RED SANDS
VEIN & VASCULAR SPECIALISTS

***PATIENT INFORMATION***

Patient Name (Last, First) _____ DOB _____

Mailing Address _____City/State_____

Phone Number _____ Email_____

Would you prefer us to remind you of your appointments with a TEXT or PHONE CALL (Circle one)

Insurance (Primary/Secondary) _____/_____

Responsible Party Name _____DOB _____ SS#_____

Relationship to patient_____

Emergency Contact(not living with you)_____ Ph#_____

***HIPPA RX CONSENT***

HIPPA consent to VIEW HISTORY of medication prescriptions. I, the undersigned, give consent to RED SANDS VEIN to view my prescription history.

Pharmacy _____ City _____

Patient Name (Please print) _____

Patient Signature _____ DATE _____

***PRIMARY CARE PROVIDER***

Primary Care Physician or Provider: _____

Phone Number _____ Fax _____

***REFERRAL***

How Did You Hear About Us? *(Please mark which options apply)*

___Provider (doctor) sent me Name of Provider _____

___Google Search ___ Magazine Ad ___ Radio ___ Other ___Friend or Relative

***INSURANCE/PAYMENT INFORMATION***

**Copays, co-insurance, and self-pay amounts are due at the time of each visit prior to meeting with the physician/physician assistant.**

**Payment in full is due within sixty (60) days from the date of service. If payment in full is not made as required, then in additional to all other amounts that may be due I agree to pay a collection fee of up to 40% of the principal amount as provided by 12-1-11 of the Utah Code Annotated, and further agree to pay all other costs of collection (whether incurred by Red Sands Vein or its assigns) including but not limited to court costs, reasonable attorney fees, and interest (both pre- and post- judgement). Any interest due hereunder shall be calculated at a rate equal to 18% per annum and may, as determined by Red Sands Vein or its assigns: (a) accrue on some or all amounts due and (b) compound as frequently as daily-meaning that accruing interest may be added to the balance owing as frequently as daily such that it shall thereafter constitute part of the amount upon which interest accrues during the next accrual period.**

**I hereby consent to being contacted by telephone at any phone number (including but not limited to wireless/cellular phone numbers) provided to Red Sands Vein by me or anyone associated with me or acting on my behalf. I understand and agree that such calls may be initiated by Red Sands Vein or any of its affiliates, agents, contractors or assigns, including but not limited to billing companies and/or third-party collection agency(ies), and that the methods of contact may include using pre-recorded/artificial voice messages and/or the use of an automated dialing device and/or the use of text messages-some or all of which may result in data charges. I also consent to receiving emails under the same terms at any email address provided by me or anyone associated with me or acting on my behalf. In granting each and all of the foregoing permissions, I understand that I am responsible for ensuring my own level of privacy.**

**Patient Signature**_____ **Date**_____


# HIPPA AUTHORIZATION FORM

I hereby authorize the use or discharge of my protected health information as described below and understand and acknowledge the following:

- I am not required to sign this authorization and may in fact refuse to sign this authorization.
- Red Sands Vein & Vascular Specialists, will not condition my treatment or payment for my treatment on obtaining this authorization from me, unless permitted by law.
- If the organization or person authorized to receive this information is not required to comply with the federal privacy regulations, the released information may be re-disclosed and would no longer be protected.
- I may inspect or copy the protected health information sought to be used or disclosed in this authorization, as permitted by the federal privacy regulations.
- I have the right to revoke this authorization at any time. My revocation must be in writing and submitted to Red Sands Veins & Vascular Specialists. If I do revoke this authorization, however, my revocation will not affect any prior actions taken in reliance on my authorization.
- If I have any questions about this authorization, I may contact Red Sands Vein & Vascular Specialists at (435)673-2301 who will provide me with more information about this authorization, or about the privacy practices.

**Initials**:_____

Patient Name:_____
The following persons or organizations are authorized to make the requested use or disclose of my protected health information:

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Power of attorney (If applicable) _____

**I certify that I have read, signed and may request a copy of this authorization**.

_____ _____

Signature of Patient Date

_____ _____

Employee Witness Date