Reno Vein Clinic

Robert F. Merchant, Jr., M.D. 10685 Professional Circle, Ste B Reno, NV 89521 775-329-3100 **John W. Daake, M.D.**

PLEASE PRINT CLEARLY

PATIENT INFORMATION

Last Name:_____ First Name:_____ MI:____ Sex: ____ Marital Status: _____

Address: _____ Birth Date: _____/ _____ / _____ Age: _____

City: _____ State: _____ Zip: _____ Social Security #: _____ - _____ - _____

Occupation: _____ Employer: _____ Email: _____

Phone Numbers: Home: _(_____)_____ Cell: _(_____)_____ Work: _(_____)_____

Referred by: Dr. _____ Family _____ Friend _____

Newspaper _____ Radio _____ Yellow Pages _____

TV _____ Internet _____ Magazine _____

In case of emergency Reno Vein Clinic should contact: _____@ (phone)_____

Relationship:_____

INSURANCE INFORMATION

Please bring all insurance cards with you to your appointment.

Primary Insurance Carrier: _____

Insured's Name _____

Insured's Date of Birth: _____ / _____ / _____

Policy or Group Number _____

Insured's Social Security # _____ - _____ - _____

Secondary Insurance Carrier: _____

Insured's Name _____

Insured's Date of Birth: _____ / _____ / _____

Policy or Group Number _____

Insured's Social Security # _____ - _____ - _____

I hereby authorize the treatment of the person or persons above, agree to pay all fees and charges for such treatment and further recognize that special arrangements for payment must be made prior to the actual delivery of service. I hereby assign, transfer and set over all of my right, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand and agree to accept full responsibility for total charges if my insurance company fails to pay. As a courtesy, The Reno Vein Clinic will bill my insurance company for charges related to services rendered.

Patient's Signature_____ **Dated** _____

Patient's Signature_____ **Updated with no changes** _____

Photography Permission / Denial

I, the undersigned, do hereby give my permission for photographs to be taken at The Reno Vein Clinic. Privacy will be maintained at all times. The Reno Vein Clinic will not use these photos for publication without a signed release. I understand that my face or identifying features will not be incorporated into any reproduction that might be made available to my healthcare insurance carrier or any other person.

Patient's Signature _____ **Witnessed by** _____ **Date** _____

□ ***I do NOT want any photographs taken at all.*** _____

Patient's Signature

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by Reno Vein Clinic and Surgery Center or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your protected health information.
- Reno Vein Clinic and Surgery Center may or may not agree to restrict the use or disclosure of your protected health information.
- If Reno Vein Clinic and Surgery Center agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the Federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to change Privacy Practices

Reno Vein Clinic and Surgery Center reserves the right to modify the privacy practices outline in the notice.

Signature

I have reviewed this consent form and the Notice of Privacy Practice (if requested) for Reno Vein Clinic and Surgery Center. I give my permission to use and disclose my health information in accordance with it.

How to file a HIPAA Complaint

Complaints must be filed in writing, either on paper or electronically, by mail, fax, or e-mail and sent to the OCR regional office. Name the covered entity involved and describe the acts or omissions you believe violated the requirements of the Privacy or Security Rule; and complaints must be filed within 180 days of when you knew that the act or omission complained of occurred. OCR may extend the 180-day period if you can show "good cause".

_____	_____	_____
Name of Patient (print please)	Signature of Patient	Date
_____	_____	_____
Name of Patient (print please)	Signature of Patient	Date - updated