ADVANCED VASCULAR ASSOCIATES
AdvancedVascular.com

Main Phone: 973-540-9700
Fax: (973) 540-9717

(Please print)

Today's Date: _____

Patient Information

Name: _____
First Name Middle Last Name

Date of Birth: _____ Age: _____ Social Security #: _____

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other _____

Home Phone: _____ Cellular: _____

E-Mail: _____

Home Address:

Address: _____ Bldg/Apt #: _____

City: _____ State: _____ Zip Code: _____

Demographics

Race:

☐ African American ☐ Asian
☐ Caucasian ☐ Hispanic
☐ Other _____

Primary Language:

☐ Italian ☐ English
☐ French ☐ Spanish
☐ Other _____

Ethnicity:

☐ Hispanic ☐ Non-hispanic

Employer Information

Employer: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Work Phone: _____

Emergency Notification

In case of emergency, who should be notified? _____

Relationship to patient: _____

Email: _____

Phone Numbers:

Home: _____ Work: _____ Cellular: _____

ADVANCED VASCULAR

131 Madison Avenue, Second Floor, Morristown, NJ 07960-7360
Voice (973) 540-9700 • Fax (973) 540-9717

CONSENT TO THE USE AND DISCLOSURE OF HEALTHCARE INFORMATION, FOR TREATMENT, PAYMENT, AND/OR HEALTHCARE OPERATIONS

Patient Name: _____ Today's Date: _____

DOB: _____ Advanced Vascular Medical Record #: _____

As used in this form, the words "I," "me," "my" and similar references means the patient whose name appears above, or the parent, legal guardian or other legally responsible person on behalf of the minor or incapacitated patient named above.

General Consent for Examination and Treatment

I hereby consent and authorize Advanced Vascular and all physicians and ancillary medical personnel of Advanced Vascular, to perform medical examinations and provide routine medical care for all my visits to Advanced Vascular. This may include routine diagnostic and laboratory procedures and tests, medication administration, and other routine care for which a specific informed consent form will not be signed by me. This consent includes consent and authorization to photograph or otherwise take images of me and/or parts of my body for purposes of identification, diagnosis, treatment, payment and healthcare operations of Advanced Vascular. Any photographs or other images taken will become part of my medical record. Advanced Vascular will not use such photographs or images for any other purposes without my specific written consent. I understand that certain procedures will require a specific informed consent, and that Advanced Vascular will provide me with information and forms prior to such procedures.

Consent to Obtain Patient Medication History

Patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history. The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record. It is very important that you and your provider discuss all your medications in order to insure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Also over-the-counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

By signing this consent form you are giving your healthcare provider permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

Acknowledgment of Receipt of Notice of Privacy Practices

I hereby affirm that I have been provided a copy of the Notice of Privacy Practices, also known as HIPAA, from Advanced Vascular. I have read and understand Advanced Vascular's HIPAA Notice of Privacy Practices, which contains information on the uses and disclosures of my protected health information ("PHI"). I understand that Advanced Vascular has the right to change its HIPAA Notice of Privacy Practices from time to time and

that whenever an important change is made, Advanced Vascular will post a new notice in the office. I may contact Advanced Vascular at any time to obtain a current copy of the HIPAA Notice of Privacy Practices.

Consent To Use and Disclose Protected Health Information for Treatment, Payment and Health Care Operations

I hereby consent and authorize Advanced Vascular to use and disclose my health information, which includes all or any part of my medical records, including drug or alcohol treatment information, genetic, genetic counseling and genetic testing information, HIV/AIDS information, and any other information concerning my diagnosis or treatment, as well as demographic information, by and to its workforce members and to health care professionals, insurance companies, medical facilities, physicians and vendors or suppliers involved, or who may become involved, with my treatment, the payment for my treatment and/or the health care operations of Advanced Vascular. I understand that, for example, my health information may be used or disclosed by Advanced Vascular to: provide for my care and treatment; communicate among various health care professionals who are involved in my care or treatment; bill for and obtain payment for care and treatment provided by Advanced Vascular; provide information to and obtain payment from my health insurance company or plan; assess and review the quality of my care; and conduct its business and health care operations. In addition, I understand Advanced Vascular may release my protected health information as required by law or court order. I understand that I have the right to request restrictions as to how my health information may be used, or disclosed to carry out treatment, payment, or healthcare operations, and that this organization is not required to agree to these restrictions, in the event of an emergency. A copy of this consent and authorization may be used in place of the original.

Consent and Authorization Disclosures to Authorized Individuals

I understand that Advanced Vascular may release my PHI to a family member, friend, or other person I indicate is involved in my care unless I object. I understand this policy and by signing below, I agree to allow Advanced Vascular and staff to communicate with the people I have listed below. This permission will stand until changed by myself. I understand that it is my responsibility to forward any changes to this release in writing and verbal changes will not be honored. I designate the following person(s) listed below as a person or persons involved with my health care and/or payment for my health care:

If you choose not to nominate anyone, please indicate this below by writing “NONE” on the space below.

Name:	Relationship:	Telephone Number:
1.		
2.		
3.		
4.		
5.		

Contact Information

I understand that if I have checked the boxes below, I agree that Advanced Vascular may leave any of the following detailed messages at the indicated telephone number: appointment reminders, insurance/ financial issues, biopsy or other test results, and any other information regarding care/treatment. I wish to be contacted in the following manner (Please check all that apply):

☐ Home Telephone:	☐ YES	☐ NO
☐ Work Telephone:	☐ YES	☐ NO
☐ Cell Telephone	☐ YES	☐ NO

If you DO NOT want our office to leave messages on your telephone answering service, please initial the line below:

☐ DO NOT LEAVE MESSAGES: _____

I have read and understand the terms of this document. I have had an opportunity to ask questions about the consent, use or disclosure of my health information, and about the contents of this form. I understand that I may revoke this consent in writing at any time.

I acknowledge, consent and agree to the terms and conditions of this document:

Name of Patient or Personal Representative (print): _____

Signature of Patient or Personal Representative: _____

Relationship to Patient (e.g., self, parent, guardian, POA): _____

Today's Date: _____

FOR OFFICE USE ONLY

☐ Consent received by _____ Date: _____
☐ Consent added to patient's medical record on: _____
☐ Consent refused by patient, and treatment refused as permitted.

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MEDICAL HISTORY

Today's Date: _____

Patient Name: _____ **DOB:** _____

Physicians

1. Primary Care Physician _____ Phone# _____

Address: _____

2. Physician who referred you today _____ Phone# _____

Address: _____

3. Cardiologist (if applicable) _____ Phone# _____

Address: _____

4. Nephrologist (if applicable) _____ Phone# _____

Address: _____

Dialysis Information (if applicable)

Type: ☐ HEMO-DIALYSIS ☐ PERITONEAL (PD)

Shift/Time of Dialysis: _____

Days: ☐ MON ☐ TUES ☐ WED ☐ THUR ☐ FRI ☐ SAT

Dialysis Center: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: ( ) _____

Nephrologist: _____

ADVANCED VASCULAR - Medical History

Patient Name: _____ DOB: _____

Please CHECK all that apply to your history and add any conditions not listed

General:
- ☐ High Blood Pressure
- ☐ High Cholesterol

Vascular:
- ☐ Aneurysm (Body Location _____)
- ☐ Blood Clots (Body Location _____)
- ☐ Carotid Artery Disease
- ☐ Peripheral Artery Disease / ☐ Leg bypass surgery or stents
- ☐ Varicose Veins

Cardiac:
- ☐ Atrial Fibrillation / ☐ Other Heart Rhythm Problem /
- ☐ Pacemaker / Defibrillator (Chest Location: ☐Right ☐Left)
  Brand: _____
- ☐ Coronary Artery Disease / ☐ Heart Attack
- ☐ Heart Bypass Surgery / ☐ Cardiac Stents
- ☐ Congestive Heart Failure
- ☐ Congestive Heart Disease
- ☐ Heart Valve Disease / ☐ Heart Murmur
- ☐ Heart Valve Surgery

Pulmonary:
- ☐ Asthma / ☐ COPD / ☐ Emphysema
- ☐ Oxygen Dependence
- ☐ Pneumonia
- ☐ Sleep Apnea

Neurological:
- ☐ Migraine Headache (Aura: Yes or No)
- ☐ Peripheral Neuropathy
- ☐ Seizures
- ☐ Stroke
- ☐ TIA or Mini Stroke (Stroke-like symptoms that typically resolve in minutes)

Endocrine:
- ☐ Diabetes: ☐ Type I ☐ Type II
- ☐ Thyroid Disease

Renal:
- ☐ Dialysis Dependence
- ☐ Kidney Failure
- ☐ Kidney Disease (Type _____)

Hematologic / Lymphatic:
- ☐ Anemia
- ☐ Blood or Clotting Disorder
- ☐ Cancer (Body Location _____)
- ☐ Lymphedema

Gastrointestinal:
- ☐ Diverticular Disease
- ☐ GERD / Heartburn
- ☐ Hepatitis / Liver Disease (Type _____)
- ☐ History of Stomach Ulcer
- ☐ Pancreatic Disease

Other:
- ☐ Arthritis / ☐ Spine Disease / ☐ Back Pain
- ☐ Autoimmune (Rheumatoid Arthritis, Lupus, Vasculiis)
- ☐ Chronic Pain / Fibromyalgia
- ☐ Depression / Anxiety
- ☐ Enlarged Prostate
- ☐ Gout
- ☐ HIV / AIDS

- ☐ Additional: _____

_____

_____

_____

_____

SURGICAL HISTORY - (Please list all previous surgeries and year)

Date: _____ Procedure: _____

Date: _____ Procedure: _____

Date: _____ Procedure: _____

Date: _____ Procedure: _____

Date: _____ Procedure: _____

ADVANCED VASCULAR - Medical History

Patient Name: _____ DOB: _____

SOCIAL HISTORY

CIGARETTE SMOKING: CURRENT : # PACKS PER DAY _____ # YEARS SMOKING _____
QUIT: # YEARS SINCE QUITTING _____ # YEARS SMOKING _____
☐ NEVER
CHEWING TOBACCO: ☐ YES ☐ NO ☐ PAST
ALCOHOL CONSUMPTION: ☐ NONE ☐ RARE
DRINKS / DAY _____ #DRINKS / WEEK _____ #DRINKS / MONTH _____

FAMILY HISTORY

Please check if applicable / provide relative:

☐ Aneurysm _____ ☐ Stroke _____ ☐ Blood clots _____ ☐ Blood Disorder _____
☐ Heart Disease _____ ☐ Sudden Death _____ ☐ Diabetes _____ ☐ Varicose Veins _____

Please list any other family medical history:

_____
_____
_____
_____

SYSTEM REVIEW
(CHECK ANY SYMPTOMS OCCURRING NOW OR WITHIN THE PAST MONTH)

Constitutional
- ☐ Fever
- ☐ Chills
- ☐ Weight loss
- ☐ Weight gain
- ☐ None

Cardiovascular
- ☐ Chest pain
- ☐ Leg / ankle swelling
- ☐ None

Respiratory
- ☐ Cough
- ☐ Shortness of breath
- ☐ Pain with breathing
- ☐ Coughing up blood
- ☐ None

Gastrointestinal
- ☐ Abdominal pain
- ☐ Abdominal pain after meals
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ None

Genitourinary
- ☐ Difficulty urinating
- ☐ Blood in urine
- ☐ None

Integumentary
- ☐ Dry skin
- ☐ Skin discoloration
- ☐ Skin ulcers
- ☐ Itching
- ☐ Rash
- ☐ None

Neurological
- ☐ Sudden muscle weakness
- ☐ Sudden paralysis or loss of feeling
- ☐ Sudden visual disturbance
- ☐ Sudden difficulty speaking or swallowing
- ☐ Dizziness / Vertigo
- ☐ Syncope (fainting spells)
- ☐ None

Musculoskeletal
- ☐ Leg pain with walking
- ☐ Leg pain at rest
- ☐ Back pain
- ☐ Joint pain
- ☐ None

Hematologic / Lymphatic
- ☐ Easy bleeding
- ☐ Enlarged lymph nodes
- ☐ None

Allergic / Immunologic
- ☐ Hives
- ☐ None

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MEDICATION RECONCILIATION

Name: _____ ALLERGIES: REACTION:

DOB: _____ _____

Today's Date: _____ _____

Pharmacy Name: _____ _____

Pharmacy Phone #: _____ _____

Facility: _____ _____

_____ _____

☐ NO KNOWN DRUG ALLERGIES

	MEDICATION:	**DOSAGE:**	**TIMES:**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

UPDATED:

DATE: _____ DATE: _____

DATE: _____ DATE: _____

DATE: _____ DATE: _____

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Name: _____ **Date of Birth:** _____

Insurance Information

1. Primary Insurance Carrier _____ Subscriber Name _____

   Subscriber Date of Birth _____ Soc. Sec. # _____

   Relationship to Patient _____

2. Secondary Insurance Carrier _____ Subscriber Name _____

   Subscriber Date of Birth _____ Soc. Sec. # _____

   Relationship to Patient _____

MANAGED CARE PATIENTS - Referrals and co-pays must be submitted to the office at the time of visit. (Insurance companies will not permit us to see patients without referrals, co-payments, and/or proper authorizations.) If you are required to submit the following information, and do not have them, you will either be rescheduled or asked to pay for the office visit in full.

Insurance Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with the above insurance companies and assign benefits directly to Advanced Vascular Associates, PC. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____
Signature of Insured/Guardian Date

Medicare Authorization

I request that payment of authorized Medicare benefits be made to Advanced Vascular Associates, PC, for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payments be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

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Payment Policy and Financial Agreement

Thank you for choosing Advanced Vascular. We are committed to providing you with quality and affordable health care, but there are fees for our services. Since we believe that good medical care starts with good communication, we have created this policy so that you understand your responsibility for payment of our fees. Insurance regulations require us to collect co-pays, co-insurance, and unmet deductibles from our patients.

Payment for all office services and supplies are due at the time service is rendered (unless we participate with your insurance).

- We accept cash, checks, MasterCard and Visa.
- Remaining balances are to be paid within 30 days of settlement with your insurance company (unless arrangements
- for pre-payment or a monthly payment schedule have been made in advance). We pre-approve the surgical procedures with the individual insurance carriers to determine benefits, but it is ultimately the patient's responsibility to pre-approve all surgical procedures and to be aware of the conditions of approval, such as obtaining a 2nd opinion, etc.
- If treatments are being recommended, the office staff will make every effort, on your behalf, to obtain the necessary pre-certifications from your insurance carrier. It is, however, your responsibility to verify that any necessary pre-certifications have been obtained prior to your treatments. Please understand that a pre-certification from your insurance company does not guarantee insurance coverage for services rendered.
- Our fees fall within a range based on the level and standard of care provided, in our regional area, and are covered up to an allowance determined by each carrier. Some carriers pay on the basis of a percentage of this usual, customary and reasonable range (UCR), and others pay on an arbitrary fee schedule, which bears no relationship to UCR. These fees are available in our business office for review.
- Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover, and regardless of our practice participation with a plan, payment for any non-covered services will be the patient's responsibility.
- We cannot be responsible for any loss of benefits; it is your responsibility to know your policy. If you have any questions concerning the above information, please do not hesitate to ask us. We are here to help you.
- If we are out of network with your insurance, we are are happy to process your insurance form for your reimbursement, but we must be provided with appropriate proof of insurance, social security number and mailing address at each visit. This is a courtesy we extend to you, but ultimately payment for all charges for care provided is your responsibility.
- **For in office vein procedures, failure to cancel your appointment with 48 hours' notice will result in a $50.00 "no-show" fee.**
- When we are a participating provider with your insurance company **referral forms, and/or preauthorization, co-pay, coinsurance, or deductible is due at time of service. We offer Care Credit financing of your vein treatments and/or deductibles. Ask us for more information.**
- Medical insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract unless we have chosen to be a participating provider with the insurance plan. Any claims denied by your insurance company, for any reason, will be your responsibility.

I have read and understand this financial agreement above and realize that all fees, regardless of the insurance coverage, are ultimately MY responsibility.

You hereby assign and authorize payment to be made directly to Advanced Vascular for the covered insurance benefits. You hereby authorize the release of medical information as may be required to process claims for payment of the medical services rendered. You hereby acknowledge receipt and acceptance of this payment policy.

Patient Signature | Printed Name | Date

Patient Account Number (for Advanced Vascular staff)