VASCULAR SURGERY ASSOCIATES

New Patient Registration

Staff Use Only: PID#:_____ Scanned by (Initials): _____

Patient Arrival Time: _____ AM / PM

PLEASE FILLOUT ALL FORMS COMPLETELY

Patient Information: *Need help with Forms?* ☐ *Y* ☐ *N* | Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Name: (LAST) _____ (FIRST)_____ (MI)_____ (Suffix) _____

Minor☐ Y ☐ N Date of Birth: _____ /_____/ _____ Social Security (Optional):_____-_____-_____ Sex: ☐ M ☐ F

Street Address: _____ (Apt #) _____ (City) _____

(State)_____ (Zip) _____ (Country) _____ Home Phone: _____ Cell Phone: _____

Best Form of Contact: ☐ Home Phone ☐ Cell Phone | Best Time: _____|May we leave a detailed voice message? ☐ *Y* ☐ *N*

Email: _____ Martial status __M__S__D__W__Other

Primary Care Physician: (Name)_____ (Phone)_____ (City) _____

Preferred Pharmacy: (Name) _____ (Location) _____ (Phone) _____

Emergency Contact: (Name) _____ (Phone) _____(Relationship)_____

Guarantor: Is your address the same as the Patient/Minor's address? ☐ Yes ☐ No | ***If no***, provide information below.

Name of Guarantor: _____ Guarantor Date of Birth: _____ / _____ / _____

Street Address: _____ (Apt #) _____ (City) _____

(State)_____ (Zip) _____ (Country) _____ Home Phone: _____ Cell Phone: _____

Patient authorization to release medical records

I _____ authorize Vascular Surgery Associates to disclose/release the following* (check all applicable)

☐ All Records ☐ Billing Records ☐ Other _____

Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse or STDs, you are hereby authorizing disclosure of this information.

To (Name of person/place recieving records):_____ **Relationship to patient:** _____

Address:_____ City:_____ State: ____ Zip: _____

Phone: _____ Fax: _____

☐ **INSURANCE**: Primary Insurance: _____ Secondary Insurance:_____

☐ **AUTO** – Name of Ins: _____Phone: _____ Accident/Claim #:_____

☐ **WORK COMP** - Company Name: _____ CompanyRepresentative:_____

Company Phone Number: _____ Email: _____

☐ **SELF PAY** (FFS)

Race:

___ American Indian or Alaskan native
___ African American
___ White
___ Other
___ Declined

Ethnicity:

____Hispanic or Latino
____Not Hispanic or Latino

VASCULAR SURGERY ASSOCIATES

Patient Acknowledgement & Consent Treatment Coverage & Communication

Please INTIAL next to your CURRENT method of coverage, and to complete the acknowledgment and consent for Medical Treatment, Notice of Privacy Practices, and Payment Policy.

___SELF PAY (FFS) PATIENT VISIT

By signing below, I acknowledge that I have been informed of my responsibility to pay for the professional services or supplies provided to me today by Vascular Surgery Associates.
I understand that these costs must be paid prior to the provision of such services through its authorized representatives.
I acknowledge and fully understand that the service(s) requested today will not be billed to any insurance carrier(s) at my request. I also understand that today's service(s) will be provided at a discounted rate and waive any right that I may have to require Vascular Surgery Associates to attempt to bill any insurance carrier for these services. I further acknowledge that if I choose to submit an itemized receipt to any insurance carrier(s) for evaluation of partial or full reimbursement for these services that Vascular Surgery Associates is exempt from any subsequent dispute regarding reimbursement but retains the option to submit these services for payment under the non-discounted insurance rates and guidelines upon mutual agreement by both parties when appropriate insurance information has been provided to Vascular Surgery Associates.

___ HEALTH INSURED PATIENT VISIT

I request that payment of authorized insurance benefits, including Medicare, be made on my behalf for any professional services or supplies provided to me by Vascular Surgery Associates.
I acknowledge that I have provided my insurance information today and authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related professional services or supplies by Vascular Surgery Associates to the Health Care Financing Administration, my insurance company or other entity upon request to secure payment of my benefits.
I understand that I am financially responsible to Vascular Surgery Associates for any charges not covered by health care benefits. It is my responsibility to notify Vascular Surgery Associates of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I understand that I am responsible for the entire bill including any unpaid balance of the professional services or supplies as determined by Vascular Surgery Associates and/or my health care insurer should the submitted claim or any part of the claim be denied for payment or apply to my co-pay, deductible or coverage limitations.

___CONSENT TO MEDICAL TREATMENT

I voluntarily present for treatment and consent to my Vascular Surgery Associates provider to provide my care. Such care may include, but is not limited to, diagnostic procedures, x-rays, blood draws, laboratory tests, medication administration, and other procedures considered advisable in my diagnosis, treatment and course of care.
I acknowledge that my treatment is intended to address specific, episodic illnesses or injuries and is not intended as a substitute for a primary care physician or other specialized physician and that no guarantee can be made or has been made as to the results of treatments or examinations at Vascular Surgery Associates.

___NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge review of Vascular Surgery Associates Notice of Privacy Practices, with a copy available upon request, as required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

___OFFICE POLICY ON PAYMENT

It is our policy to require all co-payments to be made at the time of service. The undersigned agrees to pay all costs charged by the Collection Company and reasonable attorney fee.
I understand that by signing this form I am accepting full financial responsibility as explained above for all professional services and supplies received. I understand this original authorization will be kept on file by Vascular Surgery Associates and does not expire unless written notice is provided by me.

Name: _____ Date: _____

SIGNATURE: _____

Relationship to patient:
☐Self ☐Spouse ☐Parent/**Guardian** ☐**Other**

Please tell us what you would like to be seen for today:

_____

VASCULAR SURGERY ASSOCIATES

When did it start bothering you? _____ (date of onset)

Were you injured? ❍No ❍Yes ⇨ ❍At work ❍Auto accident ❍At home ❍Other_____

Next, review the symptoms below and mark the circle(s) next to any symptoms **related to your visit today**.

If an area is normal, or not related to today's visit, do not mark that circle.

GENERAL
- ❍ Pain _____ (location)
- ❍ Fever ❍ Chills
- ❍ Fatigue
- ❍ Weakness
- ❍ Unusual weight changes

EYES
- ❍ Something in eye
- ❍ **Vision problem** (blurry, loss of sight)
- ❍ Dryness ❍ Scratchy sensation
- ❍ Redness
- ❍ Excessive tearing
- ❍ Wear glasses / contacts

EARS
- ❍ Ringing in ears
- ❍ Hearing loss

NOSE
- ❍ Nosebleed
- ❍ Sinus Pain
- ❍ Runny nose

MOUTH, THROAT
- ❍ Growth in mouth ❍ White spots
- ❍ Tongue pain
- ❍ Toothache
- ❍ Soreness ❍ Trouble swallowing
- ❍ Swelling
- ❍ Hoarseness

HEART & CIRCULATION
- ❍ **Chest pain** ❍ Tightness ❍ Pressure
- ❍ Faintness ❍ Lightheaded
- ❍ Fast heartbeat ❍ Slow heartbeat ❍ Palpitations

LUNGS
- ❍ **Shortness of breath**
- ❍ Cough ❍ Wheezing
- ❍ Snoring ❍ Apnea

STOMACH, INTESTINES
- ❍ Nausea ❍ Vomiting ❍ **Rectal Bleeding**
- ❍ Indigestion ❍ Food intolerance ❍ Cramping
- ❍ Diarrhea ❍ Constipation ❍ Bloating ❍ Gas

GENITAL
❍ Sores ❍ Discharge ❍ Bleeding ❍ Pain
❍ Swelling ❍ Abnormal Period Last Period: _____

URINARY
- ❍ Frequent urinating ❍ Painful urinating
- ❍ Losing control of urine/wetting self
- ❍ Blood in urine (discolored urine)

MUSCLES, JOINTS & BONES
- ❍ Joint stiffness ❍ Pain _____(location)
- ❍ Muscle pain ❍ Cramps _____(location)

SKIN
- ❍ **Wound**/Sore _____ (location)
- ❍ Rash _____(location)
- ❍ Dryness ❍ Itchiness

BLOOD/LYMPH
- ❍ Easy bruising ❍ Easy bleeding

ALLERGIES
- ❍ Seasonal Allergies ❍ Hives ❍ Welts
- ❍ **Other**: _____

NERVOUS SYSTEM
- ❍ **Recent head injury** ❍ Dizziness/Vertigo
- ❍ Speech problems ❍ Memory loss
- ❍ Fainting ❍ **Blacking out**
- ❍ **Seizures** ❍ **Sudden Paralysis**
- ❍ Headaches
- ❍ Poor balance ❍ Loss of coordination
- ❍ **Tingling** ❍ Numbness ❍ Weakness

PSYCHOLOGICAL
- ❍ Depression ❍ Loss of interest
- ❍ Nervousness ❍ Anxiety

HORMONES
- ❍ Heat intolerance ❍ Cold intolerance
- ❍ Night sweats
- ❍ Increased thirst ❍ Hunger

Adult History and Review of Systems Questionnaire

Note: This is a confidential record of your medical history. As your doctors, it is important for us to know this information so we can provide you with the best health care possible. The information contained here will not be released to anyone without your prior consent.

Name: _____ Date_____

SOCIAL HISTORY:

Birthplace:_____
Nationality: _____
Education: _____
Marital Status:_____
Spouse/SO: _____
Children:_____
Occupation: _____
Exercise (Type/how often): _____
Pets: _____
Recent or Frequent travel destinations:_____
_____

Tobacco Use: ☐ Yes ☐ No ☐ Former Quit:_____
If Yes* Amount smoked per day_____

Alcohol Use ☐ Yes ☐ No ☐ Former Quit:_____
_____ number of drinks per ☐ day ☐ week ☐ month

Drug Use: ☐ Yes ☐ No ☐ Former Quit:_____
If Yes* Type_____ How often:_____

Caffeine Use (coffee, tea, soda, chocolate) ☐ Yes ☐ No
If Yes* Servings per day_____

MEDICAL HISTORY:

Have you ever had any of the following? (IF YES, CHECK APPROPRIATE BOXES)

☐ Cancer
Type_____
☐ Heart Attack/Coronary
☐ Artery Disease
☐ Rheumatic Fever
☐ Heart failure
☐ High blood pressure
☐ High cholesterol
☐ Stroke
☐ Diabetes
☐ Gallstones
☐ Liver Disease
☐ Hepatitis/Jaundice
☐ Ulcer disease
☐ Heartburn/ Reflux
☐ Asthma
☐ Seizures
☐ Prostate Enlargement
☐ Cystic Fibrosis

☐ Pneumonia
☐ Tuberculosis
☐ Positive TB Skin Test
☐ Osteoporosis
☐ Arthritis
☐ Gout
☐ Frequent Bladder Infections
☐ Kidney Stones
☐ Kidney Disease
☐ Polio
☐ Chicken Pox
☐ Infectious Mono
☐ Anemia
☐ Frequent Sinus Infections
☐ Malaria
☐ Reynaud's

☐ Glaucoma
☐ Thyroid Trouble
☐ Hives
☐ Depression
☐ Head Injury
☐ Broken Bones
☐ Blood transfusions
☐ Sexually Transmitted Diseases: Herpes, HIV,
☐ Gonorrhea, Chlamydia,
☐ Syphilis
☐ Intravenous drug abuse
☐ Needle injury
☐ Mumps
☐ Migraines

IMMUNIZATIONS:

☐ Measles, Mumps and Rubella Vaccine
☐ Chicken pox vaccine
☐ Hepatitis B vaccine
☐ Influenza vaccine
☐ Pneumococcal vaccine
☐ Tetanus booster
☐ Other_____
_____

SURGICAL HISTORY: (Check appropriate box and list year)

☐ Eyes (Cataract/Glaucoma) _____
☐ Eyes (Laser or vision corrected) _____
☐ Ears _____
☐ Sinus/Nasal Septum _____
☐ Tonsils/Adenoid _____
☐ Thyroid _____
☐ Heart _____
☐ Stomach _____
☐ Varicose Veins _____
☐ Orhtopedic (kip, knee, shoulder) _____
☐ Spinal Surgery _____

☐ Gall Bladder _____
☐ Appendix _____
☐ Intestine/Colon _____
☐ Hemorrhoids _____
☐ Hernia _____
☐ Breast _____
☐ Uterus/Hysterectomy _____
☐ Ovaries _____
☐ Spinal Surgery/Neck _____
☐ Prostate _____
☐ Vasectomy _____
☐ C-section _____

☐ OTHER
☐ _____
☐ _____
☐ _____
☐ _____

ALLERGIES and Bad Reactions to Medications: _____ _____

_____ _____

_____ _____

MEDICATIONS: Name Dosage Times a day

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

PLEASE ATTACH A COPY OF YOUR MEDICATION/ALLERGY LIST TO THIS FORM

Has anyone in your FAMILY ever had? (**If yes check box and list relationship**)

☐ Cancer & Type _____	☐ Dialysis _____	☐ Crohn's/colitis _____
☐ Diabetes _____	☐ Chronic lung disease _____	☐ Alzheimer's _____
☐ Cardiac Dysrhymthia _____	☐ Tuberculosis _____	☐ Alcoholism _____
☐ Congestive Heart Failure _____	☐ Rheumatoid Arthritis _____	☐ Bleeding tendency _____
☐ Coronary Artery Disease _____	☐ Thyroid trouble _____	☐ Anemia _____
☐ Valvular heart Disease _____	☐ Osteoporosis _____	☐ Gout _____
☐ High Blood Pressure _____	☐ Cystic Fibrosis _____	☐ Depression _____
☐ High Cholesterol _____	☐ Asthma _____	☐ Mental illness _____
☐ Stroke _____	☐ Peptic Ulcer _____	☐ Seizures _____
☐ Kidney stones _____	☐ Gallstones _____	☐ Migraine headaches _____
☐ Kidney disease _____		
☐ OTHER _____		

Cancellation Policy/No Show Policy
For Provider Appointments and Surgery

Cancellation Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting a much-needed appointment.

We ask that you please cancel all appointments at least 24 hours in advance.

Late/No show Policy

We understand that delays will happen however we must try to keep patient appointments and the providers on time.

If you arrive more than **15 minutes** past your scheduled appointment time, you will be asked to reschedule that appointment. Arriving **30 minutes or more** after your appointment time will result in a no-show status and a $50 fee will be charged. This fee will have to be paid before you are able to reschedule future appointments. This fee will not be covered by your insurance.

Cancellation/No show

Due to the large block of time needed for a surgery, last minute cancellations can cause problems and added expenses.

If surgery is not cancelled at least 5 days in advance you may be charged a $75 fee.

No showing your surgical procedure will result in an additional $50.00 fee.

Both fees must be paid before surgery can be rescheduled and will not be covered by your insurance

Account Balances

All account balances must be paid in full prior to receiving further services unless arrangements have been made in advance with our billing department.

Patients who have questions about their bills or who would like to discuss a payment plan option, may call our billing office at 763-777-8113.

_____ _____/_____/_____

Patient Signature Date

Updated: October 2021