Westford Vein & Aesthetic Solutions

Date: _____

ALLERGIES: _____

Patient: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Telephone: _____ **Cell Phone:** _____

Employer: _____ **Business Telephone:** _____

Emergency Contact Name: _____ **Emergency Contact Number:** _____

Email address: _____

Male: _____ **Female:** _____

Age: _____ **Date of Birth:** ____/____/____

Primary Care Physician: _____

Referring Physician: _____

Language: _____ **Race:** _____ **Ethnicity:** _____

WORKER'S COMPENSATION/AUTOMOBILE ACCIDENT

Insurance Carrier: _____
Address: _____ Telephone: _____
Claim/File # _____ Date of Injury: _____

EXTENDED AUTHORIZATION AND CONSENT

I request that payments of medical benefits be made directly to the physician on any unpaid bills of services rendered to me on or after today's date

Signed: _____ **Date:** _____

I further authorize the release of any medical information necessary to process this or related claims. I also request payment of government benefits to the party who accepts assignment. I permit a copy of this authorization to be used in place of the original.

Signed: _____ **Date:** _____

Westford Veins & Aesthetic Solutions
5 Cornerstone Square
Suite 201
Westford, MA 01886
(978) 577-6120

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____

Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____
Date: _____

Relationship to patient (if signed by a personal representative of patient):

_____

WESTFORD VEIN & AESTHETIC SOLUTIONS

5 Cornerstone Square, Suite 201
Westford, MA 01886-2776

Referral Policy

Updated 8/31/2021

As of March 1, 2017, our office policy requires that the **Patient is responsible for obtaining all referrals from their Primary Care Physician's office** if it is required by your insurance company.

The referral consists of an authorization number, a start date, an end date, and the number of visits that your primary care doctor has obtained from your insurance company.

The referral **MUST** be in our office on or before the day of your scheduled appointment.

If our office does not receive your referral in this timely manner, your insurance company may not cover your visit and you may be responsible for the charges associated with your visit/procedure. You are encouraged to call your primary care physician's office prior to your visit for their guidelines regarding obtaining referrals. You are also encouraged to contact your insurance company to understand your deductible/co-insurance/co-pay responsibilities.

I have read, understand, and agree to the above referral policy.

Date	Signature	Printed Name

WESTFORD VEIN & AESTHETIC SOLUTIONS

5 Cornerstone Square, Suite 201
Westford, MA 01886-2776

Cancellation Agreement

As of March 1, 2016 our office requires 24-hour notice for any cancellation. This is so we can allocate other patients in need of urgent care. A $50.00 office fee or a $100.00 surgical procedure/ultrasound fee will be charged if less than 24 hours' notice is given. This fee is entirely the patient's responsibility, and is not covered by your insurance.

Payment Agreement

Payments (co-pays, deductibles) are expected at the time services are rendered. Payments and charges made at the time of services are estimates until your insurance carriers and the provider have made the appropriate adjustments to your account. Insurance companies may deny your claim, at which time you are responsible for the entire balance.

We accept the following: MasterCard, Visa, American Express, Discover, and Cash. We do not offer any in-house finance options.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to Westford Vein & Aesthetic Solutions.

I authorize Westford Vein & Aesthetic Solutions to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

_____	_____	_____
Date	Signature	Printed Name

WESTFORD VEIN & AESTHETIC SOLUTIONS
5 CORNERSTONE SQUARE (SUITE 201)
WESTFORD, MA 01886
(978) 577 – 6120

Privacy Officer: **Calin Vasiliu, M.D.**

Effective Date: **January 1, 2014**

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about out patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required to abide by the terms of the Notice of privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this notice, please contact the privacy officer at this practice.

Who Will Follow This Notice

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minim necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information about You

The following categories describe different ways that we may use and disclose medical information without you specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, and insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treat to your insurance company of payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can BE Made Without Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities of their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner of identification of a body
- If an inmate to the correctional institution or law enforcement official
- As required by the US FOOD and DRUG Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers payment activities
- Other covered entities healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public Health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Requiring your Written Authorization. Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding Your Medical Information

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the privacy officer at this practice or with the secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use to disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Right to Request Confidential Communications. You have the right to request how we should send communication to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decision about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at his practice. If you request a copy of the information we reserve the right to charge a fee for eth costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request and amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not win writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at his practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement wand will provide you with a copy of any such rebuttal. Statement s of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an Accounting of Non-Standard Disclosures. You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before January 1, 2014. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive the notice electronically, you are still entitle to a paper coy. To obtain a paper copy of the current Notice, please request on in writing from the Privacy Officer at his practice.

Changes to This Notice We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current, Notice, with the effective date in the upper right corner of the first page.