

Great Lakes Comprehensive Vein Specialists

Full Legal Name: _____ Nickname: _____

Birth Date: _____ Social Security #: _____ Male Female

Marital Status: S / D / M / W Spouse's Name: _____

Phone (Home): _____ (Cell): _____

Phone (Work): _____ Employer: _____

Home Address: _____

Street

City

State

Zip

If different than home address:

Mailing Address: _____

PO Box or Street

City

State

Zip

If you are residing in a *skilled nursing facility*, which one?

Emergency Contact (*Other than your spouse*):

Name: _____ Relationship: _____ Phone #: _____

• Primary Care Physician (Regular Doctor): _____

• Referring Physician: Same As Above / _____

• Pharmacy _____ Location: _____

INSURANCE INFORMATION (Your cards will be scanned)

Primary Insurance: _____

Is the insured/subscriber the patient? Yes No - Subscriber's Date of Birth: _____

Secondary Insurance: _____

Is the insured/subscriber the patient? Yes No - Subscriber's Date of Birth: _____

NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been offered a copy of this office's *Notice of Privacy Practices*.

RELEASE OF INFORMATION I authorize Great Lakes Comprehensive Vein Specialists to release and/or discuss information relevant to my care to the following individuals (information to your primary and referring physicians will automatically be sent):

Name/Relationship: _____ / _____

Name/Relationship: _____ / _____

MESSAGES I authorize all messages to be left for me as follows: (Select only one)

On phone #s listed above Via email: _____

Other: _____

FORM COMPLETED BY: (Printed Name) _____

Signature (Patient Or Legal Representative)

Date

~ ~ **OVER PLEASE** ~ ~

FINANCIAL AND INSURANCE POLICY

Thank you for choosing **Great Lakes Comprehensive Vein Specialists**. Please read and sign the following statement regarding our financial and insurance policies.

If you have health insurance, please understand that insurance is an agreement between you and your insurance carrier. **At all times, you are responsible for the full amount of your bill, regardless of the status of the insurance claim.**

If you do not have health insurance coverage, payment for the office visit, consultation, vascular ultrasound evaluation or procedure is expected the day the service is provided.

Great Lakes participates with Medicare, Blue Cross/Blue Shield, Blue Care Network, Priority Health and ASR/PhysiciansCare.

This office is currently not accepting new Medicaid patients.

You are responsible to:

- Verify with your insurance carrier that services performed or proposed by our office are covered under your individual plan. We suggest you contact the customer service telephone number listed on your insurance card prior to being seen in our office.
- Assist in obtaining any authorizations or referrals required by your insurance carrier.
- Pay our office for any deductible, co-payment or non-covered charges.

We will bill your insurance carrier as a courtesy to you and accept direct payment from your insurance company, if available. If you feel your insurance should have paid for a service that it denied, you should contact your insurance carrier for resolution.

We will mail a bill to you for the amount you owe us, which may be for a deductible, co-payment, co-insurance or non-covered charges. Insurance balances not paid within 60 days of the date of the service may become your responsibility. For questions regarding your bill, please call our office and we will be happy to assist you. We expect receipt of payment in full within 25 days after we mail a bill to you. We will send you up to two statements with your patient balance and then may turn all non-paid balances over to our collection agency. We are more than willing to work with you to resolve your balance; however, delinquent accounts will be referred to a professional agency and/or attorney for collections.

We accept cash, checks, money orders, Visa, Mastercard, Discover and American Express. If you need a payment plan in order to pay your balance, we offer CareCredit® services for your convenience.

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We require 24 hours advance notice to cancel an appointment without charge. Appointments cancelled without 24 hours notice may be subject to a \$25.00 cancellation fee which would be billed directly to you, not to your insurance carrier. Appointments will not be rescheduled until all outstanding fee(s) have been paid.

A \$25.00 service charge will be assessed for any returned check.

Patient/Responsible Party Signature: _____ Date: _____

If you have Medicare Part B, Please Sign Below Medicare One-Time Authorization

Print Patient name: _____ Medicare #: *(See Copy Of Card)*

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Great Lakes Comprehensive Vein Specialists for any services furnished to me by any of their representatives. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient/Responsible Party Signature: _____ Date: _____