Vascular Care
OF TEXAS, PLLC

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Patient Information Please Print

Legal Name: Last_____ First: _____M.I._____

Address: _____ City: _____ State: _____ Zip Code: _____

Age: _____ Date of Birth: _____/_____/_____ Sex: M/F Social Security #: _____-_____-_____

Driver's License #: _____ Marital Status: Single___ Married___ Divorced___ Widow(er)____

Ethnicity: Hispanic/Latino ____Not Hispanic/Latino _____ Preferred Language: _____

Race: American Indian or Alaskan____ Asian____ Black or African American____ White_____
Native Hawaiian or Other Pacific Islander____ Other Race____

Dialysis Center: _____ Phone: (___)_____

Referring Doctor: First Name: _____ Last Name: _____ Phone: (____)_____
Primary Care Doctor: First Name: _____ Last Name: _____ Phone: (____)_____
Pharmacy Name: _____ Address: _____ Phone: (____)_____
(In addition to reviewing the medication list you provide, VCT will request your medication history from your pharmacy.)

Insurance Information
Is your condition related to an on-the-job injury? Workers Compensation claims? ____Yes ____No

Primary Insurance
Policy Holders Name: _____
Policy Holder's Date of Birth: _____
Insurance Co: _____
Your relationship to the policyholder: ___ Self ___ Spouse ___ Child ___ other

Secondary Insurance
Policy Holder's Name_____
Policy Holder's Date of Birth: _____
Insurance Co: _____
Your relationship to the policyholder: ___ Self ___ Spouse ___ Child ___ other

Responsible Party Statement and Payments of Benefits
As the responsible party, I understand that my health insurance policy is an arrangement between my insurance carrier and myself. This office will prepare any necessary reports and forms to assist me and making collection from the insurance company, however, I clearly understand and agree that all services rendered to me are charged directly to me and I am responsible for all charges for services rendered. All charges not paid by my insurance company will be my responsibility. Fees for services are due at time the services are rendered.

Notice of Physician Ownership
One or more of the physicians at Vascular Care of Texas, PLLC have an ownership interest in the following facilities: North Park Heart & Vascular Outpatient Surgery Center and Wellness Ambulatory Surgery Center. I understand that my physician may refer me to one of the Facilities for services. I also understand that I may speak with the physician about his financial relationship with the Facility and I may ask my physician to provide my treatment or surgery at a facility where he has no ownership interest.

Signature: X_____ Today's Date: _____/_____/_____

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I agree to allow Vascular Care of Texas to contact me in the following methods regarding my private health information, evaluation and treatment. I authorize Vascular Care of Texas to leave message for me when I am unavailable.

	Method	Number/Address	Messages
____	Home Phone	_____	_____ yes _____no
____	Cell Phone	_____	_____ yes _____no
____	Work Phone	_____	_____ yes _____no
____	Alternate Phone	_____	_____ yes _____no
____	Text Message	_____	
____	**Email – NEEDED FOR PATIENT PORTAL** _____		**_____ yes _____no**
____	Patient Portal	____opt in?_____	_____ yes _____no

I authorize Vascular Care of Texas and medical staff to discuss my healthcare information (which may include history, diagnosis, labs, test results, treatment and other health information) with the contacts listed below. I understand that by leaving space blank I am indicating my choice to be "No Information" and I do not want any information released to anyone else. Please list all physicians that you would like medical information sent to, along with their contact information.

NAME	RELATIONSHIP TO PATIENT/PHYSICIAN	CONTACT INFO

EMERGENCY CONTACT ONLY

NAME: _____ PHONE: _____

By signing below I acknowledge that I have read and understood the information provided on the consent form. I understand the risk associated with the different methods of communication, especially e-mailed and texting, and consent to the conditions, restrictions and patient responsibilities as well as any other instructions that Vascular Care of Texas may impose.

Print Patient Name _____ Date _____

Patient/Authorized Signature _____ Relationship to patient _____

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MEDICAL HISTORY

Today's Date _____

NAME:_____ OCCUPATION:_____

What is your approximate height? _____ Weight? _____

Reason for seeing the doctor today? _____

List all major illnesses or medical problems:

List all surgeries (give dates & type)

List all medications you are allergic to and the reaction you have

PERSONAL HISTORY

Have you had any of these conditions and when:

	No	Yes	Date
Pulmonary Embolism	____	____	_____
Blood Clots/DVT	____	____	_____
Rheumatic Fever	____	____	_____
Thyroid Disease	____	____	_____
High Blood Pressure	____	____	_____
Circulatory Problems	____	____	_____
Heart Disease	____	____	_____
Heart Murmur	____	____	_____
Hepatitis	____	____	_____
Chemotherapy	____	____	_____
Excess Bleeding	____	____	_____
Diverticulosis	____	____	_____
Pancreatitis	____	____	_____
Tuberculosis	____	____	_____
Emphysema	____	____	_____
Jaundice	____	____	_____
Arthritis	____	____	_____
Cirrhosis	____	____	_____
Cancer	____	____	_____
Colitis	____	____	_____
Diabetes	____	____	_____
Ulcer	____	____	_____
Epilepsy	____	____	_____
Anemia	____	____	_____
Stroke	____	____	_____
Asthma	____	____	_____
Hernia	____	____	_____
Glaucoma	____	____	_____

FAMILY HISTORY

Has someone in your paternal or maternal family had any of these medical conditions?

	No	Yes	Relation
Pulmonary Embolism	____	____	_____
Blood Clots/DVT	____	____	_____
Diabetes	____	____	_____
Tuberculosis	____	____	_____
Lung Disease	____	____	_____
Heart Disease	____	____	_____
Stroke	____	____	_____
Kidney Disease	____	____	_____
High Blood Pressure	____	____	_____
Cancer	____	____	_____
Bleeding Tendency	____	____	_____
Do you use alcohol?	____	____	

If yes, how often? _____ How long?_____

Do you use tobacco? ____ ____

If yes, amount? _____ How long?_____

MEDICATION INFO

Medication Name:	Strength	Dosage
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____
6._____	_____	_____
7._____	_____	_____
8._____	_____	_____
9._____	_____	_____
10._____	_____	_____
11._____	_____	_____
12._____	_____	_____

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Patient Name: _____ Today's Date: _____

	NO	YES		NO	YES
CONSTITUTIONAL			Nausea		
Recent Change in appetite?			Rectal bleeding		
Fatigue			Stomach problems		
Fever			Vomiting		
Night Sweats			**GENITOURINARY**		
Weight gain			Kidney failure		
Weight loss			Kidney problems		
OPHTHALMOLOGIC			**MUSCULOSKELETAL**		
Wear corrective lenses			Joint stiffness		
Trouble with vision			Muscle aches		
RESPIRATORY			**PERIPHERAL VASCULAR**		
Cough			Blood clots in legs		
Hemoptysis			Cold extremities		
Shortness of breath			Decreased sensation in extremities		
Wheezing			Pain/cramping in legs after exertion		
Bronchitis once a month			Painful extremities		
CARDIOVASCULAR			Ulceration of feet		
Recent stress test			**SKIN**		
Chest pain			Ulcers		
Shortness of breath on exertion			Blistering of skin		
Palpitations			Discoloration		
GASTROINTESTINAL			Masses		
Abdominal pain			Skin oozing		
Blood in stool			**NEUROLOGIC**		
Constipation			Head injury		
Diarrhea			Headache		
Difficulty swallowing			Tingling/numbness		
Heartburn			Paralysis		

Vascular Care of Texas Patient Financial Policy

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. ***All co-payments, co-insurance, or deductible amounts must be paid AT THE TIME OF SERVICE.*** This arrangement is part of your contract with your insurance company. Failure on our part to collect co- payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your portion of insurance benefits at each visit. As a courtesy, our office does verify benefits with your insurance carrier; however, the insurance agreement is a contract between you and your insurance carrier. It is recommended that you verify your benefits with your carrier as well.

MEDICARE: We are a participating Medicare provider. We accept Medicare benefit amounts. Medicare as well as your secondary insurance (if any) will be billed for you. However; that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% of the allowed amount for an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for full payment of these services at the time of service.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

COPY FEE: We will provide copies of patient records at the patient's request. Copies of records may be subject to a copying fee of $25 for the first 20 pages, and 50 cents for each page thereafter. You will bear complete financial responsibility for any fee(s) incurred.

COLLECTIONS FEE: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account will be forwarded to our collection agency. If your account is sent to a collections agency, a **50% fee** will be added to your account. You bear complete financial responsibility for any fee(s) incurred.

FMLA/ DISABILITY FORMS: There will be a $25 fee for each form completed on behalf of the patient for FMLA and short or long term disability. There is no charge for completion of forms required to file medical

claims to your insurance company for services rendered by our physicians or ancillary staff. It takes 7-10 business days for the paperwork to be completed.

NO SHOW/LATE CANCELLATION FEE: There will be a $25 fee for appointments which are canceled within 24 hours of the appointment time and for failure to show for a schedule appointment. This fee is due prior to rescheduling further appointments. Repeat offenders will be required to pay a deposit to "hold" future appointment time slots.

Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or VISA/MasterCard/Discover/AMEX. An additional $25.00 will be added to your statement if the check is returned from your bank. We do not accept starter checks. In the event that your insurance company sends payment to you, the patient, it should be forwarded to our office to be applied to your balance.

I have read the above policy regarding my *financial responsibility* to Vascular Care of Texas, PLLC. for medical services provided. I agree to pay Vascular Care of Texas, PLLC any balance unpaid by my insurance carrier for myself or the below named person.

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

PATIENT ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICES: By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have (or had the opportunity to read if I so chose) and understand the Notice and agree to its terms.

Assignment of Benefits
I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Vascular Care of Texas, PLLC.** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, co-insurance, non-covered services and other fees **AT THE TIME OF SERVICE**. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize Release of Medical Information to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information:

_____

PRINT Patient Name:

_____

Signature:

Date: _____