VEIN CENTER OF LOUISIANA | ACADIANA VASCULAR CLINIC
129 Rue Louis XIV • Lafayette, LA 70508 • (Ph) 337.289.9700 • (Fax) 337. 289.9702

PATIENT INFORMATION REGISTRATION

Name: _____ **Sex**: Male or Female **Age:** _____

Prefer to be called: _____ **Date of Birth:** _____

Spouse's Name: _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Email:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Social Security #: _____

Employer Name: _____ **Occupation**: _____

Contact person in case of emergency: _____

Relation: _____ **Phone Number:** _____

Referred by: _____

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial policies of this office.

PAYMENT IS REQUIRED FOR ALL SERVICES AT THE TIME THEY ARE RENDERED.

We accept payment in the form of cash, check, MasterCard or Visa. In the event of hospitalization or major procedures, our office will file with the appropriate insurance. However, before such claims are filed, coverage will be preverified and you will be asked to pay any unmet deductible, non-covered services and co-payments. Please check the rules of your insurance coverage.

Additionally, I understand that if my account becomes **DELINQUENT** after 90 days, I will be **DISCHARGED** from the practice and will be responsible for all fees including Legal or other costs incurred in the collection of the account.

Your signature below signifies your understanding and willingness to comply with this policy. Further, your signature authorizes the doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the doctor when assigned claim is filed. I have received the notice of privacy practices.

Patient/Guardian Signature: _____ **Date:** _____

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PRIMARY INSURANCE

Policy #_____ **Group #**_____

Insured's Name_____ **Relationship to the patient**_____

Insured's SS# or Policy ID#_____

Insurance Company Name_____

Insurance Company Address_____

SECONDARY INSURANCE

Policy #_____ **Group #**_____

Insured's Name_____ **Relationship to the patient**_____

Insured's SS# or Policy ID#_____

Insurance Company Name_____

Insurance Company Address_____

FOR MEDICARE PATIENTS ONLY

PAYMENT POLICY:
Medicare: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% co-payment. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balance billed.

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 carrier 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 the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature_____ **Date**_____
Signature as it appears on Medicare Card

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file. I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature_____ **Date**_____

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Authorization for Release of Medical Information

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Day Phone: _____ Cell Phone: _____

I hereby authorize _____ (name of physician/hospital) to release information from my medical record as indicated below to:

_____ **Dr. Christopher LaGraize**
_____ **Dr. John Benjamin Luke III**
_____ **Dr. Steven L. Pike**

Information to be released:
History and physical exam: _____
Progress Notes: _____
Lab Reports: _____
X-rays, CT, Ultrasounds: _____
Other: _____

Purpose of Disclosure: (Please Circle One)

Changing Physicians • Consultation/Second Opinion • Continuing Care • Legal

Insurance • School • Workers Compensation • Other (specify): _____

I understand that this authorization will expire 90 days after I have signed the form. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations. By authorizing this release of information, my health care, and payment for my health care will not be affected if I do not sign this form. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it. I understand that in compliance with Title 40 of the Louisiana Administrative Code, Section 5123 Statute, I will pay a fee of $_____. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

_____ or _____

Signature of Patient **Date** **Parent/Legal Guardian** **Date**

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS, POWER OF ATTORNEY, ETC.

I authorize Acadiana Vascular Clinic to release any and all information pertaining to my care, including but not limited to, future appointments, treatment plans, prognosis, etc., to the following individuals:

- **If permission given, list the name(s) of the individual(s) who will have the authority to receive any & all information pertaining to your care and then sign and date the form.**
- **IF YOU DO NOT WISH ANY INFORMATION TO BE RELEASED DRAW AN "X" OVER THE TWO SECTIONS LISTED BELOW and then sign and date the form.**

Name: _____

Telephone Number: _____

Relationship to Patient: _____

Name: _____

Telephone Number: _____

Relationship to Patient: _____

Patient Signature: _____

Printed Name of Patient: _____

Date: _____

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HIPAA

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION ACADIANA VASCULAR CENTER, LLC.

With my consent, Acadiana Vascular Center, LLC may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Acadiana Vascular Center, LLC Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Acadiana Vascular Center, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Acadiana Vascular Center, LLC Privacy Officer at 129 Rue Louis XIV, Lafayette, LA 70508.

With my consent, Acadiana Vascular Center, LLC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Acadiana Vascular Center, LLC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. However, the practice is not required to agree to my requested restrictions, if it does, it is bound by this agreement.

By signing this form, I am consenting to Acadiana Vascular Center, LLC use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Acadiana Vascular Center, LLC may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____

Print Patient's Name

_____

Date

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PATIENT PORTAL

We have exciting news! We are now offering our patients access to their electronic medical records. This new feature will allow patients to view portions of their chart, request medication refills, review test results, and send **NON-URGENT** messages to their medical providers. To join the patient portal you can provide us with your email address, the email address of your trusted family member, or follow the directions below to request an account.

Please fill out the below information if you would like to have access to your health information through the patient portal.

Name: _____

Email Address: _____

_____ **I do not wish to participate**.

We will receive a notification that you have requested access and will soon link the request to your chart here at Acadiana Vascular Center LLC.

Please sign below stating that you have received this invitation to our patient portal.

_____ _____

Patient Signature **Date**

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HOW DID YOU HEAR ABOUT US?

Please check all areas that apply:

Referral from another Physician: _____

- If so, list who: _____

Family Member: _____

Word of mouth: _____

Facebook: _____

Television Ad: _____

Phone Book: _____

Internet Search/ Website: _____

Radio: _____

008 Magazine: _____

Event: _____

- If so, please list which event you saw us at: _____

Other Source: _____

(BELOW FOR OFFICE USE ONLY)

Patient Name: _____ **ID #:** _____