SONORAN
VEIN AND ENDOVASCULAR

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Financial Policy

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

PRINT NAME: _____

_____ 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:** _____

PATIENT REGISTRATION FORM

Today's Date: _____

Patient Name: _____ _____ Date of Birth: _____ Age: _____ M/F
Last First
Street Address: _____ Apt/Unit Number: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Other Phone Numbers: _____ **Okay to leave voice mail/messages: Yes or No**
Social Security Number: _____ E-Mail:_____
Marital Status (Circle One): Single/Divorced/Married/Separated/Widowed
Employer: _____ Phone: _____ Occupation: _____
Retired: _____ Looking for Employment: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____
Primary Care Physician: _____ Phone #:_____
Referring Physician: _____ Specialty Type: _____
Referring Physician Phone #: _____
Cardiologist:_____ Nephrologist (Kidney): _____
Any X-Rays/CT/MRI/CTA or Ultrasounds performed on legs? _____
If yes, when & where: _____

INSURANCE INFORMATION

Please have all Insurance cards available for photocopy at time of service

Primary Carrier: _____
Identification Number: _____
Policy Holder: _____
Employer: _____
Group Name/ Number: _____
SS Number of Insured: _____
Insured Date of Birth: _____
Relationship to Insured: _____

Secondary Carrier: _____
Identification Number: _____
Policy Holder: _____
Employer: _____
Group Name/Number: _____
SS Number of Insured: _____
Insured Date of Birth: _____
Relationship to Insured: _____

Please note preliminary documentation will not be reviewed by a physician until the date of the patient's office visit and is not intended to establish physician-patient relationship.

INSURANCE AUTHORIZATION AND ASSIGNMENT CONSENT

I request that payment of authorized insurance benefits be made either to me or on my behalf to Sonoran Vein and Endovascular, for any services provided to me by the physician or supplier. I authorize any holder of medical information about me to release to my insurer and its agents any information needed to determine these benefits payable for related services.

Patient Signature: X_____ Date: _____

PATIENT HEALTH REVIEW

Reason for Today's Visit:_____

Please list entire Surgical History:

_____

_____

Please circle any of the following health problems you have had or have now:

High blood pressure	Cataracts	High cholesterol	Pneumonia
Stroke or ministroke	Emphysema or COPD	Sleep disorders	Anemia
Gastric reflux/GERD	Aneurysm	Ulcerative colitis or Crohn's	Bladder problems
Angina/chest pain	Kidney failure	Heart attack	HIV or AIDS
Congestive heart failure	Hepatitis	Abnormal heart rhythm	Bleeding/clotting problems
Pacemaker or AICD	Thyroid problems	Varicose veins/stripping	Seizure disorder
Diabetes	Cancer	Asthma	Stomach ulcers
Liver problems	Bleeding Conditions	Prostate problems	Eye Disorder

Pain in legs with walking (claudication) ***OTHER MEDICAL PROBLEMS NOT LISTED:*** _____

Please list any medication/tape/latex allergies: _____

Please list your medications, including the strength and times a day the medication is taken

(or attach a pre-filled list to this packet)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY

Smoke? **YES** _____ packs daily / **NO** / **FORMER** _____(yr)Drink? **YES** _____per day/_____per week / **NO**

Recreational Drug Use? **YES / NO** If yes, please describe _____

Do you use oxygen? **YES / NO**

Do you use a walker? **YES / NO / AS NEEDED** Wheelchair? **YES / NO / AS NEEDED**

FAMILY HISTORY

Mother: LIVING □ DECEASED □ Father: LIVING □ DECEASED □

Please identify if any family members have the following:

Skin Cancer: Who?_____
Colon Cancer: Who?_____
Prostate Cancer: Who?_____
Breast Cancer: Who?_____
Lung Cancer: Who?_____
High Blood Pressure: Who?_____
High Cholesterol: Who?_____
Heart Disease: Who?_____
Diabetes: Who?_____
Liver Disease: Who?_____
Kidney Disease: Who?_____

Thyroid Disease: Who?_____
Eye Problems: Who?_____
Osteoporosis: Who?_____
Arthritis: Who?_____
Blood Disorders: Who?_____
Asthma: Who?_____
Allergies: Who?_____
COPD: Who?_____
Depression: Who?_____
Substance abuse: Who?_____
Psychiatric Disorders: Who?_____

Patient Name: _____ Date of Birth_____

Please indicate if you have experienced any of the following in the past year:

General
Fever _____
Chills _____
Sweats _____
Anorexia _____
Fatigue _____
Weight loss _____

ENT
Blurred or double vision _____
Vision Loss ____
Cataracts _____
Ear Ringing ____
Diminished Hearing ____

Cardiovascular
Chest discomfort _____
Skipped heartbeats _____
Swelling in ankles or feet _____
Fluttering feeling in chest _____

Respiratory
Shortness of breath _____
Chronic cough ____
Asthma _____
Wheezing _____

Gastrointestinal
Indigestion _____
Nausea _____
Vomiting _____
Diarrhea _____
Constipation _____
Abdominal pain ____
Ulcers _____

Genitourinary
Loss of bladder ___
Blood in urine ____

Musculoskeletal
Arthritis _____
Back pain ____
Joint Pain ____
Muscle weakness _____

Skin
Skin rash ____
Itching ____
Dryness _____
Suspicious Lesions _____
Ulcer ____
Lesion _____

Neurological
Memory loss ____
Seizures _____
Vertigo _____
Weakness _____
Stroke _____

Extremities
Edema ____
Open Ulcers ____
Gangrene _____
Discoloration ____

Psychological
Depression ____
Anxiety ____
Memory Loss ____
Unusual stress ____

Endocrine
Cold intolerance _____
Heat intolerance _____
Excessive thirst _____

Hematology/Lymphatic
Breast masses/Lumps ____
Enlarge lymph nodes ____
Unexplained bruising _____

Allergy/Immunologic
Hay fever _____
Dust/pollen _____
Allergies _____
Persistent Infections_____

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:_____

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: X_____

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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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