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Today's Date _____
Name _____
Address _____
City _____
State _____ Zip _____
Phone (home) _____
Phone (work/cell) _____
E-mail _____
Emergency Contact Name _____
Phone _____
Insurance Company _____
Policy/Subscriber Number _____
Group Number _____
Are you the primary carrier of the insurance? Y / N
If no, name of primary insurance holder: _____

SSN _____ - _____ - _____
Date of Birth _____
Height _____ Weight _____

FEMALE PATIENTS:
Is there any chance you may be pregnant? Y / N
Are you nursing? Y / N
Postmenopausal? Y / N
Date of last menstrual cycle: _____

CONSENT TO DISCLOSE CONFIDENTIAL INFORMATION/COLLECTION POLICY

I consent to the disclosure of the following information by VENA - THE VARICOSE VEIN INSTITUTE, LLC/RCW for the purpose of payment of medical bills for services, including complete/final diagnosis, procedure codes, test results, progress notes, reports, and discharge summaries. I may revoke this authorization by written notification. Payment is requested at the time of service. With complete insurance information, we will file a claim for you. Nonetheless, you are responsible for any balance due, as well as any late fees, collection charges, or attorney fees required to gain payment.

ASSIGNMENT OF BENEFITS AUTHORIZATION /

RELEASE OF INFORMATION TO INSURANCE CARRIERS AND MEDICARE PART B (IF APPLICABLE)

I hereby authorize payment of other insurance and/or Medicare Part B directly to the provider for services rendered to me. I agree to remain financially responsible for all charges not covered by my insurance carrier. I permit any holder of medical information about me to release to the insurance company of the Health Care Financing Administration and its agents any information to determine these benefits or the benefits payable for related services. In Medicare assigned cases, the service agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and uncovered services. Coinsurance and the deductibles are based upon the charge determination of the Medicare carrier.

Signature _____

Date _____

Person Authorized to Consent for Patient

Relationship to Patient