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Vascular & General Surgery

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PATIENT ACKNOWLEDGEMENT FORM

This form is your acknowledgement that we have informed you how to get additional information on how we may use and disclose health information about you. This notice informs you to the fact that every patient has the right to review the Notice of Privacy Practices prior to signing this form. This notice is the outcome of HIPAA (Health Insurance Portability and Accountability Act of 1996), mandated by the federal government. The act will be come law by April 14, 2003. <u>The Notice of Privacy Practices insures that your personal health information is kept private between insurance companies, billing companies, doctors, hospitals and drug companies. HIPAA does not change the quality of your healthcare, it enforces your rights to the privacy of your health information.</u>

The Notice contains a Patient Rights section describing your rights under the law. The terms of our Notice may change, if we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to the restriction, but if we do, we shall honor that agreement.

By <u>signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and health care operations.</u> You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior consent. The Practice provides this form to comply with government regulations.

<u>The patient understands that:</u>

- **Protected health information may be disclosed or used for treatment, payment or healthcare operations.**
- **The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review that Notice.**
- **The Practice reserves the right to change the Notice of Privacy Practices.**
- **The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.**
- **The patient may revoke this Consent in writing at any time and all future disclosures will the cease.**
- **The Practice may condition receipt of treatment upon the execution of this consent.**

This Acknowledgement was signed by: ____________________________

Print Name – Patient

_________________________ _________________

Signature **Date**

_________________________ ____________________________

Signature (if other than patient) **Witness**

REGISTRATION INFORMATION

(PLEASE PRINT)

PLEASE COMPLETE BOTH SIDES OF FORM

Date____________________ Home Phone____________________

Patient____

Last Name First Name Initial

Responsible Party (if a minor)____

Street Address____

City______________________________ State____________ Zip____________

Sex ☐ M ☐ F Age____ Birthdate__________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

☐ Employed ☐ Full-Time Student ☐ Part-Time Student Patient's School Name____________________

Patient Employed By____

Business Address____

Occupation______________________________ Business Phone____________________

Spouse (or responsible party) Name______________________________ Birthdate____________________

Business Name and Address____

Occupation______________________________ Business Phone____________________

Who is responsible for this account?____________________ Relationship to Patient____________________

Social Security #____________________ Spouse's Social Security #____________________

Do you have Medical Insurance? ☐ No ☐ Yes If yes,

Name of Primary Insurer____

Contract #____________ Group #____________________ Subscriber #____________________

Name of Secondary Insurer (if any)____

Contract #____________ Group #____________________ Subscriber #____________________

Are you covered under any of these programs? ☐ Medicare ☐ Medicaid ☐ CHAMPUS ☐ CHAMPVA

☐ Worker Compensation ☐ FECA Black Lung I.D. # for program you've checked____________________

If Welfare, your number____________________ County of____________________

Is your condition related to employment (current or previous) ☐ No ☐ Yes

Is your condition related to auto accident? ☐ No ☐ Yes In which state?____________________

Other Accident? ☐ No ☐ Yes Please describe______________________________

In case of emergency, who should be notified?______________________________

Phone____________________ Relationship to patient____________________

(OVER)

Please list other doctors you have seen in the past 5 years:

1.____________________ City/State__________
(General Practitioner, Specialist, or other)

Reason for seeing____________________

2.____________________ City/State__________
(General Practitioner, Specialist, or other)

Reason for seeing____________________

How did you learn of our practice?____________________

Whom may we thank for referring you?____________________

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with ____________________
Name of Insurance Company

and assign directly to Dr.____________________all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

____________________ __________
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr.____________________ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

____________________ __________
Beneficiary Signature Date

OFFICE NOTES

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INFORMATION FOR YOUR PHYSICIAN

Please answer the following questions prior to your first examination.
It will help your physician to know not only about your health but also about your family health history.

TODAY'S DATE

NAME	ADDRESS

CITY	STATE	ZIP

TELEPHONE NUMBER	DATE OF BIRTH	AGE	SEX ☐ M ☐ F	MARITAL STATUS ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

EMPLOYER	OCCUPATION	BUSINESS PHONE

EMERGENCY CONTACT	EMERGENCY PHONE

	FATHER	Present health or cause of death	MOTHER	Present health or cause of death	SPOUSE	Present health or cause of death
ALIVE ►	☐		☐		☐	
DECEASED ►	☐		☐		☐	

BROTHERS ►	NO. ALIVE	HEALTH	NO. DECEASED	CAUSE OF DEATH
SISTERS ►	NO. ALIVE	HEALTH	NO. DECEASED	CAUSE OF DEATH
CHILDREN ►	NO. ALIVE	AGES & HEALTH	NO. DECEASED	AGES & CAUSE OF DEATH

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR **BLOOD RELATIVES** ☐ Diabetes ☐ Cancer ☐ Bleeding tendency ☐ Kidney disease ☐ Tuberculosis ☐ Heart disease ☐ Stroke ☐ High blood pressure ☐ Nervous illness ☐ Allergy ☐ Other

CHECK ANY ILLNESSES OR CONDITIONS **YOU** HAVE HAD ☐ Diabetes ☐ Glaucoma ☐ Heart trouble ☐ Syphilis ☐ Vein trouble ☐ Cancer ☐ Asthma ☐ Jaundice ☐ Gonorrhea ☐ Bleeding tendencies ☐ Tuberculosis ☐ Pneumonia ☐ Kidney disease ☐ Rheumatic fever ☐ Nervous disorder ☐ Other

LIST OTHER ILLNESSES NOT REQUIRING OPERATION FOR WHICH YOU WERE HOSPITALIZED

HAVE YOU HAD SERIOUS INJURIES, BROKEN BONES, ETC.?
☐ No ☐ Yes ► LIST:

HAVE YOU HAD ALLERGY OR SENSITIVITY TO MEDICINES OR OTHER SUBSTANCES?
☐ No ☐ Yes ► LIST:

DO YOU USE TOBACCO NOW? ☐ No ☐ Yes	IN THE PAST? ☐ No ☐ Yes	TYPE AND DAILY AMOUNT	HOW LONG?

DO YOU USE ALCOHOLIC BEVERAGES? ☐ No ☐ Yes ►	TYPE	WEEKLY AMOUNT	HOW LONG?
DO YOU DRINK COFFEE? ☐ No ☐ Yes ►		WEEKLY AMOUNT	HOW LONG?

CHECK THE DISEASES AGAINST WHICH YOU HAVE BEEN IMMUNIZED
☐ Smallpox ☐ Tetanus ☐ Typhoid ☐ Polio ☐ Influenza ☐ Hepatitis B ☐ Pneumonia ☐ Other

PREVIOUS OPERATIONS (Dates, hospitals and name of surgeon)

DENTAL (List any problems you have now)

MEDICATIONS (Name or otherwise identify medicines now or recently used)

ONSET DATE OF LAST MENSTRUAL PERIOD	PERIODS ARE ☐ Regular ☐ Irregular	NUMBER OF PREGNANCIES	NUMBER OF MISCARRIAGES

HAVE YOU TAKEN CORTISONE-TYPE DRUGS? ☐ No ☐ Yes	ORAL CONTRACEPTIVES? ☐ No ☐ Yes	HAVE YOU RECEIVED A BLOOD TRANSFUSION? ☐ No ☐ Yes ► DATE:

DRESSED WEIGHT	HOW LONG HAVE YOU BEEN AT THIS WEIGHT?

WHAT IS YOUR MAIN MEDICAL PROBLEM AND HOW LONG HAVE YOU HAD IT?

WHAT IS YOUR MAIN SYMPTOM?

REVIEWED BY (Physician)	DATE