American Vascular Specialists

Patient Name (Last, First, Middle) _____

Date of Birth ___/___/___ Social Security #___/___/_____ Gender: Male ____ Female ____

Ethnicity_____ Preferred Language _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Work Phone _____ Other Phone _____

Would you like to receive text messages regarding appointments? Yes _____ No _____

Email: _____

Marital Status: Single____ Married _____ Divorced_____ Separated _____ Widowed _____

Emergency Contact Name _____

Relationship _____ Phone Number _____

Referring Physician _____ Phone Number_____

Primary Care Physician _____ Phone Number _____

Pharmacy _____ Cross Streets _____

Reason for today's visit _____

How did you hear about us? _____

Insurance Information:

Primary Insurance _____

Insured Name _____ ID Number _____

Secondary Insurance _____

Insured Name _____ ID Number _____

Patient Signature_____ Date _____

www.amvascular.com Phone 480.912.6262 Fax 480.912.6261
6636 E. Baseline Rd., Mesa, AZ 85206

AMERICAN VASCULAR SPECIALISTS' POLICY

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE.

- APPOINTMENTS -24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice; a cancellation fee of $25 may then be added to your account.

- REFERRALS- If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If your plan requires a referral and you do not obtain one, you will be held responsible for the visit charges in full at the time of service.

- CO-PAYMENTS- By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the copay at each visit. Should you not pay at the time of service and we subsequently send you a statement, an administrative fee of$20 may be added to your account.

- OUT OF NETWORK PLANS-You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their coinsurance and deductible. If we do not 'participate' with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days; you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the physician's office.

  Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to American Vascular Specialists for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

- SELF-PAY PATIENTS-Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Please note: If you have applied for AHCCCS and are in the "Pending" status and your AHCCCS request is declined, you will revert to self-pay status with this office and payment in full will be required by you.

- MEDICARE -We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

  Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to American Vascular Specialists for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.

DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS- The parent who consents to the treatment of a minor child is responsible for payment of services rendered. American Vascular Specialists will not be involved with separation or divorce disputes. You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment, you will be additionally held responsible for whatever charges we incur as a result of this.

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, OR AMERICAN EXPRESS.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient's Name:_____ DOB:_____

Responsible Party Signature:_____ Date:_____

Print Name:_____ Relationship:_____

AUTHORIZATION TO RELEASE PRIVATE HEALTH INFORMATION (PHI)

Do we have permission to leave a message regarding test results, appointments, etc. on your answering machine?

- ☐ Yes
- ☐ No

Please check one that applies

- ☐ I only want my medical information released to myself
- ☐ I give American Vascular Specialists and staff authority to release my medical information regarding my care to:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Patient Signature: _____ Date:_____

AUTHORIZATION TO TREAT/RELEASE INFORMATION

I hereby give my permission to American Vascular Specialists to administer treatment and to perform procedures that may be deemed necessary in the diagnosis and treatment of my health.

I also hereby assign to the above named practice all benefits provided by my insurance company policy or policies for medical care. I understand that I am financially responsible for any balance due on my account. I also authorize the above practice to release all of my information in the processing of my claims.

I authorize American Vascular Specialists and staff to release any information including diagnosis and records of treatment or examination to third party payers and/or other health care practitioners. I give consent for other health practitioners and medical facilities to release medical records to American Vascular Specialists as it relates to my continuing care. I understand that this consent is good for one year from the date signed and may be revoked at any time in writing.

I authorize and request my insurance company to pay directly to American Vascular Specialists and its affiliates any benefits covered by my insurance plan. I understand that my insurance may pay less than the actual bill for service. I agree that I am responsible for any changes for services rendered to myself or my dependent.

Patient Print Name_____

Patient Signature_____ Date_____

Legal Representative(if applicable) Signature_____ Date_____

Notice of Privacy Practices

HIPAA Notice of Privacy Rights

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

Please review this notice carefully. You have the right to obtain a paper copy of this notice upon request.

Patient Health Information: Under Federal Law your patient health information is protected and confidential. Patient Health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes billing and insurance information.

How we Use your Patient Health Information: We use health information about you for treatment, to obtain payment, and for healthcare operations(including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose information even without your permission.

Examples of treatment, payment, and healthcare operations: **Treatment.** We will use and disclose your health information to provide you with medical treatment of services. For example, nurses, physicians, and other members of your treatment team will record information in your record and us it to determine the most appropriate course of care. WE may also disclose the information to other healthcare providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care. **Payment.** We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization form you insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan. **Healthcare operations.** We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses: We may use your information to contact you with appointment reminders. We may also contact you to provide information about your treatment alternatives or other health related benefits and services that may be of interest to you.

Other uses and disclosures: We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes: Required by Law. We may required by law to report gunshot wounds, suspected abuse or neglect or similar injuries and events. Research. We may use or disclose information for approved medical research.

Public health activities: As required by law, we may disclose vital statistics, diseases, information to recalls of dangerous products, and similar information to public health authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs and similar activities.

Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law Enforcement purposes: subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers Compensation: we may release information about you for workers compensation or similar programs providing benefits for work related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual rights: you have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising theses rights.

Request restrictions: you may request restrictions on certain uses and disclosures of our health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

Confidential communications: You may ask us to communicate with you confidentially by, for examples, sending notices to special addresses, or not using postcards to remind you of appointments.

Inspect and obtain copies: In most cases, you have the right to look at or obtain a copy of your healthcare information. There may be a small charge for the copies.

Amend information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting disclosure: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment or healthcare operations.

Our Legal Duty: We are required by law to protect and maintain the privacy of your health information, to provide this notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices: We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and each exam room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints: if you are concerned that we have violated our privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You may also send a written complaint to the US Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact person: If you have any questions, requests, or complaints, please contact: Privacy Officer, (480)912-6262, 6636 E. Baseline Rd, Suite 100, Mesa AZ 85206

I, _____, hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signature:_____ Date:_____

Staff Witness Initials:_____ Date:_____

American Vascular Specialists

Allergies

☐ No Known Allergies

Medication	Reaction

Medications

☐ No Medications

Medication Name	Strength (mg)	Frequency

www.amvascular.com Phone 480.912.6262 Fax 480.912.6261
6636 E. Baseline Rd., Mesa, AZ 85206

American Vascular Specialists

Past Medical History (Check all that apply)

Cardiovascular
- ☐ Heart Arrhythmia
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Coronary Artery Disease
- ☐ Congestive Heart Failure

Ear, Nose, Throat
- ☐ Ear, Nose, Throat problems
- ☐ Eye Disease
- ☐ Vision Impaired
- ☐ Hearing Impaired

Musculoskeletal
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Chronic Back Pain

Endocrine
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Autoimmune Disorder
- ☐ Kidney Disease

Respiratory
- ☐ Asthma
- ☐ Chronic Lung Disease
- ☐ TB

Neurological
- ☐ Neurological Disease
- ☐ Stroke
- ☐ TIA (mini stroke)
- ☐ Chronic Headaches

Psychiatric
- ☐ Depression
- ☐ Anxiety

Other
- ☐ Anemia
- ☐ Cancer Location:_____
- ☐ Bleeding Disorder/Blood Clots
- ☐ Thoracic/Abdominal Aneurysm

www.amvascular.com Phone 480.912.6262 Fax 480.912.6261
6636 E. Baseline Rd., Mesa, AZ 85206

American Vascular Specialists

Family Medical History (Please specify relationship of family member to you)

Cancer
☐ Lung Cancer: Who?_____
☐ Skin Cancer: Who? _____
☐ Breast Cancer: Who? _____
☐ Prostate Cancer: Who? _____
☐ Ovarian Cancer: Who? _____

Heart Disease
☐ Coronary Artery Disease: Who? _____
☐ High Blood Pressure: Who? _____
☐ High Cholesterol: Who? _____
☐ Heart Attack: Who? _____
☐ Stroke: Who? _____

Endocrine
☐ Diabetes: Who? _____
☐ Kidney Disease: Who? _____
☐ Thyroid Disease: Who? _____

Vascular
☐Abdominal Aneurysm:Who?_____
☐ Thoracic Aneurysm : Who? _____

Respiratory
☐ Asthma: Who? _____
☐ COPD: Who? _____
☐ Allergies: Who? _____

Psych/Social
☐ Psychiatric Disorder: Who? _____
☐ Depression: Who? _____
☐ Substance Abuse: Who? _____

Other
☐ Osteoporosis: Who? _____
☐ Anemia: Who? _____
☐ Arthritis: Who? _____
☐ Eye Problems: Who? _____
☐ _____
_____
_____
_____

www.amvascular.com Phone 480.912.6262 Fax 480.912.6261
6636 E. Baseline Rd., Mesa, AZ 85206

American Vascular Specialists

Past Surgical History

Cardiac Surgery
- ☐ Heart Bypass
- ☐ Heart Stent
- ☐ Pacemaker/Defibrillator
- ☐ Other

Lung Surgery
- ☐ Lung Surgery

Musculoskeletal
- ☐ Joint Replacement
  Location _____
- ☐Back Surgery
- ☐ Shoulder Surgery
- ☐ Foot Surgery
- ☐ Other _____

Genitourinary Surgery
- ☐ Genitourinary Surgery
- ☐ Prostate Surgery
- ☐ Hysterectomy
- ☐ Tubal Ligation
- ☐ Breast Surgery

Gastrointestinal
- ☐ Appendectomy
- ☐ Gallbladder Removal
- ☐ Hernia Surgery
- ☐ Other _____

Vascular
- ☐ Carotid Surgery
- ☐ Aneurysm Repair
- ☐ Lower Extremity Angioplasty/Stent
- ☐ Amputation
  Location _____

Difficulty with Anesthesia or Surgery Yes _____ No_____

Social History

Occupation: _____

History of Smoking:
- ☐ Current everyday smoker
- ☐ Current some days smoker
- ☐ Former Smoker
- ☐ Never smoker

Packs Per Day: _____

Year Quit: _____

History of Drinking:
- ☐ Yes
- ☐ No

Alcohol Frequency:
- ☐ Daily
- ☐ Occasional
- ☐ Social Basis

Illicit Drug Use:
- ☐ Yes
  Type_____
- ☐ No

www.amvascular.com Phone 480.912.6262 Fax 480.912.6261
6636 E. Baseline Rd., Mesa, AZ 85206

American Vascular Specialists

Current Symptoms

Constitutional
- ☐ Fever
- ☐ Decreased appetite
- ☐ Weight changes
  - ☐ Gain
  - ☐ Loss

ENMT
- ☐ Hearing loss
- ☐ Sudden vision change
- ☐ Double vision
- ☐ Change in voice
- ☐ Difficulty Swallowing

Cardiovascular
- ☐ Chest discomfort
- ☐ Skipped heartbeats
- ☐ Fluttering in chest

Respiratory
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Asthma
- ☐ Wheezing

Gastrointestinal
- ☐ Abdominal pain
- ☐ Stomach ulcers
- ☐ Indigestion
- ☐ Constipation

Genitourinary
- ☐ Frequent urination
- ☐ Loss of bladder
- ☐ Blood in urine

Musculoskeletal
- ☐ Leg pain
- ☐ Muscle cramps
- ☐ Joint pain
- ☐ Arthritis

Skin
- ☐ Skin rash
- ☐ Chronic dry skin
- ☐ Itching

Neurological
- ☐ Dizziness/vertigo
- ☐ Lack/loss of balance
- ☐ Memory loss
- ☐ Seizures

Extremities
- ☐ Swelling
- ☐ Open ulcers/sores
- ☐ Discoloration
- ☐ Coldness in feet/toes
- ☐ Tingling in feet/toes
- ☐ Numbness in feet/toes

Psychological
- ☐ Depression
- ☐ Anxiety
- ☐ Unusual stress

Endocrine
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Excessive thirst
- ☐ Excessive hunger

Hematology/Lymphatic
- ☐ Blood clots
- ☐ Bleeding disorder
- ☐ Clotting disorder

Allergy/Immunologic
- ☐ Seasonal allergies
- ☐ Persistent infections

Other

_____
_____
_____
_____
_____
_____