PATIENT REGISTRATION FORM

OREGON VASCULAR AND VEIN INSTITUTE, LLC

Patient Information

Name: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Guarantor: _____ Relationship to Patient: _____

Social Security Number: _____ Email: _____

Marital Status (Circle one): ☐ Married ☐ Single ☐ Divorced
☐ Widow ☐ Partner ☐ Other _____

Race: _____ Ethnicity: _____ Primary Language: _____

Address: _____
(Street) (City/State/Zip)

Home Phone: (_____) _____ Cell: (_____) _____ Work: (_____)_____

Okay to leave medical information on home voicemail? ☐ Yes ☐ No
Okay to leave medical information on cell voicemail? ☐ Yes ☐ No
Okay to leave medical information on work voicemail? ☐ Yes ☐ No
Okay to send text reminders for upcoming appointments? ☐ Yes ☐ No

Preferred Pharmacy: _____ Location: _____

Primary Insurance: _____ Secondary Insurance: _____

Primary Care Provider and Location: _____

Release of Information Consent

I authorize OREGON VASCULAR AND VEIN INSTITUTE, LLC to discuss **ANY** information regarding my care with the below mentioned persons:

Name: _____ Relationship: _____

Primary Contact Number:_____ Secondary Contact Number:_____

Name: _____ Relationship: _____

Primary Contact Number:_____ Secondary Contact Number:_____

Do you have an Advanced Directive? ☐ Yes ☐ No
Do you have a Power of Attorney? ☐ Yes ☐ No

By signing below I am acknowledging the above information to be accurate. I understand that in order to revoke my consent to share my medical information with the above individuals, I need to do so in writing.

Name (Please print): _____ Date: _____

Signature: _____

FIRST NAME **LAST NAME** **DATE OF BIRTH**

1. **ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY:**
I hereby assign and authorize payment directly to Oregon Vascular and Vein Institute, LLC (Facility), and to any facility-based physician, all insurance benefits, sick benefits, injury benefits due because of liability of a third-party, or proceeds of all claims resulting from the liability of a third party, payable by any party, organization, et cetera, to or for the patient unless the account for this Facility, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient services. If eligible for Medicare, I will request Medicare services and benefits in a timely fashion so that Facility may submit remittance for services provided. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand that I am responsible for all charges not covered by my insurance company.

I understand that I am obligated to pay the account of the Facility in full and in accordance with the regular rates and terms of the Facility. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor over-payments to the above Facility may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment. I consent for the Facility to appeal on my behalf any denial for reimbursement, coverage, or payment for services or care provided to me by the Facility.

2. **PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING):**
I have been made aware and understand that the Facility medical practice primarily uses an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give consent to my providers to see this protected health information. I have been provided the Electronic Prescribing Notice included in the Notice of Privacy Practices.

3. **NOTICE OF PRIVACY PRACTICES:**
As required, pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Facility's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization, laboratory, imaging results and outpatient treatment at the Facility, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

4. **GENERAL CONSENT FOR TESTS, TREATMENT, AND SERVICES:**
I agree and understand that all health care providers including attending physicians, fellows, residents, physician assistants and nurse practitioners involved in my care in any way are responsible and liable for their own acts and omissions, and the Facility/practice is not responsible or liable for the acts or omissions of the aforementioned. Services may be performed by independent contractors who are not employed by the Facility. I am aware that the practice of medicine is not an exact science and further understand that no guarantee has been or can be made as to the results of the treatments, care or examinations at the Facility. I have furthermore, been given the opportunity to have my questions answered satisfactorily and understand the risks of procedures and/or treatments recommended to me.
I have been informed of the treatment procedures considered necessary for me and that the treatments/procedures will be directed by a physician and may be performed by such physician and/or one or more additional physicians, physician assistant, fellows, residents and employees of the Facility. I understand that one or more physicians, physician assistants, fellows and residents at the Facility may treat me or participate in my treatment. I understand that no guarantee or assurance has been made regarding (1) which physicians and/or physician assistant, nurse practitioner fellows or residents will treat me or participate in my treatment and/or (2) the results that may be obtained from treatment.

Patient Label

5. CONSENT TO PHOTO/VIDEO :

_____ *patient initials*

I consent to the photographing or videotaping, including appropriate portions of my body, for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

6. CONSENT TO PHOTOGRAPH AT THE TIME OF REGISTRATION:

○ Yes ◉ No I, or my authorized legal representative, hereby give consent to the medical practice to take my photograph at the time of registration. I understand this photograph will be stored in the medical practice's ambulatory medical record electronically as my photo identification.

7. EMAIL:

◉ Yes ○ No I hereby consent to provide my e-mail address, so that representatives from the Facility can e-mail information to me about health education or disease prevention and up-to-date information about the Facility, its affiliated physicians, and our services. I understand I will be able to change my preference at any time.

8. IMAGING SERVICES:

☐ Please check this box to allow the facility's Imaging Services to share your images with affiliated facilities, when requested, for continuing medical treatment.

9. CELL PHONES:

○ Yes ○ No I hereby consent to provide my telephone number(s), including my wireless telephone number(s), so that representatives from the Facility, its successors or assigns can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by texting, or by emailing, regarding any matter, including but not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time.

10. NO SHOW POLICY:

A "No-Show" is a patient who does not show up (in-person or via televideo) for a scheduled appointment. The following will also be considered a "No Show" appointment: Any appointment that is rescheduled with less than 24 hours notice OR showing up more than 30 minutes late for an appointment.

There will be a $50 charge for any No-Show appointment. This must be paid prior to rescheduling future appointments. After 3 No-Shows in a 12-month time frame you will no longer be permitted to schedule appointments with Oregon Vascular and Vein Institute and the Clinic will transfer you records to an alternative vascular specialist of your choosing. Oregon Vascular and Vein Institute at its discretion may make exceptions to this policy based on individual merit of missed appointments.

This policy has been developed so that we can provide the best possible care to the patients we serve as well as out of respect to our staff and providers time. Not showing up for appointments makes it difficult on others who maybe waiting to be seen in addition to being financially costly to the practice. While we understand you may need to reschedule your appointment due to an emergency or unforeseeable circumstance, we ask that you give us at least 24 hour's notice so that we may accommodate others in need.

The undersigned certifies that s/he has read the foregoing, understands it, accepts its terms, has received a copy of it and is the patient or is duly authorized by the patient as their agent to execute the above.

Patient's Signature or Legal Representative				Date	Time
					AM
Relationship to Patient			Interpreter, if Utilized	Date	Time
					AM
Witness Signature	Date	Time	If Telephone Consent, Second Witness Signature	Date	Time
					AM

Patient Label

SUBMIT FORM