THE VASCULAR GROUP

PATIENT MEDICAL RECORD #_____

PATIENT INFORMATION

DATE OF BIRTH_____/_____/_____

Male: _____ Female: _____

PATIENT NAME _____ _____ _____

LAST FIRST MI

FORMER LAST NAME _____

MAILING ADDRESS _____

CITY_____ STATE _____ ZIP_____

HOME PHONE (_____) _____ WORK PHONE (_____) _____

CELL PHONE (_____) _____ E-MAIL _____

SOCIAL SECURITY NUMBER _____ MARITAL STATUS_____

RACE

___ American Indian or Alaska Native
___ Asian
___ Black or African American
___ Native Hawaiian or Other Pacific Islander
___ White
___ Other
___ Declined

ETHNICITY

___ Hispanic or Latino
___ Not Hispanic or Latino
___ Unknown
___ Declined

PREFERRED LANGUAGE

___ English ___ Other _____
___ Spanish ___ Declined
___ Italian
___ German
___ French

1: EMERGENCY CONTACT

NAME _____ PHONE (_____) _____

RELATIONSHIP TO PATIENT _____

2: ALTERNATE CONTACT (***SOMEONE WHO DOES NOT LIVE WITH YOU)***

NAME _____ PHONE (_____) _____

RELATIONSHIP TO PATIENT _____

REFERRING PHYSICIAN

NAME _____ PHONE (_____) _____

ADDRESS _____

PRIMARY CARE DOCTOR

NAME _____ PHONE (_____) _____

ADDRESS _____

CARDIOLOGIST

NAME _____ PHONE (_____) _____

ADDRESS _____

1:PHARMACY INFORMATION

NAME _____ PHONE (_____) _____

ADDRESS _____

2:PHARMACY INFORMATION

NAME _____ PHONE (_____) _____

ADDRESS _____

GUARANTOR INFORMATION (***RESPONSIBLE PARTY FOR THE BILL IF MINOR)***

GUARANTOR NAME _____ (SSN) _____
GUARANTOR ADDRESS _____
CITY_____ STATE _____ ZIP_____
HOME PHONE (____) _____WORK PHONE (____) _____
RELATIONSHIP TO PATIENT _____ (DOB) _____

PATIENT EMPLOYER

EMPLOYER NAME_____
EMPLOYER ADDRESS_____
CITY_____ STATE_____ ZIP_____
WORK PHONE (____) _____ OCCUPATION _____

PRIMARY INSURANCE COVERAGE

INSURANCE PLAN NAME _____
ID NUMBER_____ SPECIALIST COPAY _____
GROUP NUMBER_____ EFFECTIVE DATE _____

SUBSCRIBER NAME_____
SUBSCRIBERS DATE OF BIRTH_____
SUBSCRIBERS EMPLOYER_____
RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE COVERAGE

INSURANCE PLAN NAME _____
ID NUMBER_____ SPECIALIST COPAY _____
GROUP NUMBER_____ EFFECTIVE DATE _____

SUBSCRIBER NAME_____
SUBSCRIBERS DATE OF BIRTH_____
SUBSCRIBERS EMPLOYER_____
RELATIONSHIP TO PATIENT _____

OTHER INSURANCE PLANS _____

_____

THE VASCULAR GROUP

Thank you for choosing The Vascular Group, PLLC, ("The Vascular Group") as your health care provider. We at The Vascular Group are committed to building a successful relationship with you. This document provides a clear understanding of our Patient Financial Policy and its importance to the professional relationship we build with you. Payment for services is a part of this relationship. If you have any questions or concerns regarding this policy, please do not hesitate to contact our billing department at 518-262-5205. This Patient Financial Policy applies to all services provided by The Vascular Group at all locations.

PAYMENT GUIDELINES:

Self Pay Accounts:

If you do not have health insurance, you will be considered a Self-Pay Patient. All self-pay accounts with balances up to $10,000.00 must be paid in full at the time of service. Any balance exceeding $10,000.00 per procedure/visit will be billed to you. This payment schedule is per procedure/visit and shall not be cumulative.

Insurance Plans With Which We Participate:

If you are a member of an insurance plan with which we participate, all co-pays and co-insurance payments, as required by your insurance plan, are due at the time of service. If your insurance company requires a pre-authorization or pre-determination prior to services being rendered, The Vascular Group will contact your insurance company accordingly. If the service is denied by your insurance company and you choose to proceed with the service, you will be considered a *Self-Pay Account*. In the event that your insurance coverage changes to a plan with which we are not a participating provider, refer to the paragraph below.

Insurance Plans Which We Do Not Participate:

If you are a member of an insurance plan with which we do not participate, we will accept assignment of your insurance benefits. We do require that you pay all co-pays and co-insurance payments at the time of service. The balance on your account is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide complete billing information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 30 days, the balance will be billed to you.

BILLING INFORMATION:

Billing statements will be mailed to the address of record of the responsible party listed on the patient account. Billing statements are issued monthly. Payments are due within 30 days of the date of your statement. If your account is inactive for 3 billing cycles, you will become eligible for submission to an outside collection agency. Patients will be responsible for all collection agency fees incurred by The Vascular Group in the attempt to recover outstanding patient balances.

If a patient is due a refund, The Vascular Group will issue a refund. However, if a patient is scheduled for an upcoming appointment within the year, any refund will be held and applied accordingly. If you are unable to pay in full at the time of service, please contact a representative of The Vascular Group billing department before your visit to make payment arrangements.

The Vascular Group, at its sole discretion, shall have the option of terminating its professional relationship with you as a result of your collection status.

PATIENT RESPONSIBILITES:

It is your responsibility to know your insurance benefits and the application of your insurance plan as it relates to medical treatment you seek from The Vascular Group. If your insurance carrier requires a referral for services, it will be your responsibility to contact your Primary Care Physician (PCP) to request this prior to your date of service. If we do not have a current referral on file at the time of your office visit, you may be asked to reschedule your appointment. You must furnish valid (current) proof of insurance coverage and photo id at each visit.

The Vascular Group cannot waive co-payments, deductibles, co-insurance or non-covered service amounts defined as patient responsibility under the terms of our contract with your insurance carrier. Any co-payments not made at the time of service will be assessed a $20.00 service charge.

PROCEDURE RESCHEDULING POLICY:

The Vascular Group, PLLC makes every attempt to optimally schedule any procedure ordered by your physician. We understand there may be an occasion that will require you to cancel, postpone or reschedule your procedure; however, considerable cost and time investment by our staff are required to secure your procedure date.

Accordingly, should you fail to show for your schedule procedure, or cancel or postpone within 10 business days of your procedure date, you will be charged a $100 fee upon request to reschedule. This fee must be paid prior to the procedure being rescheduled. Rescheduling fees are not covered by your insurance company and will not be credited toward any future services.

We appreciate your understanding of the above stated policy and thank you for your cooperation.

PAYMENT OPTIONS:

The Vascular Group accepts Cash, Personal Checks, Money Orders, Travelers Checks, Visa, MasterCard, Discover and American Express. Patients will be assessed a $25 surcharge for any returned check from the bank. Returned check fees can only be made in the form of cash, money order or credit card. If more than one check is returned on your account, The Vascular Group will require all future payments to be made in the form of cash, money order or credit card. Credit card payments will only be accepted for balances greater than $5.00.

THE VASCULAR GROUP

Financial Responsibility (copy furnished upon request)

I have been provided/offered a copy of The Vascular Group, PLLC Patient Financial Policy and agree to accept full financial responsibility for all services provided by The Vascular Group, PLLC.

Initial _____

Assignment of Benefits

- **Medicare Part B Patients:** I request that payment of authorized Medicare benefits be made either to me or on my behalf to The Vascular Group, PLLC for any services provided. I authorize the release of my medical information to the Centers for Medicare and Medicaid Services and/or authorized agents.
- **NON Medicare Patients:** I hereby assign all medical and/or surgical benefits to which I am entitled, including private insurance and any other health plan to, The Vascular Group, PLLC for services rendered

Initial _____

Consent to Call

As a service to our patients, we provide courtesy appointment reminder calls and possibly other important calls that may be placed using a pre-recorded message. The phone numbers you provide, including your cell phone number, are subject to receiving such calls. I hereby authorize The Vascular Group, PLLC to leave such messages.

Initial_____

The Vascular Group, PLLC Notice of Privacy Policy (copy furnished upon request)

Initial_____

HIPAA (Authorization to Release Information) (copy furnished upon request)

I hereby authorize The Vascular Group PLLC, to:

- Release any information necessary to insurance carriers regarding my care.
- Process insurance claims generated in the course of examination or treatment.
- Allow a photocopy of my signature to be used to process all current and future insurance claims.

I authorize The Vascular Group, PLLC to provide and/or discuss my care and medical needs with the individuals listed below. This order will remain in effect until revoked by me in writing.

Name _____ Relationship_____
Phone#_____

Name _____ Relationship _____ Phone #_____

Name _____ Relationship _____ Phone #_____

I HAVE READ AND UNDERSTAND THE OFFICE POLICIES AS STATED ABOVE AND VOLUNTARILY AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

Patient Name: _____ DOB _____ MR# _____

Patient/Responsible Party Signature: _____

Witness _____ Date: _____