VASCULA R
INTERVENTIONAL &
VEIN
ASSOCIATES

Today's Date:

PATIENT INFORMATION

Name: **Date of Birth:** **SSN:**

Sex: **Marital Status:** **Language:**

Address (Street, Apt/Unit, City, State, Zip):

Primary Phone #: **Secondary Phone#:** **★Email: (To be web enabled):**

Employment Status: Full time Part Time Unemployed Retired Disabled **Name of Employer:**

Race: White African American Hispanic Asian American Indian Pacific Islander Other

Ethnicity: Hispanic or Latino Not Hispanic or Latino **Decline**

Check all that apply: I have an Advanced Directive/Living Will I have a Power of Attorney
I have a Healthcare Surrogate I do not have any Health Care Plan
★ I have brought my documentation today I have **not** brought my documentation today

PHYSICIAN INFORMATION

★Referring Physician: **★Primary Physician:**

★Please name all Physicians involved in your treatment:

INSURANCE INFORMATION

Primary Insurance: **Subscriber's Name/Relationship:**

Subscriber's Date of Birth: **Subscriber's SSN:**

Secondary Insurance: **Subscriber's Name/Relationship:**

Subscriber's Date of Birth: **Subscriber's SSN:**

PRIMARY EMERGENCY CONTACT

Name: **Relationship to Patient:** **Phone #:**

Address (Street, Apt/Unit, City, State, Zip)

Allow this person access to my condition/information:
Yes **No**

★ **Pharmacy Name:** _____ **Location:** _____

RELEASE OF MEDICAL INFORMATION

Patient Name: _____Date of Birth: _____ Date: _____

I agree that Vascular, Interventional and Vein Associates (VIVA) may disclose certain portions of my health information to a relative, friend, and/or other caregiver because such person is involved with my health care or payment relating to my health care. In that instance, VIVA will disclose only information that is directly relevant to the person's involvement in my health care or payment relating to health care.

I wish to make no designation at this time.

I designate the following persons listed below as persons involved in my health care or payment related to my health care for the purpose of VIVA making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

First and Last Name: _____

Phone #: _____ Relationship to Patient: _____

First and Last Name: _____

Phone #: _____ Relationship to Patient: _____

First and Last Name: _____

Phone #: _____ Relationship to Patient: _____

First and Last Name: _____

Phone #: _____ Relationship to Patient: _____

I request that my protected health information not be disclosed to the following individuals or entities [list individuals or entities to which information would **not** be disclosed]:

_____

_____

Signature of patient: _____

MEDICAL HISTORY (PAGE 1)

Patient Name: **DOB:** **★Height:** **★Weight:**

Please check the boxes next to any medical conditions you have now OR have had in the past.

Cardiovascular Heart Attack/Myocardial Infarction Coronary Artery Disease Congestive Heart Failure High Blood Pressure High Cholesterol Heart Murmur Atrial Fibrillation Pacemaker/Defibrillator	**Bladder/Genitourinary:** Kidney Disease Kidney Stones Urinary Incontinence Bladder Cancer Prostate Cancer Dialysis M, W, F T, T, S PD
Hematological/Immune: Liver Disease/Condition Hepatitis Anemia Clotting Problems Fibromyalgia Multiple Sclerosis Lupus	**Vascular:** Abdominal Aortic Aneurysm Stroke/Paralysis TIA Phlebitis Deep Vein Thrombosis Pulmonary Embolism Varicose Veins or Spider Veins
Endocrine: Diabetes Weight Loss Weight Gain Hypothyroidism Hyperthyroidism	**Neurological:** Parkinson's Disease Alzheimer's Disease Seizures Tremors Peripheral Neuropathy Dementia
Gastroenterology: GERD/Heartburn/Reflux Disease Ulcers Difficulty Swallowing/Dysphagia Cancer of the Mouth/Throat/Neck Stomach/Intestines/Rectum	**Respiratory:** Pneumonia Asthma COPD/Emphysema Lung Cancer Chronic Cough
Musculoskeletal: Arthritis Osteoarthritis Degenerative Disc Disease Degenerative Joint Disease Osteoporosis Rheumatoid Arthritis	**Visual:** Macular Degeneration Cataracts Blurred/Double Vision Loss of Vision
Other: MRSA HIV/AIDS	Do you need assistance to walk? Yes No Are you an amputee? Yes No

★Please LIST ALL ALLERGIES to medications and describe reaction:

Personal Habits

Caffeine	**Yes No**	**How many cups per day?**	
Exercise	**Yes No**	**How often?**	**What kind of Exercise?**
★Tobacco	**Current Smoker Non-Smoker Former Smoker** **1-9 cigarettes a day 10-19 cigarettes a day 20+ cigarettes a day Other** **How many years did you smoke?_____**		
Alcohol	**Never Occasional/Social Alcoholic Former Alcoholic**		

MEDICAL HISTORY (PAGE 2)

Name: **DOB:**

★ Current Medications **See list**

Name of Medication	Dosage	Frequency

Family History: (Please write a check mark to all that apply)

	Alive	Deceased	Medical Conditions and Cause of Death
	Please Check		
Father			
Mother			
Siblings			
Children			

Surgical History	Date

Do you CURRENTLY have? If yes, please check appropriate boxes.

Hematologic	Skin	Ear, Nose, Throat, Mouth	Endocrine
Anemia	Discoloration	Dry Mouth	Excessive Hunger
Bleed or Bruise Easily	Skin Ulcers	Hearing Aid	Excessive Thirst
Blood Clots	Open Wounds	Nose Bleeds	Excessively Cold
		Vertigo	

General	Cardiovascular	Immune/Allergies	Neurologic
Chills	Chest Pain	Seasonal Allergies	Headaches
Depression	Irregular Heart Beat	Frequent Infections	Lightheaded
Fatigue	Murmur	Hay Fever	Dizziness
Fever	Tachycardia	Hives	Memory Loss
Hair Loss		Itching	Numbness
Weakness		Rashes	Seizures
		Swollen Glands	

Musculoskeletal		Digestive	Respiratory
Back Pain		Abdominal Pain	Cough
Herniated Disc	Knee pain	Heartburn	Oxygen Dependent
Leg Pain	Neck Pain	Bloody Stool	Shortness of Breath
Joint Stiffness	Muscle Cramps	Constipation	Wheezing
Joint Pain	Muscle Weakness	Diarrhea	
Joint Swelling	Muscle Pain	Loss of Appetite	
Sciatica		Nausea/Vomiting	

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Consent for Treatment and Authorization to Release Information

- I request the services of Pranay T. Ramdev, M.D, duly licensed in the State of Florida, and all staff personnel. I consent to examination, diagnostic procedures, and treatment, which may need to be performed on my behalf.
- Dr. Ramdev may, at his discretion, disclose all or part of my patient medical records to any referring physicians, employer, or insurance companies to identify me to carry out my treatment, payment and healthcare operations. Such disclosure shall include furnishing copies of said records. I authorize fax transmittal of my medical records as necessary.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which in the judgment of the attending physician or their assigned designees may be considered medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly VIVA of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury to my employer or designee understand that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

- I give VIVA permission to review my prescription history for verification of my medications.
- I understand that my prescription refills must be requested at least one week before my medication runs out.
- A photocopy of this consent shall be considered as valid as the original.
- I have received a copy of VIVA's Notice of Privacy Practice for my record. I understand that if I have questions or complaints that I should contact the Facility Privacy Official.

· Patient Initial: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature: _____DOB: _____ Date: _____

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Assignment of Benefits/Financial Policy

Vascular, Interventional & Vein Associates wants to assist you in the financial management of our relationship. Benefit verification will be provided as a courtesy and is not a guarantee of payment. Be assured that we will be ethical and fair concerning any billing or collection concerns you may have. Please be advised that this policy is subject to change. If you have any questions, please contact our billing department.

Participating Plans

- Our billing department will file your insurance for services rendered.
- The patient is responsible for presenting all current available insurance cards at the time of service.
- The patient is responsible for co-pays, deductibles, and co-insurance at the time of service. (If you have Medicare and a supplemental, we will file Medicare and a supplemental; then transfer balance to you after your supplemental has paid on the claim. If you do NOT have a supplemental insurance, you will be responsible for the 20% of Medicare allowable for each service plus any deductible.
- The patient is responsible for knowing their policy coverage, deductibles, coinsurance, etc.
- The patient is responsible for insurance follow-up with their plan regarding student status forms, annual employer claim forms, accident/injury information, and terminated insurance plans.
- If we participate with your insurance, we must collect any deductible, coinsurance and/or co-pay at the time of service. If you are unable to provide that payment, we reserve the right to re-schedule your appointment.

Non-Participating Plans

- The patient is responsible for all “out of network” patient responsibility at time of service unless other payment arrangements have been made. This would include any co-insurance, deductible, and the difference between carriers allowable and our standard fee.
- Our billing department will file the patient’s insurance as a courtesy.

Self-Pay

- Patient with no insurance coverage will be considered Self Pay.
- Self-Pay patients will sign this form indicating that they have NO health insurance.
- Payment is due at time service is rendered or arrangements must be made in advance.
- Self-Pay patients must speak with billing manager BEFORE SERVICES ARE RENDERED.

Collections

- Collection notices begin if the patient balance has not been paid in full
- All unpaid balances will be sent to an outside collection agency after all practice efforts have been exhausted.

Return Check Fee

- A fee of $25.00 will be charged to the patient account for Return Check from the bank.

Medicare Lifetime Authorization

I authorize holder of medical or other information about me to release any information needed for this or a related Medicare Claim to the Social Security Administration and Center for Medicare and Medicaid Services, its intermediaries or carriers. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider or any other party who may be responsible for paying or treatment. (Section 1128B of the Social Security Act and 31 USC 3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply. (Signature retained on file).

I assign the benefits payable for services to VIVA. Patient Initials: _____

I request this authorization also apply to all other insurance. Patient Initials: _____

I, the undersigned, have read and understand the above information. I agree to be responsible for any charges incurred by me or not payable by my insurance company. I also agree to be responsible for any legal fees and/or court costs incurred as a result of my failure to pay services rendered.

Patient Signature: _____DOB: _____ Date: _____

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to maintain these records of your health care and are dedicated to maintaining confidentiality.

The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without your authorization.

- Treatment: We may disclose your protected health information to you and to our staff or to other health care providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, we may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise.
- Payment: We may send information to you or to your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise.
- Health operations: We are allowed to use or disclose your protected health information to train new health care workers, to evaluate the health care delivered, to improve our business development, or for other internal needs.
- We are required to disclose information as required by law, such as public health regulations, health care oversight activities, certain law suits and law enforcement.

Certain ways that your protected health information could be used or disclosed require an authorization from you: use or disclosure for marketing and disclosures or uses that constitute a sale of protected health information. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. Other uses and disclosures not described in this notice will be made only with your written authorization, which you may revoke going forward in writing.

You have several rights concerning your protected health information. When you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request.

- You have the right to access your records and/or to receive a copy of your records. Your request must be in writing. We are required to allow the access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you, or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed health care provider.
- You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request, we are obligated to fulfill the request, except in an emergency where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment.
- We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item or for health operations, if you have paid for the item or service in full out of pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.
- You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing and may be revoked in writing and must give us an effective means of communication for us to comply. If the alternate means of communications incurs additional cost, that cost will be passed on to you.
- Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.
- You have the right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information.
- You have the right to receive a copy of this notice, either electronic or paper. The copy may be provided electronically with your permission.

If you have any questions about our privacy practices, please contact our Privacy Officer at the number below.

You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

Privacy Officer
Phone number: 800-735-9224

Office for Civil Rights
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

We are required to abide by the policies stated in this Notice of Privacy Practices, which became effective October 6, 2008.