**Austin Vein & Vascular Clinic**

***Dr. Neal T. Foley, M.D.***

***Board Certified, American Board of Thoracic Surgery***

*Westlake Hills Medical Center*
*5656 Bee Caves Road, Suite H-201*
*Austin, TX 78746*

## Patient Information

Last Name _____ First Name _____

Address _____ City _____ State _____ Zip Code _____

Date of Birth _____ Age ____ Sex M F Social Security # _____

Preferred Phone _____ (Home, Work, Cell)

E-mail Address _____

Emergency Contact _____ Phone # _____

Relationship _____

Primary Care Physician _____ Phone # _____

Patient Employer _____

How did you hear about us? _____ Referred by _____

## INSURED PARTY (*if other than self*)

Last Name _____ First Name _____

Social Security # _____ Date of Birth _____

Insurance Company _____ Phone # _____

Policy # _____ Group # _____

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**HIPAA/PRIVACY NOTIFICATION**: My signature on this form indicates my acknowledgement that I have been provided with the opportunity to read and have access to a copy of Austin Vein & Vascular Clinic's Privacy Notice, which explains how my health information and medical care may be used or disclosed by Austin Vein & Vascular Clinic and will NOT be discussed with anyone other than my doctors and members of my treatment team *(which will include the below authorized members)* without my permission. **Initials** _____

➔ Please provide name(s) of family members that you authorize release to: _____

**MEDICAL RELEASE/ASSIGNMENT OF BENEFITS:** I hereby authorize payment of all health insurance benefits to Austin Vein & Vascular and allow assignee to release all information necessary to secure payment, I agree that a photocopy of this authorization shall be considered as effective and valid as the original. I understand that I am legally responsible for all charges incurred whether or not they are paid by my health insurance and that any unpaid balance shall be due in-full immediately if insurance proceeds are paid directly to the patient**.** I understand that if my account should be forwarded to a collection agency, a 40% charge will be added to my account balance. Additionally, I hereby authorize release of my medical records, inclusive of all test results and pertinent information acquired during my treatment, to/from other physicians/insurance company as deemed necessary. **Initials** _____

**PHOTOGRAPHIC//VIDEO IMAGE CONSENT:** I authorize the taking and use of photographic/video images that will show ONLY the treated areas. Consent for this is given with the understanding that my case will not be identified nor will my name/face be used or revealed at any time. **Initials** _____

**HIV TESTING AFTER ACCIDENTAL EXPOSURE:** I understand that in the event a healthcare worker is exposed to my blood or body fluids during my exam/procedure, my blood may be tested for HIV antibody and other communicable diseases at no cost to me. **Initials** _____

Signature _____ Date _____