Patient Registration Information

SOUND VASCULAR & VEIN

Emergency Contact Information:

Name_____ Relationship_____

Home Phone_____ Work Phone _____ Cell Phone_____

Name_____ Relationship_____

Home Phone_____ Work Phone _____ Cell Phone_____

Name_____ Relationship_____

Home Phone_____ Work Phone _____ Cell Phone_____

Authorization for Treatment

The undersigned consents to any medical, surgical, or diagnostic services, which are ordered by a physician and/or rendered by Sound Vascular. In accordance with Washington State Law, Sound Vascular may communicate protected heath information concerning its patients to treating physicians and providers involved in patient care unless otherwise specifically instructed in writing by the patient or parent/guardian.

Assignment of Benefits/Release of Information

The undersigned authorizes Sound Vascular to release any information which is required to determine benefits, eligibility, and to process claims for payments on services rendered. The undersigned authorizes all insurance payments be made payable directly to Sound Vascular for any and all medical and surgical services rendered.

Financial Agreement

The undersigned agrees that in consideration of services rendered he/she hereby agrees to pay for services in accordance with regular rates and terms of Sound Vascular. Should the account be referred to any attorney or collection agency, the undersigned shall pay all reasonable attorney's fees and/or collection costs.

Print_____ Sign _____ Date_____