Minnesota Vein Center 400 Village Center Drive, Ste 800, North Oaks, MN 55127

Center for Advanced Treatments 651-765-8346 www.mnveincenter.com

Patient Information

Patient's Name

Last______________________First______________Middle____________

Date of Birth___________________Age_____Sex:______Email:____________

Home Address: Street_______________________________________State_____Zip___________

Home Phone:___________Cell:______________Work:______________

Which is best way to reach you? ___________________________

Occupation:_________________________Employer:___________________________________

Primary Physician:____________________________Referring Physician:____________________

Emergency Contact:____________________Relationship: ____________Phone: _______________

Insurance Information

Primary Insurance

1) Company:_______________Policy/ID # _________________ Group Number:_______

Policy Holder's Name: ________________DOB: ________ Relationship ___________

Employer's Name: ______________________________

Secondary Insurance

2) Company: ______________Policy ID# _______________Group Number :___________

Policy Holder's Name: _________________DOB: _________Relationship: ___________

Employer's Name: _____________________________

PLEASE HAVE INSURANCE CARDS AND PICTURE ID AVAILABLE TO PHOTOCOPY

How did you hear about Minnesota Vein Center?

☐ Physician Referral ☐ Family/Friend ☐ Newspaper ☐ MyTalk 107.1/ Love 105

☐ Insurance ☐ Internet Search ☐ Phonebook ☐ Other _______

RECORDS RELEASE: I hereby authorize the release of any information, including medical and billing information to my insurance company, and other providers involved in my care.

ASSIGNMENT OF BENEFITS: I hereby authorize payment of medical benefits to *Minnesota Vein Center, P.A.* for services rendered to myself and/or dependents.

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made to me on my behalf to Minnesota Vein Center, P.A. for any services furnished me by the physician/clinic/supervisor. I authorized any holder or hospital or medical information about me to permit a copy of this authorization to be used in place of the original.

Payment Policy Statement

Payment at time of service is requested unless you are insured by a PPO, Medicare, or an approved insurance carrier that will bill directly, or other arrangements have been made. All deductibles, co-payments and services not covered by your plan are your responsibility**.** Minnesota Vein Center accepts cash, check, Visa, MasterCard, Discover and Health Savings Accounts.

Signature: ____ Date: ______________________