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Return Visit Form

Demographics

Name: _____

DOB: _____/_____/_____ **Age :** _____

Change in address or phone? ☐ **Yes** ☐ **No** **If yes, please update the information below.**

Address: _____

City/State/Zip: _____ **Email Address:** _____

Home Phone: ( ) _____-_____ **Cell Phone: ( ) _____-_____**

Employment Information

☐ **Full time** ☐ **Part time** ☐ **Retired**
☐ **Unemployed** ☐ **Other:** _____

Employer Name:
_____

Work Ph : ( ) _____-_____

Emergency Contacts

Name/Relationship/Ph #

_____ _____ ( )_____

_____ _____ ( )_____

_____ _____ ( )_____

PLEASE HAVE YOUR PHOTO ID & INSURANCE CARDS AVAILABLE FOR COPYING AT EACH VISIT. ALL COPAYS ARE DUE AT THE TIME OF THE SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

Responsible Party

Name: _____
DOB: _____ **SS#**_____
Address:_____
City/State/Zip: _____
Ph: ( ) _____-_____

Insurance Information

Primary Insurance: _____

Secondary Insurance: _____

Tertiary: _____

Patient Insurance/Financial Authorization

I, the undersigned, authorize payment of medical services to Advanced Vascular and Vein Center for any services furnished to me by the provider/s. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for ANY professional services rendered. I also authorize you to release to my insurance company information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Signature: _____ **Date:** _____

Since your last visit here:

Have you developed any NEW medical conditions? ☐ Yes ☐ No
If yes, please explain:
_____

Have you had any surgeries? ☐ Yes ☐ No
If yes, please list: _____ _____

Are you taking any NEW medications? ☐ Yes ☐ No
If yes, please list:_____ _____ _____
_____ _____ _____

Have you developed any NEW allergies? ☐ Yes ☐ No
If yes, please list: _____ _____ _____

Have you started or stopped smoking? ☐ Yes ☐ No ☐N/A Please specify: _____

Have you had any NEW symptoms? ☐ Yes ☐ No
If yes, please explain:
_____

Authorized Release

I give permission to the following individual/s to have access to my medical information.
Name/Relationship _____/_____

Name/Relationship _____/_____

Name/Relationship _____/_____

I can change this information at any time by notifying Advanced Vascular and Vein Center, LLC, in writing of the changes.
Signature: _____ **Date:** _____

Consent for Treatment

I, knowing that I have a condition requiring diagnosis, treatment, or related medical care do hereby consent to such care, medical examinations, operations, procedures, therapy sessions, photographs, and/or treatment by my attending physician, their assistants, or designees as may be necessary in their professional judgment. I further acknowledge that no guarantees have been made to me as to the results of such care, medical examinations, operations, procedures, therapy sessions and/or treatments.

Signature: _____ **Date:** _____

Health Insurance Portability and Accountability Act (HIPAA) Acknowledgment

By signing below, I acknowledge that I have received the Notice of Privacy Practices of Advanced Vascular and Vein Center, which explains it legal duties and privacy practices with respect to my protected health information.

Signature: _____ **Date:** _____