2550 Denali Street Suite 1307 Anchorage Alaska 99503
Phone: 907-375-8787 Fax: 907-375-9357

Patient Registration Form

Patient Name ________________________________ Date ____________
Last First Middle

Birth date ____________________ Sex _______ SS# ______________________________

Address ____
Mailing City, State Zip Code

Home phone (_____)____________________ Work phone (_____)______________________

Marital Status: ☐ Single ☐ Married ☐ Other

Employer: ____________________________ ☐ Retired ☐ F/T Student ☐ P/T Student

Spouse's Name__________________________ SS#__________________Birth date_______________

Spouse's Employer____________________________ Employer phone#___________________

Responsible Party: If Other than Patient, Please Complete

Name_______________________________________ Relationship to Patient_________________________

Phone #'s Home________________________________ Work:_________________________

Emergency Contact: Nearest Friend/Relative Not Living With You

Name____ Relationship to Patient__________________

Address____ Phone (____)__________________

Medical Insurance Information (If you have your card , we will take a copy of you insurance cards.)

(If you do not have an insurance card, please indicate your insurance carrier and your I.D.#)

Primary Insurance:_______________________________________ ID#_________________________

Policy Holder Name:____

Secondary Insurance: ____________________________________ ID#_________________________

Policy Holder Name:____

Name of Primary Care Provider____

How did you hear about our services? ☐ ☐

→ ☐ Radio ☐ Television ☐ Website ☐ Friend ☐ Newspaper

☐ Referring Provider ____
(Name)

☐ Other ____

Financial Responsibility Statement/Release of Information Authorization

I understand that I am fully responsible for any and all charges for services rendered by The Laser Vein Center of Anchorage. If insurance information is provided, my insurance company will be billed as a courtesy to me. I am responsible for my portion of the bill at the time that services are rendered. I hereby authorize payment under my insurance to be paid directly to The Laser Vein Center of Anchorage, providers and and I further authorize realease of any information necessary to my insurance company for payment of claims. I understand a finance charge will be applied to any outstanding balance due after insurance payment or denial after a 90-day grace period.

Patient Signature___________________________________ Date____________________

In connection with the medical services which I am receiving from my physician, I agree to have photographs taken of me under the following conditions:

1. The photographs may be taken only with the consent of the physician.
2. The photographs shall be taken by my physician or a photographer approved by my physician.
3. The photographs shall be used for medical records and if in the judgment of my physician, medical research, education or science will benefit by their use. It is specifically understood that in any such publication or use I shall not be identified by name.

Patient Signature___________________________________ Date____________________

AGREEMENT AS TO RESOLUTION OF CONCERNS

Further, I understand that I am entering into a contractual relationship with Dr. Donald Ives and The Laser Vein Center of Anchorage for professional care. I further understand that meritless and frivolous claims for medical malpractice have had an adverse effect upon the cost and availability of medical care, and may result in irrepable harm to a medical provider. As additional consideration for professional care provided to me by Dr. Donald Ives and The Laser Vein Center of Anchorage, I agree not to advance, directly or indirectly, any false, meritless, and /or frivolous claim(s) of medical malpractice against Dr. Donald Ives and The Laser Vein Center of Anchorage.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I agree to use American Board of Medical Specialties board certified expert medical witness(es) in the same specialty as Dr. Donald Ives. Furthermore, I agree that these expert witnesses will adhere to the guideline and/or code of conduct defined for expert witnesses by the American Academy of Family Practice, the American College of Phlebology, and the American Society of Lasers in Medicine and Surgery.

In further consideration for this, Dr. Donald Ives agrees to the same stipulations.

Signature: ____________________________ ____________________________

Patient/Guardian Physician

____________________________ ____________________________

Date of Signature Effective from Date of Treatment