VIVID VASCULAR

FOX VEIN AND LASER EXPERTS

PATIENT INFORMATION

Patient Name: _____ Date: _____

Sex: ☐ Male ☐ Female Date of Birth: _____ Age: _____ SSN: _____

Address: _____ Apt: _____ City: _____ State: ____ Zip: _____

Home Ph: _____ Day Ph: _____ Cell Ph: _____

May we leave a message if unavailable? ☐ Yes ☐ No

Email Adress: _____ May we contact you via e-mail? ☐ Yes ☐ No

Race/ Ethnicity: _____

How did you hear about our office? ☐ Google/Internet ☐ Yelp ☐ Facebook/Instagram ☐ Website

☐ Other: _____

Referred By Physician: _____

Primary Care Physician: _____ Date of Last Physical Exam: _____

Occupation: _____ Employer: _____

Work Ph: _____ May we contact you at work? ☐ Yes ☐ No

Emergency Contact

In case of emergency, contact: _____ Relationship: _____

Address: _____ Apt: _____ City: _____ State: ____ Zip: _____

Contact Ph: _____

Insurance Information

Primary Insurance Company:_____

Policy Number: _____ Group Number: _____

Secondary Insurance Company: _____

Policy Number: _____ Group Number: _____

VIVID VASCULAR

FOX VEIN AND LASER EXPERTS

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, hereby authorize

North Beach Vascular & Aesthetics
15400 Biscayne Blvd Suite 103
Aventura, FL 33160

to release of my before and after pictures for marketing purposes. I understand that my photos may be viewed on the company website(s) (North Beach Vascular & Aesthetics/North Beach Radiology Associates/Vivid Vascular).

I understand that this consent is revocable upon written request from the practice, except to the extent that practical action has been taken under this authorization and that this authorization will remain in force and effect for a “reasonable” time in order affect the purpose for which it is given.

Patient Signature: _____ Date: _____

VIVID VASCULAR

FOX VEIN AND LASER EXPERTS

AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL RECORDS TO NORTH BEACH VASCULAR AND AESTHETICS

Physician Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

RE:

Patient Name: _____

DOB: _____ SS#: _____ MR No.: _____

I request and authorize the disclosure of all protected information for the purpose of coordination of medical treatment and care. I request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including but not limited to consultation notes, progress notes, treatment plans, ultrasound reports, test results, lab results, medical questionnaires/histories, and records received by other medical providers.

You are authorized to release the above records to:

NORTH BEACH VASCULAR AND AESTHETICS
15400 Biscayne Blvd, Suite 103, Aventura, FL 33160

Email: fax@vividvascular.com
Fax: 305-564-1693
Phone: 305-957-7277

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

VIVID VASCULAR

FOX VEIN AND LASER EXPERTS

AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL RECORDS FROM NORTH BEACH VASCULAR AND AESTHETICS

FROM: North Beach Vascular and Aesthetics
15400 Biscayne Blvd, Suite 103, Aventura, FL 33160
Ph: 305-957-7277 Fax: 305-564-1693

RE: Patient Name: _____

DOB: _____SS#: _____

I request and authorize the disclosure of all protected information for the purpose of coordination of medical treatment and care. I request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including but not limited to consultation notes, progress notes, treatment plans, ultrasound reports, test results, correspondence, statements, questionnaires/histories, and records received by other medical providers. You are authorized to release the above records to the following:

Physician Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

I understand that I have a right to revoke this authorization in writing at any time, except to the extent of information that has been released in reliance upon this authorization. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from the date of execution at which time this authorization expires.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

VIVID VASCULAR

FOX VEIN AND LASER EXPERTS

NO SHOW/CANCELLATION POLICY AND CREDIT CARD AUTHORIZATION

North Beach Vascular & Aesthetics, DBA Vivid Vascular, prides itself on providing a very personalized experience for each and every patient. In order to accomplish that, we do not overlap patient appointments or overschedule our days. If a patient does not show up for their appointment or cancels without adequate notice, the result is idle time for our staff and a missed opportunity for another patient.

We understand you could experience the need to cancel an appointment; however, if you must cancel an appointment, we must hear from you no later than 48 hours before your appointment to avoid a $75 cancellation fee. Any procedure appointment such as EVLA, chemical sclerotherapy, or cath lab procedure (IVUS, embolization, stent, etc.) that is missed, or not cancelled 48 hours, will be subject to a $250 cancellation fee. Aesthetic appointments missed or not cancelled 48 hours prior to the appointment, will be charged the full amount of the service booked for that day. If a package was purchased, the single session will be forfeited.

No appointment can be held without a credit card. We will place your credit card information on file and use this to hold all future appointments. This applies to all new and existing patients. We will never charge your credit card for any other service without specific authorization.

Payment for a missed appointment is considered a “non-covered” service by insurance carriers; therefore, the fee is the responsibility of the patient and cannot be billed to your insurance company.

Your signature below indicates your understanding of this policy and that you agree to abide by it. Please provide your credit card information below. Thank you for understanding.

I hereby authorize North Beach Vascular & Aesthetics to charge my credit card the appropriate cancellation fee as referenced above for each missed appointment. We will add an additional 3% surcharge for all credit card transactions.

Credit card type: _____ CVV code: _____

Credit card no.: _____ Exp date: _____

Billing address: _____

Signature: _____

Patient name: _____ Date: _____

VIVID VASCULAR

FOX VEIN AND LASER EXPERTS

FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive maximum allowable benefits. In order to achieve these goals, we need your help and your understanding of our payment policy. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

Payment for services is due at the time services are rendered unless other payment arrangements have been made in advance. We accept cash, check, Master Card, Visa, American Express, and Discover. We will be happy to process your insurance claim. You must realize however that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not party to that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. Our fees are based on the quality of service provided and generally fall within the USUAL, CUSTOMARY & REASONABLE range defined by most insurance companies. Please be aware that any difference between our charge for services and the USUAL, CUSTOMARY & REASONABLE amount will be your responsibility. This amount differs from one insurance company to another. You will be billed for any amount not reimbursed by your insurance company.
4. We will add an additional 3% surcharge for all credit card transactions.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. Please be aware your insurance company expects you to pay your deductible and co-insurance before they will consider coverage, therefore this amount is due on the date of service.

We do expect to be paid any balance exceeding 60 days of said professional service. Insurance regulations require that your insurance company respond to claims within 45 days. Outstanding balances exceeding 100 days may be placed in collection.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask. We are here to help you.

I give my permission to NBVA and its affiliates or contractors to contact me for any purpose at the current or any future numbers that are provided for my landline telephone, cellular or any wireless device including the use of automated dialing equipment, prerecorded voice, or text message.

Patient Signature: _____ Date: _____

I hereby assign and authorize payment to be made directly to North Beach Vascular, DBA Vivid Vascular for all covered benefits otherwise payable to me. I also authorize the release of medical information as may be required to process claims for payment of medical services rendered and it is expressly understood that the right of such information is to be privileged is hereby waived.

Patient Signature: _____ Date: _____

VIVID VASCULAR

FOX VEIN AND LASER EXPERTS

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I hereby acknowledge that I have reviewed/received a copy of North Beach Vascular & Aesthetics' NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights I may contact the privacy office at North Beach Vascular & Aesthetics. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way.

Patient Name (Please Print): _____

Patient Signature: _____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Written Acknowledgement Form but was unable to do so as documented below.

Date: _____

Reason: _____

Initials: _____

VIVID VASCULAR

FOX VEIN AND LASER EXPERTS

NOTICE OF PRIVACY PRACTICES

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

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff, and other office personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who provide "call coverage" for your health care provider.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care services you receive at this office. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment

We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health. For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that the doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

For Payment

We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations

We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care, for example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders

We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

Treatment Alternatives

We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health Related Products and Services

We may tell you about health-related products or services that may be of interest to you. Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health related products and services. If you advise us in writing (at the address listed at the top of this notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes. You may revoke your Consent at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures which occurred before that time. If you do revoke your Consent we will not be permitted to use or disclose information for purposes of treatment, payment, or health care operations, and we may therefore choose to discontinue providing you with health care treatment and services.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert Serious Threat to Health or Safety

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law

We will disclose health information about you when required to do so by federal, state, or local law.

Research

We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Organ and Tissue Donation

If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transportation.

Military, Veterans, National Security, and Intelligence

If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work related injuries or illness.

Public Health Risks

We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability, or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities

We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement
We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons, or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners, and Funeral Directors
We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death.

Information Not Personally Identifiable
We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends
We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment, that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or x-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION
We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. We must obtain your Authorization separate from any Consent we may have obtained from you. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written Authorization (different than the Authorization and Consent mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment, or health care operations, we will have to have both your signed Consent and a special written Authorization that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU
You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy
You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to our privacy official in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend
If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office. To request an amendment, complete and submit a Medical Record Amendment/Correction Form to our privacy official. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: a) We did not create, unless the person or entity that created the information is no longer available to make the amendment; b) Is not part of the health information that we keep; c) You would not be permitted to inspect and copy; d) Is accurate and complete.

Right to an Accounting of Disclosures
You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, and health care operations. To obtain this list, you must submit your request in writing to our privacy official. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You also have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are Not Required to Agree to Your Request
If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you may complete and submit a Request for Restricting Uses and Disclosures and Confidential Communications Information Form to our privacy official.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you may complete and submit the *Requests for Restricting Uses and Disclosures and Confidential Communications* form to our privacy official. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact our privacy official.

CHANGES TO THIS NOTICE
We reserve the right to change this notice and make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right-hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our privacy official. You will not be penalized for filing a complaint.