Dear _____,

We look forward to meeting you on_____ for your consultation with Dr. Gregory Landis. Please arrive 15 minutes prior to your appointment time. Failure to do so may result in rescheduling your appointment. Please bring your driver's license, insurance cards, and a list of your current medications. If you need to cancel or reschedule please let our office know at least 24 hours before your scheduled appointment time or you will be charged a $75.00 fee. Patients arriving more than 10 minutes late will be rescheduled and responsible for this charge as well.

In order to provide a safe working environment, we ask that children do not accompany you to your appointment. Due to the use of equipment such as lasers and ultrasound, please arrange for childcare before your appointment. In the event that childcare is not arranged, the result will be cancellation of services and a cancellation charge.

Office co-payments are collected at the time of check-in. During your initial consultation you may need to have a diagnostic ultrasound. Insurance companies require this documentation in order to cover your future treatments. This will result in an additional charge subject to co-insurance and deductible and will be collected AFTER your insurance has been billed. **Please bring a pair of loose-fitting shorts with you if possible.**

Attached are 5 forms to be completed before your appointment and brought with you. **Please do not mail or fax these forms into the office.** Please call our office if you have any questions and we will be happy to help!

Thank you,

Dr. Landis' Office

3515 Coolidge Road
Suite B
East Lansing MI 48823
(517) 999-3930

info@totalveincareclinic.com

visit our website: http://www.totalveincareclinic.com/

PATIENT INFORMATION

Name: _____ S.S. _____
Last First MI

Address: _____ DOB: _____

City: _____ State: _____ Zip: _____

Email: _____ May we use your email for marketing? Y / N

Home Phone: (_____) _____

Cell Phone: (_____) _____

☐ Married ☐ Widowed

☐ Single ☐ Divorced

Employer/School_____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION

Primary Policy

Subscriber Name: _____
Last First MI

Insurance Company: _____

Contract #: _____ Group #: _____

Secondary Policy

Subscriber Name: _____
Last First MI

Insurance Company: _____

Contract #: _____ Group #: _____

REFERRAL INFORMATION

Referring Physician: _____

Family Physician: _____

Would you be interested in hearing more about our Medspa services at North44 Medspa? Y / N

Patient Name:_____ Date of Birth: _____

Name of preferred Pharmacy: _____

Current Medication List **Dosage**

Please list medication allergies and reactions:

Are you allergic to Latex? **Yes or No**

Are you allergic to Iodine/Betadine? **Yes or No**

ASSIGNMENT, RELEASE and POLICIES

I certify that I have insurance coverage with the above-named insurance company(ies) and assign directly to Total Vein Care Clinic all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether paid by insurance or not.** I further understand that all co-payments and deductibles will be paid at check in unless other arrangements have been made prior to appointment date. I authorize the use of my signature on all insurance submissions. I understand that there is a **$35.00 return check fee.** I understand that if I NO-SHOW or fail to cancel my appointment 24 hours prior to my scheduled office visit, Total Vein Care Clinic has the right to charge me a $75.00 fee. Cancellation of procedures requires 48 hours notice. In the instance that I arrive to my appointment more than 10 minutes late, I understand that my appointment may be cancelled or rescheduled for a fee. I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to collection agency fees and court costs. Gregory Landis, D.O. may use my health care information and may disclose such information to the above-named insurance company(ies) and the agents for obtaining payment for services and determining insurance benefits or the benefits payable for related services. **** I understand that the below signed name is financially responsible for all charges and that full payment or insurance co-payment (which ever is applicable) is due at the time of service.**

At Total Vein Care Clinic, we pride ourselves in offering the best care and service to all our patients. Please make yourself aware of our office polices and procedures:

- ☐ To show respect for other patients and office staff, please refrain from cell phone use. We ask that phones are turned off or ringers are silenced during your appointment.
- ☐ In order to provide a safe working environment, we ask that children do not accompany you to your appointment. Due to the use of equipment such as lasers and ultrasound, please arrange for childcare before your appointment. In the event that childcare is not arranged, the result will be cancellation of services and a cancellation charge.
- ☐ During in office procedures, only the patient and clinical staff are permitted in the operating suite. This is not only to maintain a clean working environment, but also to comply with OSHA guidelines.
- ☐ Inappropriate, rude or abusive behavior will not be tolerated. We reserve the right to discharge any persons from the practice for the above-mentioned behavior.

_____ _____

Signature of patient, guardian, or personal representative | Date

_____ _____

Please print name of patient, guardian, or personal representative | Relationship to Patient

Authorization to Release Medical Information and Records

In order for our office to release any medical information regarding your care to any individual, they must be named as your personal representative. By naming this individual as your personal representative you give our office permission to communicate with them.

Name of Representative: _____
Relationship: _____
Address: _____
_____
Phone: _____

☐ I do not authorize any individual to act as my personal representative

I, _____ (full name of patient) hereby authorize Dr. Gregory Landis to release medical information from my personal medical records to:

I give my permission for this medical information to be used for the following purpose:

I do not give permission for any other use or re-disclosure of this information.
(note: Several extra lines are provided below so additional restrictions on this authorization letter may be placed. You may, however, leave these lines blank or you may want to (1) specify a particular expiration date for this letter if less than one year, (2) describe medical information to be created in the future that you intend to be covered by this authorization letter, (3) describe portions of the medical information in your records which you do not intend to be released as a result of this letter.)

_____
Full name of Patient or Legal Representative (please print)

_____ _____
Signature of Patient or Legal Representative Date of Signature

HIPAA

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

The Consent was signed by: _____

Printed Name- Patient or Representative

_____

Signature Date

Relationship to Patient

(if other than patient): _____