Chippewa Valley
VEIN CENTER
AND ENDOVASCULAR SPECIALISTS

Welcome To The Chippewa Valley Vein Center!

Name: _____ Today's Date: _____
First Middle Last

Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: ( )_____ Cell/Work Phone: ( ) _____
SSN: _____ Birth Date: _____
Occupation: _____ Employer:_____
Primary Physician: _____ Phone Number: ( ) _____

Name of Spouse: _____ Employer: _____
Birth Date: _____

Emergency, contact: _____ Relationship: _____
Home Phone: ( ) _____ Cell/Work Phone: ( ) _____

Complete this section only if someone other than the patient is financially responsible.
Responsible Party: _____ Relationship to Patient: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Telephone: ( ) _____ Cell/Work Phone: ( ) _____
SSN: _____ Birth Date: _____
Employer: _____

Do you believe payment for your services is to be covered by Worker's Compensation? _____

How did you learn about our practice?

- ☐ I found you in the Yellow Pages.
- ☐ I found your Web site on the Internet.
- ☐ The hospital call center recommended you.
- ☐ You were in my managed care plan book.
- ☐ Direct Mailing.
- ☐ Newspaper/Magazine:_____
- ☐ Dr. _____
- ☐ My friend, _____
- ☐ At a seminar. Where? _____
- ☐ Television . Channel:_____
- ☐ Radio. Station:_____
- ☐ Other: _____

I hereby authorize Chippewa Valley Vein Center to bill and receive payment directly from my insurance for services rendered or products purchased. It is also understood that any medical and/or other information necessary to process this claim will be released upon request from the insurance carrier.
I further acknowledge that the service(s) and/or items(s) may not be a covered benefit by my insurance plan. Every effort will be made to my insurer for reimbursement and in the event of insurance denial to pay I agree to be responsible for the full amount of the billed charges or the remaining balance after my insurer has paid. This consent is valid until/unless revoked in writing. I request that payment of authorized Medicare benefits be made on my behalf to The Chippewa Valley Vein Center for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Patients Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Please present your current insurance card to the receptionist with this form.