Vascular Diagnostic Center of Oak Ridge, Inc.

Welcome to our office. We are committed to providing high-quality testing with quick results in a compassionate atmosphere. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent.

PATIENT INFORMATION Date: _____

Name: _____ Date of Birth _____ Age: _____ Sex: _____
Social Security Number: _____ Email: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Employer's Name: _____ Occupation: _____
Employer's Address: _____ City: _____ State: _____ Zip: _____
Spouse's Name: _____ Employer: _____

INSURANCE COVERAGE:

Primary Coverage
Ins. Company Name: _____
ID#: _____ Group#: _____
Insured Name: _____ DOB: _____
Insured Social Security #: _____

Secondary Coverage
Ins. Company Name: _____
ID#: _____ Group#: _____
Insured Name: _____ DOB: _____
Insured Social Security #: _____

NOTICE OF PRIVACY PRACTICES:
I have been provided an opportunity to review the Notice of Privacy Practices (HIPPA).

Request a Copy ____Yes ____No Signature: _____

I wish to be contacted in the following manner (*check all that apply*):
_____ Home Phone ____Cell Phone ____ Letter (written communication) ____ Text

NOTIFY IN CASE OF EMERGENCY

Name: _____ Relationship: _____ Phone #: _____
Name: _____ Relationship: _____ Phone #: _____

RECIPIENT(s) of Health Information

I authorize the release of my health information to:
Name: _____ Relationship: _____ Phone#: _____
Name: _____ Relationship: _____ Phone#: _____
Name: _____ Relationship: _____ Phone#: _____

Referred to our office by: _____ Address: _____
Primary Care Physician: _____ Address: _____

Other than your referring physician, what other physician(s) would you like results sent to:
Physician: _____ Address: _____
Physician: _____ Address: _____

Vascular Diagnostic Center of Oak Ridge, Inc.

FINANCIAL POLICY

RESPONSIBILITY FOR PAYMENT: I understand that I, personally, am financially responsible to Vascular Diagnostic Center of Oak Ridge, Inc. for charges not covered by the assignment of insurance benefits and all non-covered charges.

PAYMENT is expected at the time of your visit. We accept cash, check, or any major credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, charges not covered by your insurance company. If you do not carry insurance, payment in full or a payment plan needs to be set up at the time of your visit. For patients with insurance, payments collected are an estimate based on the benefits provided to us from your insurance company. Once claims have processed, if there is any remaining balance, you will receive a statement in the mail.

SELF PAY PATIENTS WHO ARE NOT INSURED: Self-pay patients will be identified when they make the initial contact with the office and will be defined as a patient who has no health insurance coverage of any kind, including federal and state health care programs such as Medicare and Medicaid or other insurance coverage AND has no other responsible party covering the expenses associated with the care received from our office. Self-pay patients will be required to pay a $50.00 deposit for their visit at time of check-in and set up a payment plan.

RETURNED CHECKS: Will incur a $35.00 service fee.

AUTHORIZATION & ASSIGNMENT OF INSURANCE BENEFITS: I hereby certify that Vascular Diagnostic Center of Oak Ridge, Inc. provide information to insurance carriers concerning my illness and treatments, and I hereby assign Vascular Diagnostic Center of Oak Ridge, Inc. all payments otherwise payable to me for Vascular Diagnostic Center of Oak Ridge, Inc.

RELEASE INFORMATION: I hereby authorize and direct Vascular Diagnostic Center of Oak Ridge, Inc. to release (verbally or in writing) confidential medial information to any person, entity, government agencies, carries, or others who are utilizing reviews, transfer of medical, care, and follow-up purposes. I understand that a copy of this document may used with same effectiveness as the original.

NO SHOW POLICY: We understand that situations arise in which you must cancel your appointment. It is required that if you must cancel your appointment, you provide more than 24-hour notice. There will be minimal exceptions. Patients who do not show up nor provide more than 24-hour notice are considered NO SHOW. The patient(s) account will be charged $30.00. Please initial _____

I have read and understand the financial policies, and I agree to be bound by its terms for as long as I am a patient here at Vascular Diagnostic Center of Oak Ridge, Inc. .

Signature:_____ Date:_____

Print Name:_____

If completed by someone other than patient:

Name:_____Relationship:_____

Signature: _____