



Patient Registration Form

1405 Kellum Street Suite 300 Fairbanks, Alaska 99701
Phone: 452-8346 Fax: 451-8346

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 Fairbanks, LLC. 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 Fairbanks, LLC, providers and I further authorize release 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 Fairbanks, LLC 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 irreparable harm to a medical provider. As additional consideration for professional care provided to me by Dr. Donald Ives and The Laser Vein Center of Fairbanks, LLC, 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 Fairbanks, LLC.

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