BUNKER VEIN & imaging center

Leading-edge care. Uncommon commitment. Beautiful results.

PATIENT REGISTRATION

Please fill out completely

Name (Last) _____ (First)_____ (MI) _____

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ E-Mail _____

Sex ____ DOB _____ Age ____ SSN _____ Marital Status _____

Employer: _____Job Title:_____ Phone:_____

Employer Address:_____
Street City State Zip

Primary Care Physician _____Address_____Phone #:_____

Doctors Referral (Name & Phone of Referring Physician):_____

How did you hear about us?_____ Driver's License / ID # _____

Primary Insurance Information

Insurance _____ Member/Policy # _____Group #_____

Policy Holder's Name _____ Employer _____ Phone_____

Secondary Insurance Information

Insurance _____ Member/Policy # _____Group #_____

Policy Holder's Name _____ Employer _____ Phone _____

Financial Guarantor Information (Policy holder or person other than patient guaranteeing payment. If Self-Leave Blank)

Name (Last) _____ (First) _____ (MI) _____

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ E-Mail _____

DOB _____ Age _____ SSN _____ Relationship to Patient _____

Employer _____ Phone _____

Emergency Contact (Close friend or relative that we can contact in an emergency)

Name _____ Phone _____ Relationship_____

HIPAA Choices:

Were you offered an opportunity to review HIPAA Notice? Yes___ No___ Allow Voice Msg? Yes_____ No_____

Allow Calls to Home? Yes___ No_____ With whom may we leave a message?_____

Allow Postal Mail? Yes_____ No_____ Allow SMS (text message?) Yes _____ No_____

Allow Email? Yes_____ No_____ Allow Calls to Cell? Yes____ No_____

Self-pay and previous balance amounts are due and payable at the time of service. Insurance co-payments are mandated by your insurance company and MUST be paid at each visit. Patients with insurance claims pending will be sent statements for the full amount due until the account is satisfied. I agree that if the insurance company denies benefits for any reason, I am responsible for the full amount owed for services provided.

I request that payment of authorized insurance and Medicare benefits be made payable to the above practice on my behalf for services furnished to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. In the event that my account is turned over to a collection agency, I agree to pay all reasonable costs of collection and understand that I may no longer be a patient at this office. I understand and agree to pay a returned check charge of $25.00 for each check that is returned for any reason.

I authorize the holder of medical information about me to release any and all information to Austin Imaging & Vein Center, its agents, my insurance carrier(s), or other entities as needed to determine these benefits or the benefits for my dependents or myself. If I have health insurance coverage under an HMO, I authorize the practice to release information concerning my diagnosis and treatment to my primary care or referring physician after each visit.

I have been made aware of the privacy policies of the practice and have received (or reviewed or been given the option to receive and review) a copy of the Notice of Privacy Practices.

SIGNATURE OF PATIENT OR GUARANTOR _____ DATE _____

HIPAA PATIENT CONSENT FORM

I understand that I have certain Rights to privacy regarding my protected health information. These rights are given to me under the Health Information Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize Austin Imaging &Vein Center to use and disclose my protected health information (PHI) to carry out the following:

• Treatment (including direct and indirect treatment by other healthcare providers involved in my treatment)
• Obtaining payment from third party payers (e.g. my insurance company)
• The day-to-day healthcare operations of Vein Healthcare Center
• I have also been informed of, and given the right to review a secure copy of the Vein Healthcare Center Privacy Statement, which contain a more complete description of the uses and disclosures of my PHI and my rights under HIPAA. I understand that Vein Healthcare Center reserves the right to change the terms of this notice at anytime and that I may contact Vein Healthcare Center at any time to obtain the most current copy of this notice.
I understand that I may revoke this consent at anytime through proper notification. However, any use or disclosure that occurred prior to the revocation date is not affected.

_____ _____
Patient Signature Date

APPOINTMENT CANCELLATION POLICY

I have read and agree to the Cancellation Policy of Vein Healthcare Center that states I may be assessed a fee, if I do not give proper notice of cancellation of an appointment or procedure.

_____ _____
Patient Signature Date

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Authorization for Disclosure of Health Information

Patient Name: _____ Previous Name:_____
Date of Birth: _____ Phone:_____ SSN: _____
Address: _____
City: _____ State: _____ Zip:_____

I authorize the use or disclosure of the above named individual's health information as described below.
The following individual or organization is authorized to make the disclosure:

Primary Care Physician:
Address:
City, State, Zip:
Telephone #:_____ Fax #: _____

This request and authorization applies to:
_____Healthcare information related to the following treatment, condition, or dates:_____
_____
_____ All healthcare information
_____ Other: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual or organization.

Stephen R. Bunker, MD
2712 Bee Caves Rd. Suite #122
Austin, TX 78746
Tel: 512-726-0599 Fax: 1-800-308-9876

For the purpose of:

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: .

If I fail to specify an expiration date, event or condition, this authorization will expire in sixty days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact:

Stacia L. Ashmore
Privacy Officer for Vein Healthcare Center:

Signature of Patient or Legal Representative

_____

Date:_____

Signature of Witness

_____

Date:_____

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC – 3701.243) and federal law 42 CFR, part II.