Valley Vascular Consultants

201 Sivley Rd. Suite 530
Huntsville, AL 35801
256-265-7480
Fax 256-265-7481

4810 Whitesport Circle, Suite 204
Huntsville, AL 35801
256-715-4406

Dr. Fred Stucky | Dr. Andrew Knott | Dr. M.B. Welborn | Dr. Marco Cioppi | Dr. Benjamin D. Shepherd

Patient Name:	
Patient DOB:	

Family Practice Provider	
Heart doctor (Cardiologist)	
Kidney doctor (Nephrologist)	

Do you have Advanced Directives?	Yes / No

Preferred pharmacy, phone number & address	

Have you had the flu shot this season?	yes / no	if yes, when?

Have you ever had the pneumococcal shot?	yes / no	if yes, where and when?

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Phone: (256) 715-4406

DATE

CO-PAY $ _____

FRED S. STUCKY, III, M.D., F.A.C.S. • ANDREW W. KNOTT, M.D. • MELL BURRESS WELBORN, III, M.D., F.A.C.S. • MARCO CIOPPI, M.D., F.A.C.S. • BENJAMIN D. SHEPHERD, M.D.

PATIENT'S NAME IN FULL (NO NICKNAMES)	MARITAL (S M W D SEP)	DATE OF BIRTH	AGE	SEX	SOCIAL SECURITY NO.

ADDRESS	CITY & STATE	ZIP CODE	HOME TELEPHONE NO.
			( )

OCCUPATION (INDICATE IF STUDENT)	EMPLOYER	HOW LONG EMPLOYED?	CELL PHONE NO.
			( )

EMPLOYERS ADDRESS	CITY & STATE	ZIP CODE	BUSINESS PHONE NO.
			( )

HUSBAND, WIFE, PARENT OR GUARDIAN NAME	DATE OF BIRTH

EMPLOYER OF ABOVE NAME	CITY & STATE	ZIP CODE	BUSINESS PHONE NO.
			( )

PERSON TO NOTIFY IN CASE OF AN EMERGENCY	I ALSO GIVE PERMISSION TO RELEASE MEDICAL INFORMATION TO EMERGENCY CONTACT ☐ YES ☐ NO

ADDRESS	CITY AND STATE	ZIP CODE

HOME PHONE	BUSINESS PHONE NO.
( )	( )

OTHER DATA: This information is being obtained to comply with Federal Regulations for Electronic Medical Records (may choose more than 1)

RACE: _____ American Indian / Alaskan Native _____ Native Hawaiian _____ Asian _____ Other Pacific Islander
_____ Black / African American _____ Hispanic _____ White _____ Other Race _____ Unreported

ETHNICITY: (this is not same as Race) _____ Hispanic or Latin American _____ Not Hispanic or Latin American _____ Unreported

LANGUAGE: ____ English ____ Other ____ Indian (includes Hindi & Tamil) ____ Spanish ____ Russion ____ Unreported

INSURANCE

PRIMARY INSURANCE CO.	
NAME OF POLICY HOLDER	DATE OF BIRTH
GROUP NO.	ID NO.
SECONDARY INSURANCE CO.	
NAME OF POLICY HOLDER	DATE OF BIRTH
GROUP NO.	ID NO.
AUTOMOBILE ACCIDENT	OTHER ACCIDENT? SPECIFY:

WORKMAN'S COMPENSATION INFORMATION

WERE YOU INJURED ON THE JOB? ☐ YES ☐ NO	DATE OF ACCIDENT
WORKMAN'S COMPENSATION CARRIER	CLAIM NO.
ADDRESS	ATTENTION TO:
CITY & STATE	ZIP CODE
PHONE NO.	VERIFIED BY:
EMPLOYER AT TIME OF ACCIDENT	
DATE OF ACCIDENT	NAME OF ATTORNEY

ARE YOU IN A NURSING HOME OR SKILLED REAHB AT THE PRESENT TIME? ☐ YES ☐ NO

THE ABOVE INFORMATION, AS PROVIDED BY ME, IS CORRECT TO THE BEST OF MY KNOWLEDGE.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the above named professional association or hospital to release to my insurers full information, including copies of records and operative notes relative to this illness.

AUTHORIZATION TO RECEIVE: I hereby authorize the above name professional association or hospital to obtain information from other healthcare providers for continuation of care.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to the above mentioned for the benefits payable under the terms of my policy for this period of illness. I understand that I am financially responsible for the charges not covered by this authorization.

DATE_____ _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

* **AFTER HOUR Phone Calls:** Valley Vascular Consultants, P.C. encourages patients to call during normal business hours. There will be a $15 fee assessed for phone calls that occur when the office is closed.

* **PAPERWORK FEE:** There will be a $10 fee for paperwork and letters to be written or filled out by us.

SERVICES CAN BE CHARGED TO YOU THROUGH MASTERCARD OR VISA

Valley Vascular Consultants, P.C.
Huntsville, AL 35801

Patient Consent for the Use and Disclosure of Protected Health Information

Patient Name: _____ DOB: _____

Email address; _____

This is my consent for **VALLEY VASCULAR CONSULTANTS, P.C.** to use and disclose my protected health information to carry out treatment, payment, and healthcare operations. This is my acknowledgement that I may view **VALLEY VASCULAR CONSULTANTS P.C.** Notice of Privacy Practices.

Due to the new privacy HIPAA guidelines, we are unable to speak with family members or caregivers without your written authorization. Please complete this form and return to us at your earliest convenience.

The staff of Valley Vascular Consultants, P.C. has my permission to discuss the following with the person(s) listed below:

_____ Medical Records _____ Financial Information _____ Other: _____

Family Members:

_____ Any _____ Spouse _____ Children

Name: _____ Name: _____

Name: _____ Name: _____

Non Family Members:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____
Patient Signature

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 DME supplier, please complete certification at bottom of page)*	Provider's I.D. Code
VALLEY VASCULAR CONSULTANTS, P.C.	

Provider's Address *(Street, City, State,* ZIP Code) ☐ 201 SIVLEY ROAD, SUITE 530 HUNTSVILLE, AL 35801
☐ 4810 WHITESPORT CIRCLE, SUITE 204 HUNTSVILLE, AL 35801

Beneficiary's Name	Medicare HIC 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 MEDICARE BENEFITS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Valley Vascular Consultants, P.C. *or to* _____ *(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 Health Care Financing Administration 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 either to me or on my behalf to Valley Vascular Consultants, P.C. 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 for related services.

X _____ _____
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 patients 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 authorization for assigned claims
2. Renew the patient signature agreement if a new item is rented or purchase.
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 ASSIGNMENT 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 the 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

VALLEY VASCULAR CONSULTANTS, P.C.

FINANCIAL PAYMENT POLICY

Fred S. Stucky, III, M.D. Andrew W. Knott, M.D. Burress Welborn, III, M.D. Marco Cioppi, M.D. Benjamin D. Shepherd, M.D.

We are committed to providing you with the best possible care. We find that communication with our patients regarding our financial policy assists us in providing the best service to you. Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks and credit cards (Am Express, Discovery, MasterCard, VISA). We will be happy to process your insurance claim form for your reimbursement. In order to achieve these goals, we need your assistance and understanding of our payment policy. We have therefore taken the time to answer some of the most commonly asked questions.

1. **COPAYMENTS/DEDUCTIBLES**: Copayments and deductibles are expected at the time of service.

2. **Self Referred Self Pay Patients**: Required to pay $500.00 up front at time of service.

3. **REGARDING INSURANCE**: The doctor's service is provided directly to you, and not to an insurance company. Thus, you are expected to pay the doctor's bill should your insurance company reject/deny. We cannot render services on the assumption that charges will be paid for by the insurance company.

   Our office uses a standardized medical accounting system. As a courtesy to our patients, we will bill your insurance company for you. If the insurance company has failed to pay within 45 days, we will expect you to pay the balance of your bill in full. You must then collect from your insurance company.

   NOTE: Any and all patients who have enrolled through the Health Insurance Exchange are required to provide proof of premium payment with receipt PRIOR to any and all scheduled office visit, PV scan/study, or outpatient/inpatient procedure/surgery.

4. **SPECIAL NEEDS**: This office understands special needs. It may be necessary to set up a payment plan for your services and/or procedures. If this situation is necessary for you, please bring this to our attention as soon as possible.

5. **OUTSTANDING BALANCE/ADDED PENALTY FEE**: A penalty fee of 50% will be added to your outstanding debt prior to turning your account over to our collection agency.

6. **RETURNED CHECK FEE:** A returned check fee of $35.00 will be added to your outstanding debt for returned checks. You are expected to pay the $35.00 returned check fee, in addition to the amount of your returned check, by cash or money order.

7. **MEDICAL RECORD COPY FEE**:
   - $5.00 administrative search fee
   - $1.00 per page for the first 25 pages
   - $0.50 per page for each additional page thereafter
   - Postage under the current postage rate

We must emphasize that, as medical care providers, our relationship is with you and not your insurance company. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Thank you for taking the time to read this policy statement. If you have any questions about the above information or any uncertainty regarding your insurance coverage, please don't hesitate to ask us.

WE ARE HERE TO HELP!

I hereby understand the financial policy of this office:

Signature: _____ **Date:** _____

Name: _____

Date of Birth: _____

Valley Vascular Consultants, P.C.

Medical History Questionnaire

Today's Date: _____

Height: _____ **Weight:** _____

REASON FOR VISIT _____

_____

Referring Physician: _____ Family Physician: _____

PREVIOUS SURGERIES

TYPE OF SURGERY / DATE

_____

_____

_____

_____

SOCIAL HISTORY

Gender: ❑ Male ❑ Female

❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Other _____

Children: ❑ No ❑ Yes How many: _____

Occupation: _____ ❑ Retired

Do you have any of the following? ❑ **N/A**

❑ Advance Directive ❑ Living Will ❑ Durable Power of Attorney _____

Smoking Status: ❑ Never ❑ Quit; when: _____ How long before quitting: _____

❑ Current; packs per day: _____ How many years: _____

If current or past, what type? ❑ Cigarettes ❑ Cigars ❑ Pipe ❑ Chewing Tobacco

Do you use recreational or intravenous drugs? ❑ Yes ❑ No

If yes, what type? _____ How many years? _____

Do you drink alcohol? ❑ No ❑ Yes If yes, what type? ❑ Wine ❑ Beer ❑ Liquor

If yes, how many? _____ drinks/day (1 = 5oz wine = 12oz beer = 1.5oz liquor)

FAMILY HISTORY:

Please check any condition below that any blood relative has experienced and note relationship (e.g. father, sister, etc.)

❑ Abdominal Aneurysm	❑ Mother ❑ Father ❑ Sibling ❑ Grandparent
❑ Blood Clots in Legs	❑ Mother ❑ Father ❑ Sibling ❑ Grandparent
❑ Blood Clots in Lungs	❑ Mother ❑ Father ❑ Sibling ❑ Grandparent
❑ Diabetes	❑ Mother ❑ Father ❑ Sibling ❑ Grandparent
❑ Heart Attack	❑ Mother ❑ Father ❑ Sibling ❑ Grandparent
❑ Heart Disease	❑ Mother ❑ Father ❑ Sibling ❑ Grandparent
❑ High Blood Pressure	❑ Mother ❑ Father ❑ Sibling ❑ Grandparent
❑ Stroke	❑ Mother ❑ Father ❑ Sibling ❑ Grandparent
❑ Other : _____	❑ Mother ❑ Father ❑ Sibling ❑ Grandparent

❑ Unknown Family History

Name: _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy Location: _____

MEDICATIONS/ALLERGIES

❑ NKDA (none)

Medication Allergies - List here: _____

Latex: ❑ No ❑ Yes If yes, what type of reaction: _____

Contrast (IV Dye): ❑ No ❑ Yes If yes, what type of reaction: _____

What medications do you presently take?

Example: Lipitor	*10mg*	*2x per day*

Do you take any non-prescription medicines, herbal remedies, or tonics? (e.g. aspirin, vitamins, antacids, or cold remedies) ❑ No ❑ Yes If yes, specify below

Example: Multivitamin	*1 pill*	*1x per day*

Name: _____

REVIEW OF SYSTEMS (Check all that apply) **Height** _____ **Weight** _____

CARDIOVASCULAR ❑ N/A

❑ Chest Pain
- ❑ With Exercise
- ❑ At Rest

❑ High Blood Pressure (uncontrolled)

❑ Ankle Swelling
❑ Fainting

EYES, EARS, NOSE & THROAT ❑ N/A

❑ Blurry Vision
❑ Shade going over Eye
❑ Change in Vision
❑ Lack of Vision in Visual Field

NEUROLOGICAL (Dominant Side ❑ Right ❑ Left) ❑ N/A

❑ Difficulty Moving a Side or Limb — If yes, specify: ❑ Right ❑ Left ❑ Both Acute vs. Chronic
❑ Numbness of a Side or Limb — If yes, specify: ❑ Right ❑ Left ❑ Both Acute vs. Chronic

❑ Dizziness
❑ Loss of Consciousness
❑ Paralysis
❑ Slurred Speech

RESPIRATORY ❑ N/A

❑ Shortness of Breath If yes, specify: ❑ At Rest ❑ With Exertion ❑ Home O2 (oxygen)

GASTROINTESTINAL ❑ N/A

❑ Abdominal Pain
❑ Weight Gain/Loss Unintentional
❑ Changes in Appetite
❑ Difficulty Swallowing

VASCULAR / MUSCULOSKELETAL ❑ N/A

❑ Back Pain
❑ Arthritis
❑ Cramping with Exercise
❑ Skin Color Changes
❑ Sores on Legs and.or Feet ❑ Right ❑ Left

❑ Leg Pain at Rest (❑ Right ❑ Left ❑ Both)

How far can you walk? _____ feet, _____ yards, .

Location of your leg pain? ❑ Buttock ❑ Thigh ❑ Calf ❑ Foot

Name: _____

ARE YOU CURRENTLY ON DIALYSIS? ❑ Yes ❑ No (If yes, please complete information below)

❑ Peritoneal Dialysis ❑ Hemodialysis

Name of Dialysis Center: _____ Dialysis Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Office Phone: (_____) _____ Office Fax: (_____) _____

Days: ❑ M W F ❑ T Th Sa ❑ Right Hand ❑ Left Hand

PREVIOUS STRESS TEST? ❑ Yes ❑ No (If yes, in the past year? ❑ Yes ❑ No) ❑ **N/A**

Name of Cardiologist: _____

Address: _____

City: _____ State: _____ Zip: _____

Office Phone: (_____) _____ Office Fax: (_____) _____

MEDICAL HISTORY (Check/fill in all that apply) ❑ **N/A**

- ❑ Aneurysm
  - ❑ Thoracic (chest)
  - ❑ Popliteal (knee)
  - ❑ Abdominal (stomach)
  - ❑ Renal (kidney)
  - ❑ Other
- ❑ Headaches (severe)
- ❑ Migraines
- ❑ Stroke
  yr _____ deficits _____
- ❑ Transient Ischemic Attack (TIA)
  yr _____ deficits _____
- ❑ Dizziness
- ❑ Seizure / Epilepsy
- ❑ Alzheimer's / Dementia
- ❑ Rheumatoid Arthritis
- ❑ Carotid Stenosis (narrowing)
- ❑ Coronary Artery Disease
- ❑ Heart Attack yr _____
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Heart Valve Disorder
  - ❑ Mitral
  - ❑ Aortic
- ❑ Pacemaker / Defibrillator
  Type _____
  Year Placed _____
- ❑ Coronary Artery Bypass Grafting
  yr _____
- ❑ Coronary Artery Stent (heart)
  yr _____
- ❑ Congestive Heart Failure (CHF)
  yr _____
- ❑ A-fib
- ❑ Abnormal Heart Rhythm
- ❑ Asthma
- ❑ Pulmonary Embolism
- ❑ COPD
- ❑ Emphysema
- ❑ Sleep Apnea
- ❑ Oxygen Dependent
  _____ liters
- ❑ Gastresophageal Reflux (GERD)
- ❑ Ulcers
- ❑ Renal Insufficiency (CKD)
- ❑ End Stage Renal Disease (ESRD)
- ❑ Arteriovenous Fistula (AVF) or
- ❑ Arteriovenous Graft (AVG)
  Year placed _____
- ❑ Peripheral Stent (non-heart)
- ❑ Deep Vein Thrombus (DVT)
  Location _____
- ❑ Varicose Veins
- ❑ Spider Veins
- ❑ Diabetes
- ❑ Type I
- ❑ Type II
- ❑ Hyperthyroidism (high)
- ❑ Hypothyroidism (low)
- ❑ Cancer
  Area: _____
  Chemo when: _____
  Radiation when: _____
- ❑ Anemia
- ❑ Sickle Cell Anemia
- ❑ Factor S Deficiency
- ❑ Factor V Leiden
- ❑ Hepatitis Type _____
- ❑ HIV / AIDS
- ❑ Tuberculosis (TB)
- ❑ Other: _____

_____

_____

_____

_____

_____