# Fairing[illegible]ardiovascular & Wellness Ce[illegible]
## The Vein Treatment Center

1103 Fairington Drive
Sidney, OH 45365
937-497-1200

4960 S. County Rd 25A
Tipp City, OH 45371
937-667-2100

*Welcome to our office*

To serve you in an efficient manner, please complete the following information. All information will be kept confidential.

Today's Date_____ Family Physician(First & Last Name)_____

Referred To Our Office By_____ Reason For Visit_____

Patient's Name_____ Birthdate_____
(Last) (First) (Middle)

Address_____ City_____ Zip_____

Home Phone#_____ Cell Phone#_____ Employer_____ Work #_____

Social Security # _____ Marital Status_____

Mother's Maiden Name_____ Patient Birth City_____

Name of Spouse or Legal Guardian_____ Phone #_____

Address_____ City_____ Zip_____

Emergency Contact_____ Relationship_____ Phone #_____

As a service to our patients, we will file your insurance claim; your insurance will only pay for service considered medically necessary. We will wait 45 days on claims submitted to your insurance. If after 45 days we have not received payment from your insurance carrier, you will be billed the balance. It is therefore in your best interest to call the insurance carrier and "hurry along the process". **You are responsible for your deductible and any amounts not covered by your insurance.**

### INSURANCE #1

Primary Insurance Carrier _____ Policy #_____
(Private, Medicare or Medicaid)

Insured Name_____ Birthdate_____ SS#_____
(If Not Yourself)

Employer_____ Phone #_____

### INSURANCE #2

Secondary Insurance Carrier_____ Policy # _____

Insured Name_____ Birthdate_____ SS#_____
(If Not Yourself)

Employer_____ Phone #_____

I understand I am financially responsible for all charges rendered medical services, including the balance remaining after payment of possible insurance benefits, and any other incurred charges. I authorize the release of any medical information necessary to process my medical claims. I authorize payment of medical benefits to the above named provider for professional services rendered.

Signed_____ Date_____

*Fairington Cardiovascular*
*And*
*Wellness Center*
*The Vein Treatment Center*

Dear Patient,

Due to all the changing regulations and new restrictions that are being implemented by HIPAA, it is necessary to ask you these questions. These new rules are for your protection and this information will help us better serving you, while safeguarding your personal health information. We may ask you and your family certain questions to verify identification, thank you for your help.

***PATIENT QUESTIONAIRE***

1. Please list the family members or other persons, if any, whom we may inform about your general medical health or in case of an emergency. This information may include your diagnosis' (s), plan of treatment and medication use. Please list this (these) persons full name, relationship and phone number if possible. You may choose not to list anyone.

| *NAME* | *RELATIONSHIP* | *PHONE #* |
|---|---|---|
| | | |
| | | |
| | | |

2. Please list the names of those persons you would allow us to release sample Medications, prescriptions, lab copies, or other private health information in person on your behalf.

| NAME | RELATIONSHIP |
|---|---|
| | |
| | |
| | |

3. To help us identify you during a phone call, please provide your birth date; month, day, year___/___/____ and last four digits of your social security number_____.

4. What is your phone number?

_____

5. Is there another phone number other than your home phone where you want to receive calls about your appointments, lab or x-ray results, medication changes, or other health care information?

***Please be advised a cell phone is not a secure and private line. Information Conveyed via cell phone may be overheard.*

Phone#_____ Special Comments_____

6. Do we have your permission to leave confidential messages, such as medicine Changes, appointment reminders, and lab results on your voice mail or answering machine? This list is not inclusive of all confidential information that may be involved. Please mark only one.

*YES*_____ *NO*_____

7. Please indicate if all correspondence from our office (other than billing statement) Should be sent to you marked confidential and in a sealed envelope. ***PLEASE MARK ONE.***

*YES*_____ *NO*_____

8. Please indicate if all correspondence, (lab, test results, appointments reminders, etc.) to be sent if other than your home address. Full address including city, state and zip code.

_____

9. Please print the address of where you would want your billing statement to be If other than your home.

_____

***I have received a copy of the Notice of Privacy Policy for this office. I understand as a patient I have rights and have been informed.***

_____ _____

Patient or Guardian Signature Date

Fairington Cardiovascular & Wellness Center
Advanced Cardiovascular Services

1103 Fairington Drive
Sidney, Ohio 45365

Phone 937-497-1200
Fax 937-497-7013

*ALL **MEDICARE** PATIENTS MUST FILL OUT THE FOLLOWING INFORMATION:*

MEDICARE EXTENDED AUTHORIZATION
"SIGNATURE ON FILE"

I authorize any holder of medical or other information about me to release to the Social Security administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3821 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

BENEFICIARY NAME _____ MEDICARE INSURANCE NUMBER _____

SIGNATURE OF PATIENT _____ TODAYS DATE _____

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*PLEASE FILL OUT THIS SECTION IF YOU HAVE A **SECONDARY INSURANCE** TO MEDICARE.*

MEDIGAP AUTHORIZATION

I authorize any holder of medical or other information about me to release to _____
SECONDARY INSURANCE
any information needed for this or a related Medigap claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

SIGNATURE OF PATIENT _____ TODAYS DATE _____

INSURANCE POLICY NUMBER _____

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# The Vein Treatment Center

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## FINANCIAL POLICIES

If you do not have insurance.....

1. All office visits are payable at the time of your visit. Payment may be made by cash, check, Visa, MasterCard, or by Care Credit. A prompt payment discount can be offered if the balance is paid in full on the date of service.

If you have health insurance.....

1. Due to contractual agreements with certain insurance plans, **ALL CO PAYS are required to be paid at the time of service. If your co pay is not paid then you will be assessed at $15.00** service fee.

2. IF you are responsible for a deductible or co-insurance, you will be billed for the remaining balance after payment by your insurance company. This balance is due and payable within 15 days upon receipt of your statement. **If your balance remains unpaid you will be assessed a $10.00 service charge.**

3. Our office will be happy to submit to any insurance that you may have. You will be asked to assign benefits to Advanced Cardiovascular Services. Should you decline to do so, you will be required to pay in full before you will receive a completed insurance form or an itemized statement. It is our office policy to submit all charges when they are incurred. To avoid any delay, please make sure our receptionist has a current copy of your insurance card on file.

4. For Medicare patients, you are responsible for all deductibles and coinsurance of 20%. If Medicare does not file directly to your secondary insurance; we will need the necessary information in order to do so.

Non-covered services.....

Medicare and other health insurance companies will only pay for services that it determines to be reasonable and customary. If Medicare or other health insurance company determines a particular service, although it would otherwise be covered, is not reasonable and necessary under the Medicare standards. Medicare or other health insurance company will deny payment for that service. If payment is denied, you will remain responsible for the charges.

Cosmetic treatment.....

**Insurance carriers do not cover treatments that are considered cosmetic and not medically required. You will be required to pay for this service in full at the time of service.**

Payment methods.....

1. Cash, check, Visa or Master Card, or Money Orders.

2. Care Credit Program. This program will allow you to pay your balance interest free up to 1 year depending on your balance. Our billing department will assist you in setting this account up.

3. Payment Plan directly with our office. Each account will be set up on monthly payment plan according to their balance. Payments are due each month and will be assessed a $15.00 monthly service charge for each month a balance is carried with our office.

If you have any questions concerning our policies, please feel free to discuss them with our **Billing Manager or Office Manager.**
Thank you, Fairington Cardiovascular and Wellness Center & the Vein Treatment Center