Name: **MR#:**

DOB#_____ Today's date:_____

******* PLEASE LIST ALL PRIOR SURGERIES ON THE BACK OF THIS FORM *******

GENERAL REVIEW (circle one)

High Blood pressure	Yes	No
High cholesterol	Yes	No
Diabetes	Yes	No
Current smoker	Yes	No
Previous smoker	Yes	No

How long did you smoke for: _____

Do you take aspirin?	Yes	No
Do you take plavix?	Yes	No
Do you take coumadin?	Yes	No

When did you quit smoking: _____
How many packs per day do you smoke: _____

CARDIOVASCULAR

Recent chest pain (angina)	Yes	No
Prior Heart attack	Yes	No
Congestive Heart Failure (CHF)	Yes	No
Heart bypass surgery	Yes	No
Hearth valve surgery	Yes	No
Heart artery angioplasty (ballooning)	Yes	No
Palpitations	Yes	No
Shortness or breath	Yes	No
Altered heart rhythm (arrythmia)	Yes	No
Pacemaker	Yes	No

EYES

Glaucoma	Yes	No
Cataracts	Yes	No
Double or blurry vision	Yes	No
Blindness (permanent or temporary)	Yes	No

MUSCULOSKELETAL

Arthritis	Yes	No
Back Problems	Yes	No

RESPIRATORY

Asthma	Yes	No
Bronchitis	Yes	No
Emphysema	Yes	No
History of pneumonia	Yes	No
Chronic cough	Yes	No
Productive cough	Yes	No

NEUROLOGIC

Severe or migraine headaches	Yes	No
History of fainting	Yes	No
Recent arm or leg numbness	Yes	No
Transient loss of vision	Yes	No
Seizures	Yes	No
Stroke	Yes	No

GASTROINTESTINAL

Recent weight loss	Yes	No
Acid reflux / heartburn	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Blood in stool	Yes	No

HEMATOLOGIC

Bleeding Problems	Yes	No
Clotting problems	Yes	No
History of phlebitis (clots in veins)	Yes	No
Easy bruising	Yes	No

Hepatitis	Yes	No
History of an ulcer	Yes	No
History of gall bladder problems	Yes	No
History of jaundice	Yes	No
History of hernia	Yes	No

GENITOURINARY

Bladder Infections	Yes	No
Kidney Infections	Yes	No
Dialysis	Yes	No
Prostate Problems	Yes	No

EARS, NOSE, MOUTH AND THROAT

Difficulty hearing	Yes	No
Mouth sores	Yes	No
Sore throat	Yes	No

PSYCHIATRIC

Mental Illness	Yes	No
Depression	Yes	No

SKIN

Rash	Yes	No
Psoriasis	Yes	No
Sores	Yes	No

FAMILY HISTORY OF:

Heart Disease	Yes	No
Aortic Aneurysm	Yes	No
Peripheral Arterial Disease (PAD)	Yes	No
Varicose veins	Yes	No
Clotting problems	Yes	No
Bleeding problems	Yes	No

The Vascular Group, PLLC Patient Financial Policy

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 With 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.

PAYMENT OPTIONS:

The Vascular Group accepts Cash, Personal Checks, Money Orders, Travelers Checks, Visa, Master Card, 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.

I _____acknowledge that I have received a copy of **The Vascular Group Patient Financial Policy** and agree to its terms and conditions

_____ _____

Signature of Patient (or responsible party) Date Signed

The Vascular Group

PATIENT MR #

PATIENT INFORMATION: **DATE OF BIRTH**_____/_____/_____

Male: _____ Female: _____

PATIENT NAME _____ _____ _____

LAST FIRST MI

OTHER NAMES USED_____

MAILING
ADDRESS:_____

CITY_____STATE_____ ZIP_____

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

CELL PHONE (_____)_____ E-MAIL _____

SOCIAL SECURITY NUMBER _____ MARITALSTATUS _____

RACE
___American Indian or Alaskan Native
___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: _____

PRIMARY CARE DOCTOR
NAME:_____PHONE:(_____)_____

REFERRING PHYSICIAN
NAME:_____ PHONE: (_____)_____

CARDIOLOGIST
NAME: _____ _ PHONE: (_____)_____

1:PHARMACY INFORMATION
NAME:_____PHONE: (_____)_____
ADDRESS: _____

2:PHARMACY INFORMATION
NAME:_____PHONE: (_____)_____
ADDRESS: _____

GUARANTOR INFORMATION ***(WHO WILL BE RESPONSIBLE 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_____
GROUP NUMBER_____ SPECIALIST
COPAY_____
EFFECTIVE DATE_____ IMAGING COPAY
_____

SUBSCRIBER NAME_____
SUBSCRIBER'S DATE OF BIRTH_____
SUBSCRIBER'S SOCIAL SECURITY NUMBER_____
SUBSCRIBER'S EMPLOYER_____
RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE COVERAGE:
INSURANCE PLAN NAME:_____
ID NUMBER_____
GROUP NUMBER_____ SPECIALIST
COPAY_____
EFFECTIVE DATE_____ IMAGING COPAY
_____

SUBSCRIBER NAME_____
SUBSCRIBER'S DATE OF BIRTH_____
SUBSCRIBER'S SOCIAL SECURITY NUMBER_____
SUBSCRIBER'S EMPLOYER_____
RELATIONSHIP TO PATIENT _____

The Vascular Group
Financial Responsibility / Assignment of Benefits / HIPAA

Financial Responsibility

Your signature on this form acknowledges that you have been provided a copy of The Vascular Group Patient Financial Policy and you agree to accept full financial responsibility for all services provided by The Vascular Group as explained in the Patient Financial Policy.

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 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 for services rendered.

Authorization to Release Information

I hereby authorize The Vascular Group 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.
- This order will remain in effect until revoked by me in writing.

HIPAA

Your signature on this form acknowledges the receipt of Notice of Privacy Practices of The Vascular Group.

I authorize The Vascular Group to provide and/or discuss my care and medical needs with the individuals listed below.

Name _____ Relationship_____

Name _____ Relationship _____

Patient Name: _____ DOB _____ MR# _____

Patient/Responsible Party Signature: _____

Witness _____ Date: _____