

# Austin Vein & Vascular Clinic

## PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex M F Social Security # \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_

Relationship \_\_\_\_\_ Referred By \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Patient Employer \_\_\_\_\_

## INSURED PARTY (if other than self)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone # \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

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My signature on this form indicates my acknowledgement that I have been provided with the opportunity to read and receive a copy of Austin Vein & Vascular's Privacy Notice, Which explains how my protected health information may be used or disclosed by Austin Vein & Vascular Clinic. Austin Vein & Vascular Clinic may not discuss with anyone other than your doctors and members of your treatment team about your health information or medical care without your permission. Please provide name(s) of family members that you authorize release to: \_\_\_\_\_

**MEDICAL RELEASE/ASSIGNMENT OF BENEFITS:** I hereby authorize payment of all health insurance benefits to Austin Vein & Vascular Clinic and allow assignee to release all information necessary to secure payment. I agree that a photocopy of this authorization shall be considered as effective and valid as the original. I understand that I am legally responsible for all charges incurred whether or not they are paid by my health insurance, and that any unpaid balance shall be due in full immediately if insurance proceeds are paid directly to me. I understand that if my account should be forwarded to a collection agency, a 20% charge will be added to my account balance. I hereby authorize release of my medical records, inclusive of all test results and pertinent information acquired during my treatment, to/from other physicians as deemed necessary.

**HIV TESTING AFTER ACCIDENTAL EXPOSURE:** I understand that in the event a healthcare worker is exposed to my blood or body fluids during my exam/procedure, my blood may be tested for the HIV antibody and other communicable diseases at no cost to me.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**5656 Bee Caves Rd., ste H-201  
Austin, TX 78746  
512-732-7370  
Fax 512-732-8332**