GVS Georgia Vein Specialists

790 Church Street
Suite 400
Marietta, GA 30060

6002 Professional Parkway
Suite 260
Douglasville, GA 30134

Phone: 678.626.0019 **Website: www.gavein.com**

PATIENT REGISTRATION

Patient Name - Last, First, Middle Initial			Date of Birth	Sex ☐ Male ☐ Female
Street Address	Apt #	City	State	Zip
Mailing Address (if different from above)				
Home Phone #	Cell Phone #	Email Address		
Marital Status ☐ Single ☐ Married	Driver's License #	State	Patient's Employment Status ☐ Full-time ☐ Part-time ☐ Retired ☐ Not Employed	
Patient's Occupation	Employer			
Employer's Address	City	State	Zip	
Work Phone # (and extension)	May we call you at work? ☐ Yes ☐ No			

Referring Physician

Referring Physician (must have First and Last name)	Physician's Phone #
Family or Primary Physician (must have First and Last name)	Physician's Phone #

Emergency Contact

Last Name	First	
Relationship to Patient	Daytime Phone #	Cell Phone #

Financial Information *(please bring your insurance card(s) to your appointment)*

Primary Insurance			Secondary Insurance		
Insurance Company Name			Insurance Company Name		
Name of Insured / Relationship			Name of Insured / Relationship		
Group #	Policy #		Group #	Policy #	
Beginning Coverage Date	HMO or PPO	Co-pay Amount	Beginning Coverage Date	HMO or PPO	Co-pay Amount

How did you hear about Georgia Vein Specialists?

☐ My Doctor Referred Me ☐ GVS Website/Internet Search ☐ Friend / Family Member ☐ GVS Brochure
☐ Community Health Event ☐ Magazine (please specify) _____ ☐ Other (please specify) _____

AUTHORIZATION TO CONTACT ME: I authorize Quantum Radiology to contact me, either by phone or by mail to provide a reminder of an appointment, and/or information about any new technology or services that Quantum Radiology will be offering. ☐ **Yes** ☐ **No**

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE: I hereby acknowledge that Quantum Radiology has provided me a copy of their Privacy Notice.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY / ASSIGNMENT OF BENEFITS: The information above is accurate and true to the best of my knowledge. I authorize Quantum Radiology Northwest to file insurance claims on my behalf to Medicare or other insurance plans shown above. I understand that I am responsible for any deductible, co-payment, or non-covered service at the time that services are rendered. I authorize payment of any benefits due under my insurance plan to Quantum Radiology when insurance is filed on my behalf. I understand that I may be charged for missed office visits not canceled at least 48 hours in advance. I understand that it is my responsibility to understand the benefits of my insurance plan AND that I am financially responsible for any services not covered by my plan.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize Quantum Radiology to release any medical information pertaining to my diagnosis and treatment to 1) any requesting physician or medical facility providing my medical care; 2) my insurance plan, employer (if employer-funded plan), Medicare, or other payer/provider of medical benefits which may or will pay for part of my medical expenses. I understand that release of this information may be required in order to obtain payment for medical expenses. This authorization applies to all information regarding my care, which may include information otherwise privileged or confidential by law (including information related to psychiatric care, drug/alcohol abuse, and HIV/AIDS confidential information). I hereby release Quantum Radiology from any and all liabilities, which may arise from the release of the information described above. This authorization will remain in effect for ONE (1) YEAR from the date of my signature.

Patient Signature: **Date:**