LEE GOLDBERG, MD
JOSEPH DEBOE, DNP
JENNIFER WARD, DNP
CARDIOLOGY

vein & aesthetics
OF TUCSON

Dr. Lee Goldberg, MD
2504 E. River Rd., Suite 101
Tucson, AZ 85718
520-445-7693

New Patient Intake Form

Patient Legal Name: _____

Date Of Birth: _____ Email: _____

Phone #: _____ SSN #: _____

Address: _____

City: _____ State: _____ ZIP: _____

Race: □ White □ Hispanic □ Asian

□ African American □ Pacific Islander □ American Indian

□ Alaska Native □Refuse to Report □ Other: _____

Marital Status: □ M □ S □ D □ W

Primary Care Physician: _____ Phone #: _____

Emergency Contact Name: _____ Phone: _____ Relation: _____

Power of Attorney: YES or NO Name: _____ Relation: _____

How Did You Hear About Us: □Online Search □Instagram □Facebook □Other: _____

Primary Insurance: _____

ID #: _____ Group: _____

Policy Holder Name: _____ DOB: _____ Relation: _____

Secondary Insurance: _____

ID #: _____ Group: _____

Policy Holder Name: _____ DOB: _____ Relation: _____

Patient Signature/ Parent or Guardian: _____ **Date:** _____

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Authorization for Release of Medical Information

Patient's Full Name: _____

Date of Birth: _____ Phone Number: _____

Address: _____

THIS AUTHORIZES:

Lee R. Goldberg, M.D. ● Jennifer Ward, DNP. ●Vein & Aesthetics of Tucson

3955 E. Fort Lowell Rd, Suite 113 • Tucson, AZ 85712

2504 E. River Rd., Suite 101 . ● Tucson, AZ 85718

Release information to: (primary care, other providers, family members)

_____

_____

_____

This authorization releases Lee R. Goldberg, MD, Jennifer Ward, DNP, Vein and Aesthetics of Tucson and any staff, employees and agents of any responsibility for information contained in such records released in case of loss or theft from my person, or distress any type caused to me of other, Lee R. Goldberg, MD, Jennifer Ward, DNP, and Vein and Aesthetics of Tucson will not be held liable for any misuse or misunderstanding of the information contained herein as a result of this release.

I authorize the release of all my medical records, including all HIV and communicable disease related information.

_____ _____

Patient Signature/ Parent or Guardian **Date**

_____ _____

Signature of Witness Date

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Practice Guidelines and Patient Financial Policies

1. **INFORMATION**: You agree to provide your correct name, current and correct address, cellular or other phone number, insurance information, Social Security number, driver's license, or picture identification at the time of registration, or as requested by the practice, and additionally as any of the above information changes at any time.

   Initials_____

2. **FINANCIAL RESPONSIBILITY**: By these initials and your signature below, you accept financial responsibility for all charges for services rendered to you. If a minor or under guardianship, the parents or guardian accompanying the patient assumes this liability.

   Initials_____

3. **PAYMENT METHODS**: We accept cash, check, and several major credit cards. Front office staff may be contacted regarding credit cards accepted or insurance companies in which the practice participates with.

   Initials_____

4. **APPOINTMENTS**: Our office will schedule appointments as a common courtesy for patients and in consideration of your time. Minors must be accompanied by a parent or guardian to be seen; unless special arrangements have been made with the office. We require a minimum of 24 hours (or the Friday before a Monday appointment) notice of cancellation, as a courtesy to other patients seeking services. A fee of $50.00 will be charged for non- cancelled and missed appointments. A pattern of non-cancelled, and or missed appointments may result in discharge from the practice.

   Initials_____

5. **FORM FEES:** Our office charges for additional paperwork outside of the completion of the medical record. The following fees apply and are subject to change: (a) FMLA, immigration, disability, and drivers license's forms- $25.00

   Initials_____

6. **MEDICAL RECORDS:** The medical chart is the property of the practice. However, copies of your pertinent medical information are available upon request. We will charge a fee of $25.00 for copies of your medical records.

   Initials_____

7. **INSURANCE CO-PAYMENTS, DEDUCTIBLES, AND CO-INSURANCE:** Insurance companies do not pay all fees and may exclude certain services from coverage. It is your responsibility to understand your insurance plan. All copayments, deductibles, and coinsurance, or non-covered services are to be paid in a timely fashion according to office policies. All copayments, deductibles, and coinsurance for testing, are to be paid at time of services rendered to you.

   Initials_____

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8. **COLLECTION AND BANK FEES:** Accounts more than 90 days old are subject to transfer to an outside collection agency. These agencies charge fees. In the event a lawsuit is necessary for collection, prevailing party is awarded attorney's fees. In addition, banks charge for checks that do not clear or cannot be cashed. You agree to be liable for all such fees with a minimum charge of $25.00.

   Initials_____

9. **PATIENT DISCHARGE:** The practice reserves the right to discharge a patient for any reason. Please note that discharges may occur for failure to meet your obligations under this document. In addition, because of care quality considerations, the practice may discharge you for failure to comply with treatment plan(s) as outlined by your practitioner.

   Initials_____

10. **INSURANCE CLAIMS:** If applicable, our office will submit insurance claims. You agree to allow our practice to "accept assignment" of benefits and receive payment directly from your insurance company. In the event your insurer sends payment for a claim from our office to you directly, you agree to endorse the payment to our practice in fulfillment of any amounts due within 10 days of postmark.

    Initials_____

I have read and understand all the terms of this policy and by my initials and my signature below, I attest that I fully understand each item and agree to the terms above.

_____ _____

Patient Signature/ Parent or Guardian **Date**

_____ _____

Witness Signature Date

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Acknowledgement Receipt / Notice of Privacy Practices

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") I have the right to privacy regarding my protected health information. I understand that this information will be used to carry out treatment, payment and health care operations.

You may refuse to Sign this Acknowledgement

I, _____ have received a copy of the office's Notice of Privacy Practices.
(Please print name)

Signature: _____ **Date:** _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify): _____

_____

_____