TOTAL VEIN CONCEPTS

Greenbrier Healthplex
713 Volvo Parkway, Suite 105 ♦ Chesapeake, Virginia 23320
Phone (757) 893-1413 ♦ Fax (757) 466-8017

Welcome To Our Office!

Name:____ Today's Date:____________________
First Middle Last

Home Address: ____

City: ______________________________ State: ________ Zip: ____________

Telephone: ( ) ________________ Birthdate: ________________ Age: ____________

Email Address: ____________________________ May we contact you via email? Yes No

Occupation: _________________________________ SSN: ________________

Employer: ____ Years There: ____________

Employer's Address: ____

City: ______________________________ State: ________ Zip: ____________

Work Phone: ( ) ________________________

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: ____________________________ Relationship to Patient: ________________

Home Address: ____

City: __________________________ State: _________ Zip: ___________

Telephone: ( ) ________________ Birthdate: _______________ Age:_______

Occupation: ____ SSN:________________

Employer: ____ Years There: __________

Employer's Address: ____

City: __________________________ State: ________ Zip: __________

Work Phone: ( ) ________________________

In case of emergency, contact: ____________________________ Relationship: ________________

Home Phone: ( ) ____________________ Work Phone: ( ) ________________

Primary Care Physician & Office Phone #: ____

Insurance Information

[Primary Insurance]

Name of Insurance Company: ____

Address: ____

City: _________________________________ State: _________ Zip: ____________

Insured's Name: ____

Group Number: ____________________ Policy ID Number: ____________________

[Secondary Insurance]
Name of Insurance Company: ____________________

Address: ____________________

City: ____________________ State: __________ Zip: ____________

Insured's Name: ____________________

Group Number: ____________________ Policy ID Number: ____________________

Did your injury happen on the job? Yes No
If yes, on what date did the injury occur? ____________________
Did you report the accident to your employer? Yes No

How did you learn about our practice?

- ☐ Dr. ____________________ recommended you.
- ☐ My friend, ____________________ recommended you.
- ☐ The hospital call center recommended you.
- ☐ You were in my managed care plan book.
- ☐ I found you in the Yellow Pages.
- ☐ I found your Web site on the Internet.
- ☐ I heard you speak at a seminar. (Given where? ____________________)
- ☐ Other: ____________________

Do you wish phone calls to be confidential? Yes No
May we contact you at work? Yes No
Please list an email address and another mode of contact (example: home or work phone#) for appointment reminders, etc: ____________________

____

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts. See our complete financial policy for details.

Method of Payment for Today's Visit: ___Check ___Visa/MC

TREATMENT AND FINANCIAL RESPONSIBILITY STATEMENT

A. I hereby apply for treatment by the above physician. Such treatment to include examination and such other procedures as they deem necessary.
B. I,____________________ (Patient/Guardian) accept responsibility to pay all services rendered on my behalf.
C. This will authorize the filing of any insurance in force and the direct payment to MEDICAL CENTER RADIOLOGISTS of any amounts due on my claim under the above stated policy (policies).
D. I authorize the release of medical information in order to process this claim.

I agree to all of the above and acknowledge receipt of a copy of this agreement.

Signature of Patient or Responsible Party: ____________________ Date: ____________

Witness: ____________________ Date: ____________