SpotlessVeinCare

HORMOZE A. GOUDARZI, M.D., P.A.

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PATIENT INFORMATION

This Form Must Be Completed Annually

Today's Date _____

Patient Information

Last Name	**First Name**	**Middle Name**	
Birth Date	**Social Security Number**	**Race**	**Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Street Address Apt #	**City**	**State**	**Zip**
Mailing Address Apt #	**City**	**State**	**Zip**
Sex ☐ Female ☐ Male	**Home Phone**	**Cell Phone**	
Employer	**Address**	**Business Phone**	
E-mail Address			
Emergency Contact	**Emergency Contact Phone**		
Preferred Pharmacy	**Address**	**Pharmacy Phone**	
Primary Care Physician	**Who referred you to our office?**		

→ **Do you give permission to our office to send secure messages via text ☐ or email ☐? No ☐**

Insurance Information

Primary Insurance		**Secondary Insurance**	
Policy #	**Group #**	**Policy #**	**Group #**
Name of Policyholder		**Name of Policyholder**	
Address of Policyholder City	**State Zip**	**Address of Policyholder City**	**State Zip**
Policyholder Phone	**Policyholder Birth Date**	**Policyholder Phone**	**Policyholder Birth Date**
Social Security Number of Policyholder	**Employer of Policyholder**	**Social Security Number of Policyholder**	**Employer of Policyholder**
Relationship to Patient		**Relationship to Patient**	

HIPAA Authorization Acknowledgement and Consent

I acknowledge that upon my request a copy is available of Hormoze A. Goudarzi MD, PA's Notice of Information Practices . I hereby authorize Hormoze A. Goudarzi MD, PA to release to the below listed individuals, upon their request and without further authorization from me, information concerning treatments the above listed patient receives as a patient of Hormoze A. Goudarzi MD, PA and copies of any and all medical records. This authorization is made at my request and will not expire unless revoked by me. I understand that I may revoke or restrict at any time the right of any of these individuals to receive this medical information by providing said revocation or restriction to Hormoze A. Goudarzi MD, PA in writing. I understand that Hormoze A. Goudarzi MD, PA will not condition treatment upon whether I authorize these individuals to receive this information. I understand that any health information and medical records disclosed to the below listed individuals may possibly be re-disclosed by them without any restrictions under federal or state privacy regulations.

Name of person to disclose information:	**Name of person to disclose information:**
Relationship	**Relationship**

PLEASE CONTINUE TO BACK →

TERMS OF RECEIPT OF MEDICAL CARE OR TREATMENT

CONSENT FOR TREATMENT: The patient is under the control of the attending physician. The undersigned consents to any medical treatments or procedures (except for invasive procedures which require special consent), X-ray, examination, diagnostic and laboratory procedures, medications, injections, taking of photographs or video for clinical, education or identification purposes, and hospital services rendered to the patient under the general and special instructions of the attending physician(s) or other providers assisting in the care of the patient. The undersigned is aware that the practice of medicine is not an exact science and acknowledges that no guarantee or assurance has been made or implied to the patient as to the result that may be obtained from examination or treatment. The undersigned has been informed of his/her patient rights and responsibilities.

RELEASE OF INFORMATION: The undersigned hereby authorizes Hormoze A. Goudarzi MD,PA to disclose the patient's medical record or other medical information to any person or corporation which is or may be liable for all or part of Hormoze A. Goudarzi MD,PA charges or to any person or corporation who has the responsibility for reviewing such charges, including but not limited to medical service organizations, health maintenance organizations, insurance companies, employers, welfare funds, or peer review organizations. The undersigned agrees Hormoze A. Goudarzi MD,PA may copy medical record(s) which is/are to be sent to a receiving facility in the event the undersigned must be transferred to another care provider/facility. The undersigned acknowledges and consents that the medical records, laboratory results, radiology reports and billing information may be sent or disclosed to another medical facility, physicians office, or provider involved in the care of the patient or responsible for any part of the patient's charges.

REQUEST FOR PAYMENT, ASSIGNMENT OF BENEFITS, AND RELEASE OF INFORMATION FOR MEDICARE PATIENTS: The undersigned requests payment of authorized Medicare benefits, if any, for any services furnished to the patient by Hormoze A. Goudarzi MD,PA and hereby assigns such benefits otherwise payable directly to the patient, to Hormoze A. Goudarzi MD,PA. The undersigned authorizes Hormoze A. Goudarzi MD,PA to submit a claim for such services to Medicare. The undersigned authorizes any holder of medical or other information about the patient to release to Medicare, or its agents, claims processors or utilization reviewers, any information needed to determine these benefits or benefits for related services.

ASSIGNMENT OF INDIVIDUAL BENEFITS: If the undersigned is entitled to medical benefits of any type whatsoever arising out of any policy of insurance insuring patient or any other party liable to patient, the undersigned authorizes Hormoze A. Goudarzi MD,PA to submit a claim for such services, and benefits are hereby assigned to Hormoze A. Goudarzi MD,PA for application on the patient(s) bill. It is agreed that Hormoze A. Goudarzi MD,PA may receive any such payment and such payment shall discharge the paying insurance company of any and all obligations under the policy to the extent of such payment. The undersigned and/or patient are responsible for charges not covered by the insurance. The undersigned certifies that the patient information contained on this form that is given by or on behalf of the patient is applying for payment from all third party payors is correct.

FINANCIAL AGREEMENT: The undersigned understands and agrees that the patient and guarantor are financially responsible to Hormoze A. Goudarzi MD,PA for charges for medical services or treatments provided to, or on behalf of, the patient if such services are not covered by the hospitalization plan, insurance, or Medicare. The undersigned certifies that he/she had read the foregoing and is the patient or guarantor of this bill, or is duly authorized by the patient as patient's general agent to execute the document and accept the terms. In the event my account(s) is not satisfied in full my account may be reported to the credit bureaus. The undersigned hereby agrees that upon discharge of the patient by Hormoze A. Goudarzi MD,PA the undersigned will be responsible for the patient and will make necessary arrangements to have the patient transferred from Hormoze A. Goudarzi MD,PA.

I HAVE READ, OR HAVE HAD EACH OF THE SECTIONS READ TO ME, AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED.

By affixing my signature below, I affirm that I am the patient or I am authorized to act on behalf of the patient to sign this document verifying consent to the above stated terms.

Patient Signature _____ Date _____

Guarantor Signature _____ Date _____

Relationship to Patient _____

THIS FORM IS PART OF THE PERMANENT MEDICAL RECORD