New Patient Information and Notice of Privacy Practices

Date:

Patient Name: _____ _____ ___
(Please Print) Last First MI

Contact Phone #: _____ Cell Phone #: _____

E-Mail Address: ____ ____ Date of Birth: ____ /____/_____ Sex: M ____ F __
By providing us with your e-mail addresses you give us permission to contact you or to send you promotions and our monthly specials.

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Single: __ Married: __ Widowed: __ Separated: __ Divorced: __

Referred By: _____

Did you see our TV ad or hear about Vivesse on the radio? _____ If yes, on which station? _____

Primary Care Physician: _____ Phone #: _____

Employer: _____Occupation:_____

Name of Emergency Contact: _____

Phone #: _____ Relationship: _____

Vivesse accepts VISA, MasterCard and personal checks.

Medical Professionals at Vanishing Veins and Vivesse

1. **Lori L. Greenwald, MD – Vascular surgeon, phlebologist, aesthetic medicine**
2. **Katie Roach, APRN - Phlebologist**
3. **Amanda Scranton, APRN - Aesthetic Medicine**
4. **Danielle Beaulieu, APRN - Phlebologist, Aesthetic Medicine**
5. **Jodi Daniels - Medical Aesthetician**

Protected Health Information and Privacy Notice

The Health Insurance Portability and Accountability Act HIPPA) requires Vivesse to maintain the privacy of your protected health information, provide you with a notice of our legal obligations and privacy practices, and abide by its terms. Your protected health information is information about you, created or obtained by us, including personal identification information, information about your past, present or future physical or mental health or condition, as well as information regarding payment for the provision of your health care. Our **Notice of Privacy Practices** describes your rights to access and control your protected health information and informs you of certain obligations we have regarding the use and disclosure of this information. If you would like a copy of our Notice of Privacy Practices, you may request it at any time.

Please sign on the line below to acknowledge you have read the above statement regarding the Notice of Privacy Practices.

Patient's Signature:_____Date:

Note: To ensure the confidentiality of your protected health information, we will not disclose such information to anyone, including your spouse, without your express authorization. To authorize us to disclose information about your healthcare to any other person(s), please provide their name(s) and relationship to you in the space below. I authorize Vivesse to release my protected health information to:

Individual(s): Relationship to Patient:

_____ _____

_____ _____

If you do not wish to receive a copy of our Notice of Privacy Practices please check the box below and sign in the space provided.
□ I have read the Notice of Privacy Practices and do not wish to receive a copy.

Patient's Signature: _____ Date: