PREMIER
Heart & Vein Care

PATIENT INFORMATION

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Address: _____ Sex: ____ M ____ F

City, State, Zip Code: _____ Social Security #: _____

Home Phone Number: _____ Is it OK to leave Message? ____ Y ____ N

Cellular Phone Number: _____ Is it OK to leave Message? ____ Y ____ N

The best number to reach you: ____ Home ____ Cell Email _____

May we put you on our mailing list? ____ How did you hear about us? _____

Marital Status: ____ Married ____ Single ____ Divorced ____ Widowed _____ Race _____ Ethnicity

Referring Physician: _____ Primary Care Physician: _____

PATIENT EMPLOYMENT INFORMATION

____ Employed ____ Retired ____ Unemployed ____ Self-Employed

Employer Name: _____

Employer Address: _____

City, State, Zip Code: _____

Employer Ph #: _____

EMERGENCY CONTACT

Name: _____

Address: _____

_____

Phone #: _____

Relationship: _____

PRIMARY INSURANCE

Ins Co. Name: _____

ID Number: _____

Group/Policy Number: _____

Subscriber Name: _____

Subscriber Phone #: _____

Subscriber Employer: _____

Subscriber Date of Birth: _____

Subscriber Social Security #: _____

SECONDARY INSURANCE

Ins. Co. Name: _____

ID Number: _____

Group/Policy Number: _____

Subscriber Name: _____

Subscriber Phone #: _____

Subscriber Employer: _____

Subscriber Date of Birth: _____

Subscriber Social Security #: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

(Please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor and/or Premier Heart and Vein Care and authorize Premier Heart and Vein Care to furnish information regarding my illness to my insurance carrier. I have been informed of HIPPA Patient Privacy Rules. **I understand that I am financially responsible for any amount not paid by my insurance company. I acknowledge receipt of the HIPPA Privacy Policy.**

_____ _____

Patient/Patient's Representative Signature Date

CONDITIONS OF SERVICE
FINANCIAL POLICY
HIPAA POLICY ACKNOWLEDGMENT

Thank you for choosing Premier Heart and Vein Care. This document represents our established *Conditions of Service* that will be used to resolve any issues or disputes pertaining to cardiac and vein care services rendered by the practice. We ask you to read, sign, and return this agreement prior to any treatment.

CONSENT TO TREATMENT: The patient identified below consents to diagnostic and therapeutic cardiac and vein care evaluations and treatment, which may be performed or assisted by Dr Kenneth Stevens and his staff. These evaluations and treatments may include, but are not limited to, initial evaluation or consultation, history, and physical examination, and periodic follow up. Cardiac assessments include electrocardiograms, and blood work. Vein assessments and treatments include lower extremity venous ultrasound study, infiltration of tumescent local anesthesia, radiofrequency ablation, ultrasound-guided sclerotherapy, Veinlite sclerotherapy, and/or conservative vein therapy. Appropriate referrals will be facilitated as well to optimize patient care as well for services unavailable within the practice.

PAYMENTS: Premier Heart and Vein Care participates with many insurance plans as a convenience to our patients. Your insurance company determines your co-payment and/or deductibles. Our contracts require that all medical facilities collect these fees, to ensure the insurance policy is enforced. **Please understand that payment of your bill is considered in part the responsibility of the patient.** Payment, according to the policies below, is due at the time of service. We accept cash, checks, Care Credit, Visa, American Express, and Master Card. "Returned Checks" will be charged a $50.00 fee. It is your responsibility to contact us as soon as you are aware that your check has been returned without payment. Also, if you write a dishonored check you will be required to pay via cash or credit card.

PATIENTS WITH INSURANCE: For us to correctly bill your insurance company we will need a copy of your health plan ID card and proper identification at the time of your visit. You are responsible for payment of these items not payable by your insurance plan including but not limited to deductibles, co-pays, co-insurances, and non-covered services. If your insurance requires prior authorization for treatment or procedure, we will be happy to assist you; however, it is the patient's responsibility to ensure authorization is obtained before we perform any procedure. For services deemed "not medically necessary" by your insurance plan you will be required to read and sign a Patient Responsibility Agreement with this Office each time you request those types of treatment. Co-payment is required to be paid at the time of your office visit according to our agreement with your health plan. Any "co-insurance" amount you owe for rendered services are due and payable upon receipt of our bill. Accounts not paid within sixty (60) days will be considered delinquent and must be paid prior to scheduling your next office visit.

PATIENTS WITHOUT INSURANCE: Payment in full is due at the time of service. If you are Premier Heart and Vein Care patient and you are unable to pay the entire balance at the time of service, we offer a payment option under our agreement with Care Credit, a patient payment finance company. We will not be able to perform any treatment or procedure without receipt of full payment at the time of your visit.

MEDICARE: Our office will submit your Medicare charges to Medicare and your secondary insurance if applicable. You are responsible for deductibles, co-pays and any non-covered services for which we have on file a signed Advanced Beneficiary Notice!

MISSED APPOINTMENTS: Office Visits, Follow-ups, and Ultrasound Testing: **Please notify this office at least 24 hours in advance of any cancellations.** If not notified you will be charged a $25.00 fee for an office visit, $50.00 fee for a scan or $150.00 for a procedure. There will be a **No-Show fee** for any patient that does not call in to cancel an appointment. The fees are the following: **$100.00 for a follow up appointment, $150.00 for a scan and $250.00 for a procedure**.

PERSONAL VALUABLES: It is understood and agreed that Premier Heart and Vein Care shall not be held liable for the loss, theft or damage to any personal property left behind in any dressing room, exam or treatment room including but not limited to cash, coin, checkbooks, jewelry, documents, eyeglasses, hearing aids or other personal property.

CONSENT TO PHOTOGRAPH/VIDEO TAPING/TEACHING: Premier Heart and Vein Care 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. There may be other Physicians and Technicians observing your procedure (with your permission) to enhance their medical education and training as we are a teaching facility.

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 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.

RELEASE OF INFORMATION: I authorize Premier Heart and Vein Care to release my insurance carrier(s) and its agents and/or my Medigap insurer any information needed to determine benefits or benefits payable to Premier Heart and Vein Care for related services.

DEFAULT: I understand that regardless of insurance coverage, that if after defaulting my account is placed in the hands of an attorney or collection agency for collection, the undersigned agrees to pay for any unpaid balance and all attorney and/or collection fees.

Thank you for taking the time to read and understand our Financial Policy. Our practice believes good communication is essential in our relationship with our patients. Please let us know if you have any questions or concerns before signing below. Your signature indicates that you have read this policy and understand and agree to its terms.

_____ I have read and agree to the Financial Policy and Release Information paragraphs stated above.
(INITIALS)

_____ I have been offered/given a copy of Premier Heart and Vein Care's HIPAA Policy and Patient's Rights and Responsibilities and I have been given the opportunity to ask questions.
(INITIALS)

_____	_____	_____
Signature	Print	Date

Medical Records Release

I hereby authorize Premier Heart and Vein Care to RELEASE or OBTAIN my medical record information as specified below

Patient Name: _____ Date of Birth: _____

Premier Heart and Vein Care may **RELEASE** copies of my medical records to:

_____
Physician/Institution Name

_____
Address

_____
City, State, Zip Code

_____
Fax Number

Premier Heart and Vein Care may **OBTAIN** copies of my medical records from:

_____
Physician/Institution Name

_____
Address

_____
City, State, Zip Code

_____
Fax Number

INFORMATION TO BE RELEASED: Please check all that apply.

☐ Office/Consult Notes

☐ Radiology/Imaging Studies (CT, MRI etc.)

☐ Lab Results

☐ Other: _____

MEDICAL RECORDS SHOULD BE SENT TO:

PREMIER HEARTAND VEINCARE

3231 S. Higuera St.
San Luis Obispo, CA. 93401

Phone: 805-540-3333
Fax: 805-540-3344

Information to be excluded from the release:

_____
(please specify information to be excluded)

This information will be used for the following purpose: Treatment, Payment (e.g. insurance co.) and Routine Healthcare Operations.

This authorization is valid for one year from the date of the authorization or until _____
(insert date here)

_____
Signature of patient or patient representative

_____
Date

_____
Printed name of patient or representative

_____
Relationship to patient