authorized insurance and Medicare benefits be made payable to Albert Vein Institute on my behalf for services furnished to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. In the event that my account is turned over to a collection agency, I agree to pay all reasonable costs of collection and understand that I may no longer be a patient at this office. I understand and agree to pay a returned check charge of $25.00 for each check that is returned for any reason. In case of default, I agree to pay any and all costs of collecting this account including, but not limited to, attorney fees and court costs.

I authorize the holder of medical information about me to release any and all information to Centers for Medicare or Tricare Services, its agents, my insurance carrier(s), or other entities as needed to determine these benefits or the benefits for my dependents or myself. If I have health insurance coverage under an HMO, I authorize Albert Vein Institute to release information concerning any diagnosis and treatment to my primary care or referring physician after each visit.

I have been made aware of the privacy policies of Albert Vein Institute and have received (or reviewed or been given the option to receive and review) a copy of the Notice of Privacy Practices.

SIGNATURE OF PATIENTS, INSURED OR GUARANTOR_____