



ATLANTIC VEIN & VASCULAR ASSOCIATES, PLLC

Patient Registration Form

Today's Date ___/___/___

Title: Ms. ___ Mr. ___ Mrs. ___ Miss ___ Dr. ___ Other ___

Patient's Name: Last _____ First _____

Date of Birth: ___/___/___ SSN: _____ - _____ - _____

Address: _____

Zipcode: _____ City: _____ State: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Email: _____

Marital Status: _____ Sex: _____

How did you hear about us?

Facebook ___ Yellow Pages ___ Friend ___ Relative ___ Other ___

If other, please explain: _____

Guarantor Information:

Name: _____ Relationship: _____

Date of Birth: ___/___/___ SSN: _____ - _____ - _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Atlantic Vein & Vascular Associates, PLLC
FINANCIAL AGREEMENT & RELEASE OF INFORMATION

AUTHORIZATION FOR TREATMENT

I hereby authorize treatment by Atlantic Vein & Vascular Associates and/ or affiliated medical staff member(s) on behalf of myself and legal responsibilities, including the patient whom I have medical power of attorney over.
The possibility exist (during treatment) for health care workers to become directly exposed to my blood or bodily fluids. In the event of such exposure, State Law requires a sample of my blood to be tested for the presence of infectious diseases.

RELEASE OF INFORMATION

I hereby authorize the release of any and all medical and/or charge information as is necessary for reimbursement from any third party or governmental agency involved in the payment of my treatment including but not limited to Insurance Payers, HMOs, Workers Compensation carriers, Medicare, Tricare and Medicaid. I also authorize the taking and use of photographs. I understand these photos will become a part of my medical record

RELEASE OF MEDICATION HISTORY

I hereby authorize the release of any and all medication history information as is necessary and pertinent for my medical care at Atlantic Vein & Vascular Associates.

OBLIGATION OF PAYMENT

I direct and assign payment from any insurance coverage, workers compensation, governmental agency or disability benefits, and assignment of proceeds from all settlements, judgments or verdicts in favor of the undersigned from third party liability claims for injuries treated hereunder in an amount equal to the full amount of all charges (including attorney's fees, collection agency fees, cost and interest) due hereunder is to be made to Atlantic Vein & Vascular Associates, PLLC. I am responsible to Atlantic Vein & Vascular Associates, PLLC for any charges not covered by my insurance, including but not limited to co-payments, deductibles and fees for non-covered services. The patient and the undersigned guarantor are primary liable for payment of the Patient's account and unless otherwise indicated by my initialing here, _____ (initials). Atlantic Vein & Vascular Associates will send all appointment reminders and billing information to the person responsible for payment of my bill. It is their sole responsibility to comply timely with all requirements, and supply all information and documents necessary to obtain payment of benefits by any third party or government entity as listed above. Some insurance plans (i.e., Medicare, Blue Cross, Champus) require that lab work be billed directly by the laboratory performing the testing. In these instances, a separate statement and bill will be sent from the lab performing the test.

NO SHOW AND CANCELLATION POLICY

We require a 48-hour notice, in advance, to cancel or reschedule any appointment or surgery. All appointments or surgeries that are missed without a call in advance are deemed a "No Show/No Call" and will incur a \$50 fee. This charge is not covered by your insurance and you will be responsible for this payment. This charge is payable at your next appointment.

PAST DUE BALANCES AND PROCEDURES FOR COLLECTION

Any balance remaining on the account after any insurance pays will be due upon receipt of my statement. Charges for non-covered services are due at the time of service. The undersigned agrees(s) to pay all charges made by medical providers at their current rate. The obligation of each undersigned is an original, direct and independent promise to pay based on the exclusive credit of each, and not a collateral or contingent promise to answer for the debt of another. If a payment is not made, I understand that Atlantic Vein & Vascular Associates, PLLC may take action to collect its fees. I agree to pay all costs incurred by Atlantic Vein & Vascular Associates, PLLC for collecting its fees, including collection agency and attorney's fee of forty-three percent (43%) of the unpaid bill. The return check fee is \$38.00.

*Thank you for selecting **Atlantic Vein & Vascular Associates, PLLC** as your Health Care partner.*

*Billing is handled by **Express Billing Systems**. For insurance or billing questions please contact **Express Billing Systems** at 757-410-8967.*

Patient Name (Please Print): _____ MRN: _____

Patient/Guarantor (Signature): _____ Date: _____

Witness: _____ Date: _____

Atlantic Vein & Vascular Associates, PLLC
NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

This is notice that Atlantic Vein & Vascular Associates, PLLC participate with the Privacy Practice HIPAA regulations. It is our intent to protect our patient's confidentiality within all reasonable means.

The HIPAA regulations are meant to protect your personal health information. However, frequently the practice encounters patients who appoint others to call the office to arrange appointments and take care of the financial aspects of their care.

Please indicate below, if, there are any persons whom you may provide the practice authorization to release information regarding your appointments, financial and/or medical information.

Please circle any that may apply

_____ Appointments Financial Medical All
Name

_____ Appointments Financial Medical All
Name

Please indicate if you would like a copy of our HIPAA policy Yes No (internal use only: yes given initial _____)

Our practice not only respects your privacy, but your time as well. While it is our intent to always see patients at their scheduled appointment, there are unpredicted events that occur throughout the course of a busy day. Please authorize how we may communicate with you while you are a patient.

_____ cell phone call _____ home phone _____ work phone

Signature of Patient or Legal Guardian

Date

HISTORY & PHYSICAL

CHIEF COMPLAINT (WHY ARE YOU HERE): _____

PROVIDERS: WHO REFERRED YOU: _____ WHO IS YOUR PRIMARY CARE: _____

DIALYSIS PATIENTS: NEPHROLOGIST: _____ DIALYSIS UNIT: _____ DIALYSIS DAYS: _____

PHARMACY NAME, LOCATION & PHONE #: _____

MEDICATIONS: _____

ALLERGIES: YES NO IF YES LIST W/ REACTION: _____

	YES	NO		YES	NO		YES	NO
ANGINA/CHEST PAIN	<input type="checkbox"/>	<input type="checkbox"/>	↑ URINE FREQUENCY	<input type="checkbox"/>	<input type="checkbox"/>	MEMORY LOSS	<input type="checkbox"/>	<input type="checkbox"/>
REST PAIN - CHEST	<input type="checkbox"/>	<input type="checkbox"/>	RENAL FAILURE	<input type="checkbox"/>	<input type="checkbox"/>	INSOMNIA	<input type="checkbox"/>	<input type="checkbox"/>
MI (DATE _____)	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	WT LOSS	<input type="checkbox"/>	<input type="checkbox"/>
AORTIC ANEURYSM	<input type="checkbox"/>	<input type="checkbox"/>	SKIN ULCERS	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>
HYPERTENSION	<input type="checkbox"/>	<input type="checkbox"/>	STROKE	<input type="checkbox"/>	<input type="checkbox"/>	FATIGUE	<input type="checkbox"/>	<input type="checkbox"/>
CABG	<input type="checkbox"/>	<input type="checkbox"/>	HALLUCINATIONS	<input type="checkbox"/>	<input type="checkbox"/>	TEMP. VISION LOSS	<input type="checkbox"/>	<input type="checkbox"/>
HX OF HEART FAILURE	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	DIFF. SWALLOWING	<input type="checkbox"/>	<input type="checkbox"/>
HEART STENT	<input type="checkbox"/>	<input type="checkbox"/>	HISTORY OF BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>
ARRHYTHMIA	<input type="checkbox"/>	<input type="checkbox"/>	FEVER	<input type="checkbox"/>	<input type="checkbox"/>	DIARRHEA	<input type="checkbox"/>	<input type="checkbox"/>
VALVE DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	GLASSES	<input type="checkbox"/>	<input type="checkbox"/>	CONSTIPATION	<input type="checkbox"/>	<input type="checkbox"/>
CALF PAIN	<input type="checkbox"/>	<input type="checkbox"/>	HOARSENESS	<input type="checkbox"/>	<input type="checkbox"/>	IMPOTENCE	<input type="checkbox"/>	<input type="checkbox"/>
REST PAIN - LEGS	<input type="checkbox"/>	<input type="checkbox"/>	SHORTNESS OF BREATH	<input type="checkbox"/>	<input type="checkbox"/>	BURNING URINATION	<input type="checkbox"/>	<input type="checkbox"/>
WEAKNESS	<input type="checkbox"/>	<input type="checkbox"/>	↑ BOWEL HABIT	<input type="checkbox"/>	<input type="checkbox"/>	BACK PAIN	<input type="checkbox"/>	<input type="checkbox"/>
VISION LOSS	<input type="checkbox"/>	<input type="checkbox"/>	PEPTIC ULCER	<input type="checkbox"/>	<input type="checkbox"/>	SCARS	<input type="checkbox"/>	<input type="checkbox"/>
HEARING LOSS	<input type="checkbox"/>	<input type="checkbox"/>	BLOODY URINE	<input type="checkbox"/>	<input type="checkbox"/>	SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>
COPD/EMPHYSEMA	<input type="checkbox"/>	<input type="checkbox"/>	DIALYSIS	<input type="checkbox"/>	<input type="checkbox"/>	ANXIETY	<input type="checkbox"/>	<input type="checkbox"/>
↓ APPETITE	<input type="checkbox"/>	<input type="checkbox"/>	JOINT PAIN	<input type="checkbox"/>	<input type="checkbox"/>	HIGH CHOLESTEROL	<input type="checkbox"/>	<input type="checkbox"/>
PANCREATITIS	<input type="checkbox"/>	<input type="checkbox"/>	DERMATITIS	<input type="checkbox"/>	<input type="checkbox"/>	DVT	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>			

SURGICAL HISTORY (OPERATIONS WITH DATES):

FAMILY HISTORY:

MOM: DIAB ATTACK ↑ BLOOD PRESS STROKE BYPASS VASCULAR DISEASE CLOT BLEEDING TENDENCY CANCER
DAD: DIAB ATTACK ↑ BLOOD PRESS STROKE BYPASS VASCULAR DISEASE CLOT BLEEDING TENDENCY CANCER
BROTHER: DIAB ATTACK ↑ BLOOD PRESS STROKE BYPASS VASCULAR DIS CLOT BLEEDING TENDENCY CANCER
SISTER: DIAB ATTACK ↑ BLOOD PRESS STROKE BYPASS VASCULAR DIS CLOT BLEEDING TENDENCY CANCER
OTHER: DIAB ATTACK ↑ BLOOD PRESS STROKE BYPASS VASCULAR DIS CLOT BLEEDING TENDENCY CANCER

SOCIAL HX:

SMOKING: NEVER PAST PRESENT <1 PPD 1-2 PPD >2 PPD PACK YEARS:
ALCOHOL: NEVER OCCASIONAL ABUSE _____ #DRINKS/WEEK

ATLANTIC VEIN & VASCULAR ASSOCIATES

GENERAL MEDICAL RECORDS RELEASE AND AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please complete the following information:

Patient Name: _____

Address: _____

Phone: _____

SSN: _____ DOB: _____

I authorize the disclosure/release of the following information:

- All records X-Ray/radiology records
 Laboratory/pathology records Pharmacy/prescription records
 Other (describe) _____

Please send the above records listed above to:

Atlantic Vein & Vascular Associates
329 Phillip Avenue # 102
Virginia Beach, VA 23454
Phone# 757-437-2882
Fax# 757-502-8800

The information may be used/disclosed for each of the following purposes:

- At my request (patient) For employment purposes For payments/insurance
 For my health care Other: _____

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law.

By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Signature of patient (or patient's
personal represent)

Date

Printed name of patient representative

Representative's authority (guardian, POA)