Pt. Name _______________

DOB _______________

CONSENTS

Photo Consent

*I understand that my medical photos may be required by insurance carriers in order to authorize procedures or payments to Lake Washington Vascular. Your name must be attached to your claim.

______**Initials**

*I will _____ will not ____ allow my medical photos to be used by Lake Washington Vascular for the following purposes:

_____ Patient Education

_____ Marketing purposes

I understand my identity and personal information will remain confidential. I also understand that I may revoke permission at any time.

Permission to Contact for Research

Lake Washington Vascular participates in clinical research trials to help advance the understanding and treatment of vascular disorders. If you are a candidate for a research trial, may we contact you to discuss possible participation?

Yes_____________ No _____________

I acknowledge and understand this information will be kept in my Medical Record. It is my responsibility to notify Lake Washington Vascular should any of these authorizations and consents change.

______**Initials**

Lake Washington Vascular may use unidentified patient data (data with no patient names or personal information attached) for quality improvement or research database purposes.

______**Initials**

Consent for Prescription history queries

I, the undersigned, give consent to Lake Washington Vascular to retrieve my prescription history queries up to 1 year from pharmacy benefit managements, payers, and pharmacies. That history will be requested from DrFirst/Surescripts when an appointment is scheduled, the appointment status changes, or a medication is ordered for the patient.

_____ **Initials**

Assignment of Benefits

I, the undersigned, give consent to Lake Washington Vascular, PLLC and its providers to render the professional services to the patient identified herein.

I. the undersigned. acknowledge that I have received and read a copy of the Payment Policy for Lake Washington Vascular, PLLC. I assume full responsibility for payment of this account. I recognize that the provider cannot accept responsibility for collecting any insurance claim or negotiating any settlement of a disputed claim. In the event of default in the payment of any amount due, and if this account is placed in the hands of an agency or attorney for collection or legal action, I agree to pay an additional charge equal to the cost of collection including agency and attorney fees, and court costs; incurred and permitted by the laws governing these transactions, no less than 35% of the principle amount. A finance charge of 18% APR may be charged on all balances over 30 days, regardless of pending insurance claims.

I assign all insurance benefits for treatment to be paid directly to Lake Washington Vascular, PLLC and request that this assignment remain on file with my insurance carrier.

______**Initials**

Notice of Privacy Practices Attestation

Requests for Patients Protected Health Information (PHI) will be requested and disclosed in accordance with HIPA A and the Lake Washington Vascular, PLLC Notice of Privacy Practices. I hereby acknowledge receipt of such, and should I have questions or concerns, or wish to invoke my rights, I may contact Health Information Management.

______**Initials**

Payment Policy Attestation

I hereby acknowledge receipt of the Lake Washington Vascular, PLLC Payment Policy, and should I have questions or concerns, I may contact Lake Washington Vascular, PLLC.

______**Initials**

Signature:________________________________ **Date:** ____________

LAKE WASHINGTON VASCULAR, PLLC
PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name: ____________ **First Name:** ____________ **Middle Name:** ____________

Address: ____________ **City:** ____________ **State:** ______ **Zip Code:** ______

Social Security Number: ____ / ____ / ____ **Date of Birth:** ____ / ____ / ____ (mm dd yyyy) **Sex:** ☐ F ☐ M

Marital Status: ☐ S ☐ M ☐ W ☐ D **Spouse Name:** ____________

Language Preference: ☐ English ☐ Spanish ☐ Russian ☐ Other: ____________

Occupation: ____________ **Employer:** ____________

Referred by: ☐ M.D. ☐ N.P. ☐ Friend: ____________ (Last) (First) (Phone #)

Primary Care Physician: ____________ (Last) (First) (Phone #)

Send additional reports to the following physicians: ____________ (Last) (First) (Specialty) (Phone #)

____________ (Last) (First) (Specialty) (Phone #) ____________ (Last) (First) (Specialty) (Phone #)

Race: ☐ White ☐ Hispanic ☐ African American ☐ American Indian ☐ Middle East ☐ Asian ☐ Other: ____________

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic/Latino

PATIENT CONTACT INFORMATION

Home: (______) ____________ **OK to leave message:** ☐ Yes ☐ No

Cell: (______) ____________ **OK to leave message:** ☐ Yes ☐ No

Email: (______) ____________ **OK to leave message:** ☐ Yes ☐ No

Preferred Method of Contact (circle one) Home Cell Email

Automated Calls: As an added convenience, we offer automated appointment reminders via a text message or an automated call for those who want to participate. The reminders are sent from a computer and cannot be used as a way for you to communicate back to us. If you should need to reach us, please call our main number. If at any time you should change your mind, please let us know what other method you would prefer for appointment reminders.

EMERGENCY CONTACT INFORMATION

Person to contact in case of emergency

Name: ____________ **Relationship to Patient:** ____________

Address: ____________ **Phone:** (______) ____________

City: ____________ **State:** ______ **Zip:** ______

I authorize the physicians and staff of Lake Washington Vascular to release information regarding my condition and/or treatment to:

____

INSURANCE

PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD, AND PAY YOUR APPLICABLE CO-PAYMENT.

Primary Insurance Company: ____________ **Policy #** ______ **Group #** ______

Primary Subscriber: ____________ Subscriber Name Relationship DOB

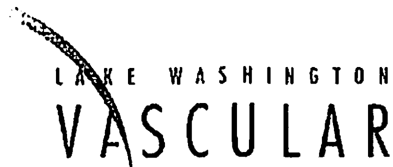
Secondary Insurance Company: ____________ **Policy #** ______ **Group #** ______

Secondary Subscriber: ____________ Subscriber Name Relationship DOB

☐ **No Insurance**

Signature: ____________

POS Reorder # 1606975



Payment Policy

We at Lake Washington Vascular are sensitive to the ever-increasing cost of health care. For this reason, each of our providers is dedicated to rendering only those professional services that are deemed to be necessary and appropriate. To assist us in controlling the costs associated with these services, we have implemented the following payment policy. We encourage you to retain this copy of our payment policy for your records.

Fees

Lake Washington Vascular offers a broad range of diagnostic and interventional services. Each of these services is billed separately. The fee for a particular service is available upon request.

Additional fees may be assessed for returned checks and copies of medical records.

Payment at the Time of Service

Patients without insurance coverage are required to make payment at the time of service.

Patients with insurance are expected to pay their co-payment or other co-insurance at the time of service.

Insurance

We bill insurance carriers as a courtesy to our patients. This requires that we have the signature of the patient and/or guarantor on file. We may attempt to verify insurance benefits in advance; however, this is not a confirmation or guarantee of insurance coverage or payment. Thirty days are allowed for insurance claims to be processed after which the patient is held responsible for payment. Resolution of coverage disputes with an insurance company is the responsibility of the policyholder. We will not bill insurance plans for which the patient is not the subscriber or a member.

Billing

Insurance claims are prepared and submitted on a regular basis. Statements are prepared and mailed to patients every 30 days. These statements provide an itemization of all account activity. Account balances older than 30 days may be subject to a finance charge of 18% APR. Accounts declared delinquent may also be subject to collection and legal fees no less than 35% of the principle amount.

Exceptions

Requests for exceptions to this payment policy are reviewed by a Patient Account Representative on a case-by-case basis. When payment by installment is deemed necessary, a written agreement will be drafted by the Patient Account Representative and signed by the responsible party(ies).

Daniel Pepper, M.D., Kathleen D. Gibson, M.D., Brian Ferris, M.D., Renee Minjarez, M.D., Elena Rinehardt, M.D.