



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:				Relation:
Secondary Insurance:				
ID #:				Group:
Policy Holder Name:		DOB:		Relation:
Patient Signature/ Pa	rent or Guardian:		Date:	

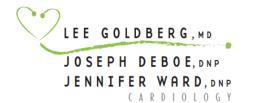






Authorization for Release of Medical Information

Patient's Full Name:	
Date of Birth:	Phone Number:
Address:	
	THIS AUTHORIZES:
Lee R. Goldberg, I	M.D. ● Jennifer Ward, DNP. ●Vein & Aesthetics of Tucson
3955 E. Fo	rt Lowell Rd, Suite 113 • Tucson, AZ 85712
2504 E. R	River Rd., Suite 101 . ● Tucson, AZ 85718
Release information to: (primary care, o	ther providers, family members)
staff, employees and agents of any resploss or theft from my person, or distress	lberg, MD, Jennifer Ward, DNP, Vein and Aesthetics of Tucson and any ponsibility for information contained in such records released in case of any type caused to me of other, Lee R. Goldberg, MD, Jennifer Ward, son will not be held liable for any misuse or misunderstanding of the of this release.
I authorize the release of all my medical i	records, including all HIV and communicable disease related information.
	
Patient Signature/ Parent or Guardian	n Date
Signature of Witness	 Date





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





8.	These agencies charge fees. In the event a la	more than 90 days old are subject to transfer to an outside collection agency. wsuit is necessary for collection, prevailing party is awarded attorney's fees. In lear or cannot be cashed. You agree to be liable for all such fees with a minimum
	Initials	
9.	occur for failure to meet your obligations unde	the right to discharge a patient for any reason. Please note that discharges may this document. In addition, because of care quality considerations, the practice eatment plan(s) as outlined by your practitioner.
	Initials	
10.	assignment" of benefits and receive payment	ice will submit insurance claims. You agree to allow our practice to "accept directly from your insurance company. In the event your insurer sends payment agree to endorse the payment to our practice in fulfillment of any amounts due
	Initials	
	ead and understand all the terms of this policy a d agree to the terms above.	nd by my initials and my signature below, I attest that I fully understand each
Patient	Signature/ Parent or Guardian	Date
 Witness	Signature	Date





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.

l,(Please prin	have received a copy of the office's Notice of Privacy Practices. t name)
Signature:	Date:
For Office Use Or	ıly
We attempted to	nly obtain written acknowledgement of receipt of our Notice of Privacy Practices, but ould not be obtained because:
We attempted to	obtain written acknowledgement of receipt of our Notice of Privacy Practices, but ould not be obtained because:
We attempted to acknowledgement co	obtain written acknowledgement of receipt of our Notice of Privacy Practices, but ould not be obtained because:
We attempted to cacknowledgement control of the control of the control of the categories of the catego	obtain written acknowledgement of receipt of our Notice of Privacy Practices, but buld not be obtained because: used to sign