

## **WELCOME TO OUR OFFICE**

				Today's Date:			
	First	Mic	ldle	Last			
Date of Birth:			Age:	Social Sec. No.			
Billing Address:					. <u> </u>		
		Street		City	State	Zip	
Home Address:		Street		City		7:	
				·	State	Zip	
Home Phone: _	e: Cell Phone:		Email:				
Marital Status:	Single	Married	Divorced	Widowed			
Employer:	mployer:			Work Phone Number:			
Employer Addres	ss:	Street					
		Street		City	State	Zip	
Emergency Conta	act Name:			Relationship:			
Home Address:							
		Street		City	State	Zip	
		Street		City	State rk Phone:	1	
Home Phone: _		Street	Phone:	Wo		1	
Home Phone: Who is your prim Complete this se	nary care physic	Street Cell	Phone:	City Wo mancially responsible.			
Home Phone: Who is your prim Complete this se Responsible Part	nary care physice ction only if so	Street Cell ian: omeone other than	Phone:	City Wo mancially responsible.	o to Patient:		
Home Phone: Who is your prim Complete this se Responsible Party Date of Birth:	nary care physic ection only if so y Name:	Street Cell ian: omeone other than	Phone:	City  Wo  nancially responsible.  Relationship  Social Security No.:	o to Patient:		
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Home Phone: Who is your prim Complete this se Responsible Party Date of Birth: Home Address: Home Phone:	nary care physic ection only if so y Name:	Street Cell cian:  meone other than  Street	Phone:	City  Mo  nancially responsible.  Relationship  Social Security No.:  City	o to Patient:	Zip	
Home Phone: Who is your prim Complete this se Responsible Party Date of Birth: Home Address: Home Phone:	nary care physic	Street Cell cian:  Street  Street	Phone:	City  Mo  nancially responsible.  Relationship  Social Security No.:  City	o to Patient:	Zip	

## **INSURANCE INFORMATION**

Patient Name	e:			Today's Date:
	First	Middle	Last	
Primary Insu	rance Co. Name:			
Insured's Na	me:			Relationship to Patient:
Date of Birth	:		Social Security	Number:
ID Number:				Group Number:
Secondary In	surance Co. Name:			
Insured's Na	me:			Relationship to Patient:
Date of Birth	:		Social Security	Number:
ID Number:				Group Number:
Tertiary Insu	rance Co. Name:			
Insured's Na	me:			Relationship to Patient:
Date of Birth	:		Social Security	Number:
ID Number:				Group Number:
Signature of	Patient or Responsible Pa	arty:		Date:
	Please	have insurance	cards ready fo	or receptionist to copy.
I hereby auth	NT AUTHORIZATION orize Vein Clinics of Hawa t and authorize and/or order	ii and/or any authori any related services	zed persons empl s on my behalf.	oyed by them to perform and/or initiate medical evaluation
Signature:				Date:



## **Notice of Privacy Practices and Policies**

This notice describes how medical information about you may be used and disclosed and your rights regarding access to this information.

Your rights as a patient related to your medical information are as follows: You have the right to request restrictions on the way we use your medical information. You have the right to request and receive information from us in a different way or manner. You have the right to review your medical information. You have the right to request that we amend your medical information. You have the right to know how we have used and to whom we have disclosed your medical information. We will not use or disclose your health information without your authorization except as otherwise described in this notice of privacy practice and policy.

It is our responsibility to protect your medical information, provide you with our notice of privacy policies and abide by these policies. We do reserve the right to change our privacy practices.

May we leave messages containing Private Health Information at your home or on your answering machine? Yes No
May we send you appointment reminders or test results via mail? Yes No
May we discuss Private Health Information with your PCP, spouse, significant other, parents, siblings or children? Yes No Please specify to whom we may leave information, including your primary care physician.
May we leave a message at your place of employment? Yes No N/A
If you believe your privacy rights have been violated, you may file a complaint with our practice, or with the Secretary of the Department of Health and Human Services; Office of Civil Rights, 200 Independence Avenue, SW, Washington, D.C., 20201, or phone (202) 619-0257 or toll free (877) 696-6775. To file a complaint with our practice, contact Leonette Meyer, 65-1158 Mamalahoa Hwy, Suite 16, Kamuela, HI, 96743, or phone (808) 885-4401. All complaints must be submitted in writing. You will not be penalized for filing a complaint. Updated: 5/16/2016
Signature