Patient Name:_____

Date of Birth:_____ Social Security Number (SSN):_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

Employer Name:_____ Employer Phone:_____

E-Mail Address:_____

Whom may we thank for referring you! (Please mark all that apply)

☐ Danbury News Times	☐ Connecticut Post	☐ Billboard
☐ Postcard Mailing	☐ Mall Banner	☐ T.V. Commercial
☐ Facebook	☐ Twitter	☐ Expo / Fair / Seminar
☐ Google Search	☐ Pandora Radio	☐ Vein Institute of CT Website

☐ Referring Physician:_____

☐ Current Patient of Vein Institute:_____

Assignment of Benefits and Information Release

I hereby assign all medial and/or surgical benefits, to which I am entitled to Vein Institute of Connecticut. This assignment remains in effect until revoked by me in writing. A facsimile or photocopy of this assignment is to be considered valid as an original. I hereby authorize said assignee to release all information necessary to secure payment. I consent to the release of information by Vein Institute of Connecticut and its employees/representatives to facilitate peer review and of my treatment including utilization a quality management. I understand that Vein Institute of Connecticut will maintain the confidentiality.

I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that my medical insurance is a contract between myself and the insurance company and/or my employer. Vein Institute of Connecticut is not a party to said contract. I understand that I am responsible for legal and/or collection fees necessary to settle my account, should it become delinquent.

PRINTED NAME:_____ DATE:_____

SIGNATURE:_____

AUTHORIZATION TO LEAVE MESSAGES

Due to confidentiality laws we are unable to leave messages for you anywhere unless you authorize us to do so.

I, _____(Date of Birth)_____

Authorize any provider or member of the staff at Vein Institute of Connecticut to leave messages regarding my treatments, laboratory, diagnostic test results, billing matters and or any other information concerning my treatment.

I authorize staff at the Vein Institute of Connecticut to leave messages on my:

☐ HOME PHONE:_____ ☐WORK PHONE:_____

☐CELL PHONE:_____ ☐OTHER:_____

AUTHORIZATION TO TALK TO SOMEONE ELSE REGARDING TREATMENT OR BILLING

I authorize any provider or member of the staff at Vein Institute of Connecticut to leave messages regarding my treatments, laboratory, diagnostic test results, billing matters and or any other information concerning my treatment with:

- Name:_____ Phone:_____
  Relationship:_____
- Name:_____ Phone:_____
  Relationship:_____

Please note that The Vein Institute of Connecticut allows you to revoke authorization privileges at any time.

PATIENT SIGNATURE:_____ DATE:_____