Patient Information

VANISHING VEINS NORTHWEST

Services provided by Vantage Radiology & Diagnostic Services

Last Name _____ Middle _____ First _____

DOB _____ Sex _____ SSN _____

Primary Address _____ City _____ State _____ Zip _____

Mail Address _____ City _____ State _____ Zip _____

Home Phone _____ Other Phone _____

Primary Care Physician _____ Phone _____

Referring Physician _____ Phone _____

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Employment Status: Full Time ☐ Part Time ☐ Student ☐ Unemployed ☐ Homemaker ☐ Retired ☐

Email Address _____

Emergency Contact Information

Name _____ Phone _____ Relationship _____

Insurance Information

Primary Insurance _____ Policy # _____ Group # _____

Policy Holder Name _____ Holder's DOB _____ Sex _____

Employer _____ Emp. Address _____ Emp. Phone _____

Relationship to Insured: Spouse ☐ Child ☐ Other ☐ Phone _____

Secondary Insurance _____ Policy # _____ Group # _____

Policy Holder Name _____ Holder's DOB _____ Sex _____

Employer _____ Emp. Address _____ Emp. Phone _____

Relationship to Insured: Spouse ☐ Child ☐ Other ☐ Phone _____

Authorization for Release of Information: I acknowledge that Vantage Radiology & Diagnostic Services is doing business as Vanishing Veins Northwest. I authorize Vanishing Veins Northwest to release all medical information (including but not limited to, information on psychiatric conditions, alcohol and drug abuse) requested by my health insurance carrier, Medicare or any other third party payers. I authorize Vanishing Veins Northwest to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance or health plan administrator to release such information to Vanishing Veins Northwest. I hereby give my permission for before and after photos of my legs to be used in marketing materials; so long as no patient identifiers are included.

Assignment of Benefits: I request that payment of authorized insurance benefits to be made on my behalf to Vanishing Veins Northwest I agree that these provisions will remain in effect until I provide written revocation to Vanishing Veins Northwest.

I hereby acknowledge that I am personally responsible for the cost of all procedures provided by Vanishing Veins Northwest. I understand that Vanishing Veins Northwest will make reasonable efforts to collect payment from my medical insurance provider, however, in the event that an insurance company denies payment or only makes a partial payment; I agree to be responsible for the full amount of billed charges or any remaining balance that may be due. I agree to pay Vanishing Veins Northwest any amounts due within 15 days of receiving an invoice.

By signing this form, you also acknowledge receipt of the Notice of Privacy Practices of Vanishing Veins Northwest. ☐

Patient/Guardian Signature: _____ Date: _____