ATLANTIC VEIN & VASCULAR ASSOCIATES, PLLC

Patient Registration Form

Today's Date__/__/____

Patient's Name: Last_____ First_____

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

Address: _____

Zip code: _____ City: _____ State: _____

Home Phone: _____Mobile Phone: _____Work Phone: _____

Email: _____ Contact Preference: Home __ Mobile__ Work __

Marital Status: _____ Sex: _____ How did you hear about us? _____

Insurance Information:

Primary Insurance _____Subscriber Name: _____

Subscriber Date of Birth: ___/___/____ Relation: _____

Secondary Insurance _____Subscriber Name: _____

Subscriber Date of Birth: ___/___/____ Relation: _____

Tertiary Insurance _____Subscriber Name: _____

Subscriber Date of Birth: ___/___/____ Relation: _____

Patient/Guarantor Signature: _____

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): _____

Patient/Legal Guardian 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

In case of Medical Emergency we may contact:

_____ _____ _____ _____
Name Relation Home Phone Mobile Phone

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

ATLANTIC VEIN & VASCULAR ASSOCIATES

HISTORY & PHYSICAL

REASON FOR YOUR VISIT: _____

PHARMACY NAME, LOCATION & PHONE #: _____

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

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

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

MEDICATIONS:_____
_____
_____

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

SURGICAL HISTORY (OPERATIONS WITH DATES):

_____
_____

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

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
5589 Greenwich Road, Suite 100
Virginia Beach, VA 23462
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)

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending a written request to Atlantic Vein & Vascular Associates 329 Phillip Avenue # 102 Virginia Beach VA 23454