SONORAN
VEIN AND ENDOVASCULAR

PATIENT UPDATE FORMS

9192 W. Union Hills Drive, Peoria, AZ 85382 — **Phone: 602.374.4101**
7425 E. Shea Boulevard, Suite 112, Scottsdale, AZ 85260 — **Fax: 602.441.0522**

1551 S. 2nd St., Gallup, NM 87301 — **Phone: 505.542.0090**
Fax:505.542.0155

3625 Crossings Dr. #B Prescott, AZ 86305 — **Phone: 928.250.7700**
Fax:928.946.0024

Financial Policy

Thank you for choosing Sonoran Vein and Endovascular for your healthcare needs. Please review our financial policy and *initial* the appropriate spaces below.

PRINT NAME: _____ **DOB:** _____

_____ I authorize Sonoran Vein and Endovascular to bill my insurance company on my behalf. I authorize the release of any information necessary to determine these benefits or the benefits payable for related services. They will agree to invoice my insurance company in a timely manner as long as the information provided is accurate.

_____ I understand it is my responsibility to know my healthcare policy, verify all benefits, and my coverage information prior to services being rendered. I understand it is my responsibility to **ALWAYS** notify Sonoran Vein and Endovascular of any changes to my insurance plan or policy prior to my visit.

_____ I agree to pay my co-pay, coinsurance, deductible, 20% of potential services to be rendered or any uncovered services my insurance company deems "patient responsibility" **AT TIME OF SERVICE**. I understand Sonoran Vein and Endovascular accepts personal checks, most major credit cards, debit cards, and cash as form of payment.

_____ I understand I **must pay any outstanding patient balance prior to scheduling future appointments.**

_____ **I understand that I may be personally responsible for payment if:**

- I do not have active insurance coverage (please ask about our "Cash Pay" policy)
- I receive a service that is not covered by my policy or if my insurance is not accepted by Sonoran Vein and Endovascular
- My insurance company denies my claim for any reason that is not resolvable

_____ **I agree to pay a fee if:**

- I "No Show" or if I decide to cancel an appointment that I have scheduled without giving adequate notice (24 hour). There will be a $50 fee for all weekday appointments between 7:00 a.m. and 5:00 p.m. There will be a $75.00 fee for **ANY** appointment that is scheduled as a "Procedure" including ultrasound appointments, as these require certain time frames for scheduling purposes.

_____ I agree to pay in a timely manner. I understand a $10 processing fee may be assessed if more than three consecutive statements need to be mailed and I do not pay my balance in full or agree to a payment plan. Furthermore Sonoran Vein and Endovascular reserve the right to send me to collections if an amicable agreement for any unpaid balance cannot be decided. In the event my account is sent to a collection agency I understand there will be an additional charge of 50% of the balance due to cover the cost of collection.

Patient Signature: X_____ **Date:** _____

Sonoran Vein and Endovascular is Owned by Dr. David J. Nye
Accreditations: COLA, ASF, ACR

PATIENT INFORMATION FORM – UPDATED

Patient Name: _____ **DOB:** _____

Address: _____ **Apt #:** _____

Cell Phone Number: _____ **Home Phone Number:** _____

EMERGENCY CONTACT INFORMATION

Name/Relationship: _____

Emergency Phone Number: _____ MARK HERE IF NO EMERGENCY CONTACT: ☐

INSURANCE INFORMATION – PLEASE PROVIDE UPDATED COPY OF INS. CARD(S)

Primary Insurance: _____ Group Number: _____

Insurance Policy Number _____ Insurance Phone Number: _____

Secondary/Supplemental Insurance: _____ Group Number: _____

Insurance Policy Number: _____ Insurance Phone Number: _____

MEDICATION LIST: PLEASE UPDATE (OR PROVIDE A LIST AND WE WILL COPY)

_____

_____

_____

MEDICATION ALLERGIES:

PHYSICIANS CARING FOR YOU:

Primary Care Physician: _____

Referring Physician: _____

Nephrologist (Kidney Physician): _____

Cardiologist (Heart Physician): _____

Other: _____

By signing you acknowledge all information to be accurate to the best of your knowledge:

X_____ **Date:** _____

Patient Signature

X_____ **Date:** _____

Employee Signature

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NOTICE OF PRIVACY PRACTICES, ADVANCE DIRECTIVES AND EMERGENCY INFORMATION

Patient Name: _____ **D.O.B**_____

Privacy Practices/HIPAA/Bill of Rights

☐ I acknowledge that I have received a written copy of Patient Rights and Responsibilities, Ownership Disclosure, and Notice of Privacy Practices prior to rendering of any services.

☐ I am giving consent for uses and disclosure for Sonoran Vein and Endovascular employees to leave messages on my: ☐Home ☐Cell ☐Work

The family member(s), relative(s) or significant other(s) I have listed may have access to my protected health information for the purpose to carry out treatment and/or payment of health care operations and are the following people/person:

1. Name of Person/Relationship: _____ Phone: _____
2. Name of Person/Relationship: _____ Phone: _____

EMERGENCY CONTACT: If the emergency contact is the same, please mark here: ☐

If NO ONE is the preferred contact for the above consent, please mark here: ☐

Advance Directives

I understand I have the right to makes choices regarding life-sustaining treatment, including resuscitation measures. (Choose one below)

☐**Yes, I have provided facility with a copy of my Advance Directives/Living Will/Health care Proxy.**

☐**Yes**, I have an Advance Directive/Living Will/Health Care Proxy, **but did not bring it with me at this time.**

☐**No, I do not have** Advance Directive/Living Will/Health Care Proxy. I have been offered information on how I can obtain an Advance Directive/Living Will/Health Care Proxy.

***(If "Yes" is chosen above**, I agree the facility has explained their policy regarding the honoring of this document and that if necessary; I will be resuscitated and transferred to an acute care hospital. I agree to proceed with proposed procedures as scheduled.)*

Emergency and Non-Emergency Contacts and Transportation

Emergency Contact/Relationship: _____

Emergency Phone Number(s): Cell: _____Home:_____

I acknowledge that all the information provided it correct to my knowledge. If any information may change I will inform Sonoran Vein and Endovascular.

I hereby authorize and consent to being transferred via ambulance to an acute care hospital if my physician determines that it is necessary. I further authorize the release of my medical records from the hospital to be set back to the surgery center.

Today's Date: _____

Patient Name (Printed): _____

Patient Signature: X _____

Witness Signature: _____

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Notice of Privacy Practices and HIPAA

As a patient of Sonoran Vein and Endovascular we want to provide you with the best possible care. We want you to feel free to make full disclosure of information to the physician so that effective treatment can be provided. As required by the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Sonoran Vein and Endovascular, is providing you, the patient of the patient's legal representative, with a copy of our Privacy Notice. HIPAA regulations require us to provide this information to you and to obtain your signature or the signature of your legal representative as proof that you have received our Privacy Notice. *Our policy is to protect the confidentiality, integrity, and security of the protected health and personal information of our patients and to prevent unauthorized access to, or the use of such information. This policy applies to both current and former patients.*

Protected Health Information (PHI) is individually identifiable health and personal information and includes any information obtained by Sonoran Vein and Endovascular, in connection with providing health care treatment, obtaining payment and related healthcare operations. This relates to past, present for future information that Sonoran Vein and Endovascular, receives from you as our patient. We will use this information to provide caring and quality medical care for you. Examples of PHI include diagnosis treatment and communications, oral and written, and including answering machines, voice mail and e-mail, used for follow-up, appointment scheduling, reminders, and test results reporting. As part of our standard healthcare operations, we may share this information with a facility such as a hospital, laboratory, diagnostic service or healthcare provider to coordinate your treatment plain in the most efficient manner. For insurance carriers, your information will be used for claim submission and to obtain payment for services provided. We will exchange data with your insurance carrier for activities such as confirming your eligibility with the plan, benefit and coverage determinations, and pre-certification/authorization and utilization review. Your information is maintained in our office in our practice management information system. We also maintain information about you in our Electronic Medical Record system (EMR). Sonoran Vein and Endovascular limits access to your PHI to those employee's and business associates who need to know this information and we restrict the types and amount of information provided to the which is "minimally necessary" in order to carry out their work. We do not disclose PHI to third parties for purposes other than treatment, payment or health care operations unless the following exceptions occur:

- We receive a signed authorization from you to release your individually identifiable information. An Authorization from will be signed by you, the patient, or authorized guardian. This authorization will be placed in your medical record. It may be cancelled by you, the patient, or authorized guardian at any time. If you desire limited access or specific individual's access to your PHI, please complete a Request to Restrict Use and Disclosure of Protected Health Information form.
- Federal, state or other applicable law requires us to share PHI
- Workers' Compensation purposes

You have the right to request a review of your PHI, to amend your records, and request restrictions on how your PHI is used. You may request an accounting of how your PHI has been disclosed. Any request for amendments or restrictions to the use of your PHI must be in writing. You have a right to request a copy of your medical record. Sonoran Vein and Endovascular will make every effort to provide you with your record within a reasonable amount of time and subject to normal copying charges. If you have any questions, comments or complaints regarding the management of your PHI, please contact our office and the Practice Manager. If such complaints are unresolved you have the right to report to the Department of Health and Human Services.

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PATIENT RIGHTS & RESPONSIBILITIES

This accredited facility presents these Patient Rights and Patient Responsibilities to reflect the commitment 10 providing quality patient care, facilitating dialogue between patients, their physicians, and the facility management, and promoting satisfaction among the patients and their designated support person(s), physicians, and health professionals who collaborate in the provision of care. This facility recognizes that a personal relationship between the physician and the patient is an essential component for the provision of proper medical care. When the medical care is rendered within an organizational structure, the facility itself has a responsibility to me patient to advocate for expanded personal relationships and open communications between patients and their designated support persons, physicians and the organization's staff members. This facility has many functions to perform, including but not limited to preventing and treating medical conditions, providing education to health professionals and patients and conducting clinical research. All these activities must be with an overriding concern fŏr the patient and above all the recognition of his or her dignity as a human being. Although no catalogue of rights can provide a guarantee that the patient will receive the kind of, he she has a right to expect, these patient rights are affirmed and actively incorporated into the care provided in this facility.

1. The patient has the right to received considerate and respectful care in a safe setting.
2. The patient has the right to know the name of the physician responsible for coordinating his/her care.
3. The patient has the right to obtain information from his or her physician in terms that can be reasonably understood. Information may include, but is not limited to his or her diagnosis, treatment, prognosis, and medically significant alternatives for care or treatment that may be available. When it is not medically advisable to share specific information with the patient, the information should be made available to an appropriate person in his or her behalf. When medical alternatives are to be incorporated into the plan of care, the has the right to know the name of the person(s) responsible for the procedures and/or treatments.
4. The patient has the right to obtain the necessary information his or her physician to give informed consent before the start of any procedure and/or treatment. Necessary information includes, but is not limited to, the specific procedure and/or treatment. The probable duration of incapacitation, the medicallysignifican risks involved, and provisions for emgerncy care.
5. The patient has the right to expect this accredited ambulatory surgery facility will provide evaluation, services and/or referrals as indicated for urgent situations. When medically permissible, the patient or designated support person(s) will receive complete information and explanation about the need for and alternatives to transferring to another facility. The facility to which the patient is to be transferred must first have accepted the patient for transfer.
6. The patient has the right to refuse treatment to the extent permitted by law. and to be informed of the medical consequences of his or her action.
7. The patient has the right to obtain information about any financial and/or professional relationship that exists between this facility and other health care and educational institutions insofar to his or her care is concerned. The patient has the right to obtain information about any professional relationships that exist among individuals who are involved in his or her procedure or treatment.
8. The patient has a right to be advised if this accredited ambulatory surgery facility proposes to engage in or perform human experimentation affecting his or her care or treatment. The patient has the right to refuse to participate in research projects.
9. The patient has the right to every consideration for privacy throughout his or her medical care experience, including but not.limited to, the following. Confidentiality and discreet conduct during case discussions, consultations, examinations, and treatments. Those not directly involved in his or her care must have the permission of the patient to be present. All communications and records pertaining to the patient's care will be treated as confidential.
10. The patient has the right to expect reasonable continuity of care, including, but not limited to the following. The right to know in advance what appointment times and physicians are available and where. The right to have access to information from his or her physician regarding continuing health care requirements following discharge. The number to call for questions or emergency care.
11. The patient has the right to access and examine an explanation of his or her bill regardless of the source of payment.
12. The patient and support person(s) have the right to know what facility rules and regulations apply to their conduct as a patient and guest during all phases of treatment.
13. The patient has the right to be free from all forms of abuse, neglect, or harassment
14. The patient has the right to exercise his or her rights without being subjected to discrimination or reprisal.

Patient Responsibilities

It is the patient's responsibility to participate fully in decisions involving his or her own health care and to accept the consequences of these decisions if complications occur.

It is the patient's responsibility to follow up on his or her physician's instructions, take medications when prescribed. and ask questions that immerge concerning his or her own health care.

It is the patient's responsibility to provide name of support person in case of emergency and have this support person available when advised to do so.

Direct any care concerns or complaints to:

Facility Director: Nicki Nelson RN Phone: (602)374 4101

Director of Clinical Compliance of AAAASF: Ilnana Wolff Phone: (888) 545-5222 Email: info@aaaasf.org

Department of Health: 250 N. 17th AVE. PHX, AZ 85007 Phone: 602-542-6128
Office of the Medicare Beneficiary Ombudsman Phone: 1-800-MEDICARE (1-800-633-4227) Website: **HTTPS://WWW.MEDICARE.GOV/BASICS/YOURMEDICARE-RIGHTS/GET-HELP-WITH-YOUR-RIGHTS-PROTECTIONS**