PLEASE COMPLETE AND RETURNTO THE FRONT DESK ALONG WITH YOUR DRIVER'S LICENSE AND INSURANCE CARDS

PATIENT INFORMATION -- PLEASE PRINT

Patient Number _____ Date _____

Last Name _____ First Name _____ Middle Name _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Social Security Number _____ Date of Birth _____

Place of Employment _____ Work Phone _____

Marital Status _____ Spouse's Name _____

Primary Insurance Company _____ Policy Number _____

Secondary Insurance Company _____ Policy Number _____

Co-pay (if any) _____ Yes No Referral Required?

Primary Care Physician (if any) _____ Phone Number _____

Assigned Hospital (if any) _____ Phone Number _____

EMERGENCY CONTACT – DOES NOT LIVE IN YOUR HOME

Name _____ Relationship _____ Phone Number _____

Date Updated _____ By _____

- ☐ Advanced Care Plan Provided
- ☐ Surrogate Decision Maker Identified

_____

- ☐ Discussed with Patient but no Plan Provided
- ☐ Patient Refused to Discuss

Vascular ASSOCIATES

NAME: _____

DATE OF BIRTH: _____

REASON FOR VISIT: _____

PRIMARY CARE PHYSICIAN: _____

REFERRING PHYSICIAN: _____

PHARMACY: _____

ALLERGIES: _____

MEDICINE LIST: _____
_____
_____
_____
_____
_____

PAST MEDICAL HISTORY: Circle all that apply

HYPERTENSION	DIABETES	CHRONIC KIDNEY DISEASE	
VARICOSE VEINS	CANCER	STROKE	Dialysis
DVT/BLOODCLOTS	HEART DISEASE	AFIB	HEART VALVE
PACEMAKER	HIV	COPD / LUNG DISEASE	
VASCULAR DISEASE	CHF	HEPATITIS / LIVER DISEASE	

SURGERY HISTORY:

VASCULAR SURGERY OF ANY KIND _____

OTHER: _____ _____
_____ _____ _____
_____ _____

FAMILY HISTORY:

	MOTHER	FATHER	PATERNAL GRAND	MATERNAL GRAND	SIBLINGS	CHILDREN
HYPERTENSION						
DIABETES						
HEART DISEASE						
STROKE						
DVT/BLOOD CLOTS/PE						
ASTHMA						
COPD						
CANCER						
VASCULAR DISEASE						
KIDNEY DISEASE						
VARICOSE VEINS						

SOCIAL HISTORY:

	CURRENT	QUIT	HOW MUCH	WHEN START	WHEN ENDED	NEVER
SMOKING						
CHEWING TOBACCO						
VAPE						
ALCOHOL						

Drinking Habits Heavy Social Moderate

Type Liquior Beer Wine

REVIEW OF SYSTEMS

CONSTITUTIONAL	☐ Fever/Chills ☐ Fatigue ☐ Weight gain ☐ Wheelchair bound ☐ Weight loss ☐ Recent illness ☐ Change in Appetite
HEENT	☐ Vision Changes ☐ Sinus Problems ☐ Eye Pain ☐ Sore Throat ☐ Redness ☐ Headaches ☐ Color Blindness ☐ Nose Bleeds
RESPIRATORY	☐ Pain with Breathing ☐ Blood in Sputum ☐ Cough ☐ Night Sweats ☐ Wheezing ☐ Shortness of Breath at rest with activity ☐ O2 Dependent ☐ CPAP/Breathing Machine at night
CARDIOVASCULAR	☐ Chest Pain ☐ Palpitations ☐ Edema/Swelling ☐ Claudication
NEUROLOGICAL	☐ Dizziness ☐ Previous CVA/TIA ☐ Loss of Consciousness ☐ Weakness
GASTROINTESTINAL	☐ Abdominal Pain ☐ Heartburn ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Blood in Stool
MUSCULOSKELETAL	☐ Back Pain ☐ Muscle Pain ☐ Neck Pain ☐ Muscle Weakness ☐ Joint Pain ☐ Cold Extremities
SKIN	☐ Rash ☐ Itching ☐ Dryness ☐ Wounds ☐ Color Change
HEMATOLOGY	☐ Bleeding Gums ☐ Easy Bruising ☐ Prolonged/Excessive bleeding
PERIPHERAL VASCULAR DISEASE	☐ Wounds ☐ Leg Cramps ☐ Leg Swelling ☐ Leg Heaviness/Numbness ☐ Varicose Veins ☐ Pain in Lower Leg/Feet ☐ Amputation ☐ Discoloration/Redness ☐ Cold Extremities ☐ Numbness/Tingling
DIALYSIS	☐ YES ☐ NO

Medicare Part B

Extended Patient Signature Authorization

TO BE COMPLETED BY PROVIDERS OF SERVICE – Please print or type

Provider's Name *(If you are a DMA supplier, please complete certification at bottom of page)*	Provider's I.D.Code
Provider's Address *(Street, City, State, ZIP Code)*	
Beneficiary's Name / Medicare HI number / Applicable MEDIGAP Group Number	

TO BE COMPLETED BY BENEFICIARY OR AGENT – Directions For Payment Of Benefits And Release Of Medical Information

STATEMENT FOR PAYMENT OF MEDICAL BENEFITS

I request that payment of authorized Medicare benefits be made on my behalf to Dr. H,B,T,G,A, S,N,K,W,L,M, DS or to Nephrology Associates of Mobile, P.A. (the Supplier) for any services or items furnished to me by the physician or supplier, I authorize any holder of medical information about me to release to Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

****

STATEMENT FOR PAYMENT OF MEDIGAP BENEFITS

I request that payment of authorized MEDIGAP benefits be made on my behalf to Nephrology Associates of Mobile, P.A. for any services furnished to me by the physician/ supplier. I authorize any holder of medical information about me to release to (name of MEDIGAP Insurer)_____ any information needed to determine these benefits or the benefits payable.

_____ Signature of Beneficiary or Person Signing for Beneficiary

_____ Date Signed

Address of Person Signing for Beneficiary (*Street, City, State, ZIP Code*)	Relationship of Agent to Beneficiary
Reason Beneficiary Is Unable To Sign	

IMPORTANT INFORMATION FOR PHYSICIANS

In submitting claims under this procedure, PHYSICIANS undertake:

1. To complete and submit promptly the appropriate Medicare billing form for all services covered by the request for payment – even those in which the physician has not accepted assignment.
2. To incorporate, by stamp or otherwise, information to the following effect on any bills they send to Medicare patients. "DO NOT USE THIS BILL FOR CLAIMING MEDICARE BENEFITS. A CLAIM HAS BEEN OR WILL BE SUBMITTED TO MEDICARE ON YOUR BEHALF." This requirement is necessary to prevent patient from submitting duplicate claims.
3. To cancel the authorization on request by the patient.
4. To make the patient signature files available for carrier inspection upon request.

IMPORTANT INFORMATION FOR SUPPLIERS

1. Only use this extended patient signature request for assigned claims.
2. Renew the patient signature agreement if a new item is rented or purchased.
3. Place alongside the beneficiary's signature the following statement. "RESPONSIBILITY FOR OVERPAYMENT ON ASSIGNED CLAIMS ACCEPTED."

DURABLE MEDICAL EQUIPMENT SUPPLIERS AGREEMENT

NOTE: THE FOLLOWING STATEMENT MUST BE SIGNED BY THE DME SUPPLIER PRIOR TO AUTHORIZATION OF PAYMENT FOR RENTAL OF DURABLE MEDICAL EQUIPMENT IN ASSIGNED CASES.

This supplier assumes unconditional responsibility for refunding of all overpayments for assigned claims for rental of durable medical equipment that may result from the failure of the Carrier to receive prompt notice of return of, or the end of need for the rental of equipment, or the death or institutionalization of the Beneficiary.

_____ Signature of Durable Medical Equipment Supplier

_____ Date Signed

Vascular Associates of South Alabama, LLC
VASA
1551 Old Shell Road
Mobile, Alabama 36604
Phone 251-410-8272 / Fax 251-410-8273
Benjamin Makamson D.O. / Lee Ferguson D.O. / Michael Hogan M.D./Ralph Pfeiffer M.D.

ASSIGNMENT OF INSURANCE BENEFITS

I do hereby authorize payment of all benefits, basic and major medical, to be made directly to Vascular Associates of South Alabama, LLC. I also agree to pay for services I receive that are not covered by my medical insurance as well as for any deductible or co-payment due at the time of service.

_____ _____

Signed Date

CONSENT FOR TREATMENT

Knowing that I am suffering from a condition requiring diagnosis and/or medical treatment, do hereby voluntarily consent to such diagnostic procedures, hospital care, examinations, a treatment as are necessary in the judgment of the physician(s) in charge of my care.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me in the results of examination or treatment in the hospital or office. I hereby authorize Vascular Associates of South Alabama, LLC, to retain or dispose of any specimens that may be taken during examinations or treatment.

_____ _____

Signed **Date**

_____ _____

Authorized Representative **Relationship**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I give permission to Vascular Associates of South Alabama, LLC, to submit full medical records, within discretion, to my insurance companies if they so request and to other physicians that I am consulting if they so request.

_____ _____

Signed Date Signed

PATIENT CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Vascular Associates of South Alabama, LLC, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Vascular Associates of South Alabama, LLC's, Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have received the practice's Notice of Privacy Practices prior to signing this consent. Vascular Associates of South Alabama, LLC, reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Vascular Associates of South Alabama, LLC's,, P.C Privacy Officer at 1551 Old Shell Road, Mobile, AL 36604..

With my consent, Vascular Associates of South Alabama, LLC, may share my protected health information (PHI) with the following individuals: Please list names, numbers & relationship.

_____

_____

With my consent, Vascular Associates of South Alabama, LLC, call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations (TPO), such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Vascular Associates of South Alabama, LLC, may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations (TPO), such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

By signing this form, I am consenting to Vascular Associates of South Alabama, LLC's use and disclosure of my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO).

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign the consent, Vascular Associates of South Alabama, LLC, may decline to provide treatment to me.

_____ _____

Signed Date Signed

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

PEASE REVIEW IT CAREFULLY

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if yo request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within on of th categories.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may disclose your record to an insurance company , so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you t doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or the hospital. For example, we may disclose medical information about you to people outside the practice who may be involved in your medical care, such as family members, clergy or other person who are a part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to ru the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE. This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated at th practice, whether made by practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that i currently in effect. Other ways we may use or disclose your protected health information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners; medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donations protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures"." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny you request for an amendment.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny you request to inspect and copy in certain very limited circumstances.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatmen payment and health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in you care or the payment for your care, like a family member or friend. *We are not required to agree to your request.* If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the practice's waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact Andrew Radoszewski, Clinic Administrator, 251.343.5004. All complaints must be submitted in writing You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, i writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact the Privacy Officer.

_____ _____

Patient Signature Date Signed

_____ _____

Patient Representative Signature Relationship to Patient