

# PATIENT REGISTRATION FORM

Today's Date      /      /     

PATIENT INFORMATION					
Patient Name Last                      First                      Middle			<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms		Marital Status (circle) Single/ Married / Divorced /Sep/ Widow
Is this your legal name? <input type="checkbox"/> YES <input type="checkbox"/> NO		If not, what is your legal name?		Birthdate / /	Age                      Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> T
Street or Mailing Address (circle one)                      City                      State                      Zip Code			Home Phone Number (      )		
Cell Phone Number (      )		E-Mail Address		Social Security	
Occupation		Employer		Employer Phone Number	
<b>Employment Status:</b> <input type="checkbox"/> 1 – Full-Time <input type="checkbox"/> 2 – Part-Time <input type="checkbox"/> 3 – Not Employed <input type="checkbox"/> 4 – Self-Employed <input type="checkbox"/> 5 – Retired <input type="checkbox"/> 6 – Active Military <b>Student Status:</b> <input type="checkbox"/> F – Full-Time Student <input type="checkbox"/> P – Part-Time Student <input type="checkbox"/> N – Not a Student					
<b>Race:</b> <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Other <input type="checkbox"/> Declined <b>Ethnicity:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Declined <b>Language:</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Indian <input type="checkbox"/> Japanese <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Russian <input type="checkbox"/> Other _____					

Pharmacy:		Do you have a living will? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Referred By ( Please check one box)			
<input type="checkbox"/> Dr. _____ <input type="checkbox"/> Insurance <input type="checkbox"/> Hospital <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other _____			
Other Family Members Seen Here			
PCP Name		Phone #	

RESPONSIBLE PARTY INFORMATION			
Responsible Party: <input type="checkbox"/> Another Patient <input type="checkbox"/> Guarantor <input type="checkbox"/> Self			<input type="checkbox"/> Check here if information is same as patient
Name		Address	Home Phone Number
Birth Date / /		E-Mail Address	(      )
Occupation	Employer	Employer Address	Employer Phone Number (      )

INSURANCE INFORMATION					
Is this visit for one of the following? <input type="checkbox"/> WORKERS COMPENSATION (WC) <input type="checkbox"/> OCCUPATIONAL MEDICINE (OM) <input type="checkbox"/> MOTOR VEHICLE ACCIDENT (MVA) <input type="checkbox"/> ACCIDENT DATE _____					
Does the patient have healthcare coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO			Insurance Name		
Name of Insured	Social Security Number	Birth Date / /	Effective Date / /	Group ID	Subscriber ID (Policy Number)
Patient Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					
Name of Secondary Insurance		Name of Insured	Date of Birth / /	Group ID	Subscriber ID (Policy Number)
Patient Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					

EMERGENCY CONTACT			
Name (Last, First)		Relationship to Patient	Home Phone Number (      )
			Other Phone Number (      )

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

\_\_\_\_\_  
Patient/ Guardian Signature

\_\_\_\_\_  
Date

# HighPoint Vascular and Vein

---

## FINANCIAL POLICY

Thank you for choosing us as your health care provider. The following is our Financial Policy. Our main concern is you receive the proper and optimal treatment needed to restore and maintain your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our staff.

1. Your insurance will be filed as a courtesy to you; however you are responsible for the entire bill. **All co-payments, unmet deductibles and other patient responsible services must be paid at the time of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**
1. In the event your insurance company does not pay the claim within a reasonable amount of time (45 – 60 days) then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.
2. If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.
3. Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.
4. **PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUESTS:** I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I request that payment of assignment benefits be made on my behalf.
5. **FINANCIAL AGREEMENT:** The undersigned in consideration of the services to be rendered to the patient is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided. The undersigned agrees to be responsible for charges not covered by insurance. It is understood the obligation to pay the practice may not be deferred for any reason, including pending legal actions against other parties to recover medical costs.
6. **CONSENT FOR ROUTINE TREATMENT** I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s) at Portland Family Wellness. I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any hospital or emergency medical personnel, physician, or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination at Portland Family Wellness. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me.
7. **ADVANCE DIRECTIVE:**  I have executed an Advance Directive  I have not executed an Advance Directive

I have read and fully understand the Financial Policy and have been given the opportunity to ask questions.

\_\_\_\_\_  
Signature of patient, legal representative for health care services

\_\_\_\_\_  
Date

If other than patient:

\_\_\_\_\_  
Relationship of Representative

\_\_\_\_\_  
Reason individual is unable to sign, i.e. minor or legally incompetent



**HIPAA ACKNOWLEDGEMENT, PATIENT CONSENT AND FINANCIAL POLICY**

**I. CONSENT FOR TREATMENT:** I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s). I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any medical personnel or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

**II. NOTICE OF PRIVACY PRACTICES:** Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change; if we change our notice, you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office. The Clinic provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

\_\_\_\_\_  
Patient  
Initials

- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the notice of privacy practices.

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the individuals listed below. Please note that this does not allow these individuals to obtain copies of my medical records without a complete and valid authorization from me.

NAME	RELATIONSHIP	CONTACT NUMBER

**III. ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION:** I authorize Clinic to provide a copy of the medical record of my treatment, and a summary of care record to my

primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility(ies) to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence,, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this episode of care, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Clinic, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

**IV. PARTICIPATION IN HEALTH INFORMATION EXCHANGE(S):** Federal and state laws may permit this Clinic to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I hereby authorize Clinic to provide a copy of my medical record or portions thereof to any health information exchange or network with which Clinic participates and to any other participant in such health information exchange or network for purposes of treatment, payment, health care operations, and the purposes discussed above, and in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or networks with which Clinic participates may be found in the Notice of Privacy Practices, which is available on the Clinic website, and this list may be updated from time to time if and when Clinic participates with new health information exchanges or networks. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.

**V. EMAIL AND TEXT COMMUNICATIONS:** If at any time I provide an email or text address at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the Clinic to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer-assisted technology, or by electronic mail, text messaging, or by any other form of electronic communication from Clinic, its affiliates, contractors, servicers, Clinical providers, attorneys, or agents, including collection agencies. Practice may contact me via email and/or text messaging to remind me of an appointment, to obtain feedback on my experience with the Practice's healthcare team, and to provide general health reminders/information.

**VI. FINANCIAL POLICY:** The undersigned, in consideration of the services to be rendered to the patient, is obligated to pay the medical practice in accordance with its regular rates and terms,

and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided.

- The Clinic will file your insurance as a courtesy to you; however, you are responsible for the entire bill. All co-payments, unmet deductibles, and other patient-responsible services must be paid at the time of the visit. If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. If you do not have insurance, payment in full will be expected at the time of the visit.
- In the event your insurance company does not pay the claim within a reasonable amount of time (45-60 days), then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.
- If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.
- Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.

**PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUESTS:**  
If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate State agency for payment of a Medicaid claim. I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I request that payment of assignment benefits be made on my behalf.  
I acknowledge receipt of the HIPAA Acknowledgement and Consent Form. I further acknowledge that I have been given the opportunity to ask questions.

\_\_\_\_\_  
Printed Name of Patient or Representative

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

Relationship to Patient (if other than patient) \_\_\_\_\_

**CLINIC STAFF USE ONLY**

Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known:  
\_\_\_\_\_

\_\_\_\_\_  
Witness (Staff) Signature

\_\_\_\_\_  
Witness (Staff) Printed Name

Date: \_\_\_\_\_

# HighPoint Vascular and Vein

## HIPAA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under law. You have the right to review our Notice before signing this acknowledgement. The terms of our Notice may change; if we change our notice you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office.

The practice provides this form to comply with the Health Information Portability and Accountability Act of 1996. (HIPAA)

The patient understands that:

- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the notice of privacy practices.

I acknowledge receipt of the Notice of Privacy Practices.

\_\_\_\_\_  
Printed Name of Patient or Representative

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Relationship to Patient (if other than patient) \_\_\_\_\_

Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known:

Witness \_\_\_\_\_

Printed Name- Practice Representative

Witness \_\_\_\_\_

Signature

\_\_\_\_\_  
Date



# HIGHPOINT

VASCULAR & VEIN ASSOCIATES

## HIGHPOINT HEALTH PARTNERS

### CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. We request timely notification to our practice to enable another patient, waiting for an appointment, to be scheduled. Our goal is to provide the highest quality of care and service to you and other patients. Please review our policy below:

- **Office Appointment**
  - 24 hours notice is required to be timely
  - \$25 fee for a "No-Show" or Cancellation without timely notice

The definition of a "No Show" is an appointment for which the patient does not attend and has not provided a call to cancel the office appointment or procedure appointment. Patients who incur a "No-Show" or untimely Cancellation two (2) or more times in a 12 month period, will be required to obtain a new referral from their Primary Care Physician.

No Show/Untimely Cancellation fees are billed directly to the patient after the date of the missed appointment. These fees must be paid in full before the patient's next appointment. Unfortunately, insurance does not cover this fee for the patient.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived with management approval.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Please note that it is the patient's responsibility to call and reschedule a follow-up appointment in the event of a No Show or Cancellation to ensure that you are able to obtain proper care.

Questions about cancellation and no show fees should be directed to the Billing Department (615-328-5253). Please sign that you have read, understand and agree to this Cancellation and No show Policy.

Patient Name (Please Print) \_\_\_\_\_

Signature of Patient or Patient Representative \_\_\_\_\_

Date of birth \_\_\_\_\_