VEIN THERAPIES
of Chattanooga, PLLC

PATIENT INFORMATION

Last Name: ________________________________ First:____________________________ MI:___________

Sex: _________ Marital status: _______________

Street Address: ____

City: ____ State: __________ Zip Code: _____________

Home Phone: __________________________________ Cell Phone: _________________________________

Social Security Number: ____________________________ Date of Birth: (mm/dd/yy) _________________

Employer: ____ Work Phone: _________________________

Spouse/Guardian Information:

Spouse/Guardian Name: _____________________________ Date of Birth (mm/dd/yy) ________________

SSN: _______________________________

Employer:____ Work Phone:____________________________

Emergency Contact:

Name: ____ Phone: ________________________________

Relationship to Patient: ________________________________

Insurance:

Primary: ___________________________ Policy No.______________________ Group No: ______________

Secondary: _________________________ Policy No.______________________ Group No: ______________

We request your permission to send a brief report of the services provided to our patients' referring, primary care and/or OB/GYN physicians.

Referring Physician:

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Primary Care Physician:

____

OB/GYN:

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Release of Information, insurance benefits determinations, and payment:

I hereby authorize and direct Vein Therapies of Chattanooga, PLLC., when and as requested, to disclose any or all pertinent aspects of information in my medical records to my physicians listed above and any persons, corporation, or agency which is or may be liable for all or part of this office's services, including, but not limited to, insurance companies, health maintenance organizations, preferred provider organizations, or its intermediaries or carriers when so requested by the carrier.

I also authorize and direct the named insurer to pay directly to Vein Therapies of Chattanooga, PLLC any or all benefits up to the amount of my bill accruing in connection to my treatment.

I understand I am financially responsible to pay Vein Therapies of Chattanooga, PLLC for services Dr. Coates and ancillary personnel provide. If after my insurance is filed, and should it be determined that this is not a covered service, I understand that I am still financially responsible for all services rendered. **Initial here_______**

As our patient, under the Health Information Portability and Accountability Act of 1996 (HIPAA), the federal privacy act, you have specific privacy rights. We are required by law to attempt to obtain acknowledgement of receipt of "Patient Notice of Privacy Rights".

We are required to have a notice available for our patients detailing how medical information about you may be used and disclosed and how you can get access to this information. You have a right to review our notice before signing this acknowledgement. A copy of our "Patient Notice of Privacy Rights" is posted in our waiting room and is made available from the receptionist to each patient. The terms of our notice may change. Any change in our notice will be posted in our waiting room.

I acknowledge the receipt of a copy of the "Notice of Privacy Practices" from Vein Therapies of Chattanooga, PLLC. **Initial here_______**

How should we contact you: (Please circle)

1. We (may / may not) leave a detailed message on your answering machine.
2. We (may / may not) leave a detailed message with someone at home.
3. We (may / may not) call you at work.

How did you hear about Vein Therapies of Chattanooga, PLLC? Please check all that apply:

☐ **MD referral** ☐ **Web site** ☐ **Newspaper** ☐ **Magazine** ☐ **Friend or Family** ☐ **TV**
☐ **Radio** ☐ **Other**

Patient/Guardian Signature:

________________________________**Date:**__________________