SOUTH FLORIDA VASCULAR ASSOCIATES
Leading Change in Vascular Care

New Patient Information

Patient Name: _____Date_____

Address: _____ City/State/Zip_____

SS#_____ Birth Date _____ Age _____ Sex M/F Marital Status: S M D W

Phone#: Home _____ Mobile _____ Email_____

Occupation _____ Employer's Name_____

Spouse Name_____Mobile_____Employer _____

Certified Nursing Assistant/Transportation Co. Name_____No._____

In case of emergency notify _____Phone #_____

Primary Care Physician _____Phone #_____

Referring Physician (if other than PCP) _____ Phone #_____

**Reason for today's visit_____

List all Physician's that are involved in your care (full names and phone numbers):

Nephrologist: _____ Cardiologist: _____

Podiatrist: _____Wound care: _____

Other: _____

Pharmacy Name: _____ Phone #: _____

Pharmacy Address: _____

Primary Insurance: _____Policy Holder: _____

Policy #: _____Group #: _____ Relation: _____Phone: _____

Secondary Insurance: _____Policy Holder: _____

Policy #: _____Group #: _____ Relation: _____

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(Form Revised 03-01-2017)

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Medical History Questionnaire

Name: _____ Reason for consultation? _____

Weight? _____ pounds Height? _____feet _____inches

13. Have you ever been diagnosed with any of the following? (Check all the apply)

☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Over Weight ☐ Heart Disease

14. Have you ever smoked? Yes No currently smoking? Yes No How Much? _____ Quit Date? _____

15. Do you drink alcohol? Yes No Amount per week? _____

16. Have you used any recreational drug? Yes No currently using? Yes No kind?_____

17. List your ALLERGIES to medications or drugs: ☐ **NO ALLERGIES**

_____

18. Indicate your reactions to the above named allergies:

Rash hives face swelling shortness of breath other: _____

19. ***Are you allergic to IODINE (x-ray dye/contrast)?*** Yes No Reaction: _____

20. List your medications, dosage and frequency below:

Medication Name	Dosage	Frequency	Indication (reason for taking it)

21. Have you ever had or been treated for **HEART PROBLEMS**? (Check all the apply) ☐ **NONE APPLY**

☐ Heart Attack (Year) _____ ☐ Chest pain or Angina ☐ Heart Murmur

☐ Atrial Fibrillation ☐ Mitral Valve Prolapse ☐ Pacemaker ☐ Other: _____

22. Have you ever had or been treated for **RESPIRATORY PROBLEMS**? (Check all the apply) ☐ **NONE APPLY**

☐ Asthma ☐ COPD ☐ Chronic Cough ☐ Oxygen Dependent ☐ Tuberculosis

23. Have you ever had or been treated for DIGESTIVE TRACT PROBLEMS? (Check all the apply) ☐ **NONE APPLY**

☐ Liver Problems ☐ Peptic Ulcer ☐ Gastritis ☐ Hepatitis

☐ Hiatal Hernia ☐ GE Reflux ☐ Cirrhosis

24. Do you have any SKIN DISORDERS? (Check all the apply) ☐ **NONE APPLY**

☐ Open wound(s) ☐ rash ☐ skin pigmentation ☐ Other: _____

25. Have you ever had or been treated for NEUROLOGIC PROBLEMS? (Check all the apply) ☐ **NONE APPLY**

☐ Stroke (Year)_____ ☐ Mini-Stroke or TIA (Year) _____ ☐ Pain in arms or legs

☐ Frequent Headaches/Migraines ☐ Seizure/Convulsion/Epilepsy ☐ Herniated Disk

☐ Spinal Stenosis ☐ Paralysis Spinal Cord Injury ☐ Numbness or tingling of arms/legs

1. Have you taken any of the following medications in the past week? (Check all the apply) ☐ **NONE APPLY**

   Aspirin Products..... Bufferin, Excedrin, Ecotrin, etc.

   Blood Thinning Drugs..... Coumadin, Heparin, Persantine, Lovenox, Plavix, Pradaxa, Efferin, Warfarin

   Reason for taking blood thinner? _____

2. Have you been treated for nervous or emotional problems? (Circle all that apply) ☐ **NONE APPLY**

   Depression Anxiety Panic Attacks Bipolar disorder Other: _____

3. Have you ever had or been treated for MUSCLE, BONE, or JOINT PROBLEMS? (Circle all the apply)

   ☐ **NONE APPLY**

   Rheumatoid Arthritis Back Pain or Sciatica Muscle Cramps or Weakness

   Neck Problems Difficulty Walking Degenerative (Osteo-) Arthritis

4. Please describe any medical problems not discussed above:

_____

5. Have you ever had surgery or anesthesia? Please list below:

Year	Surgery	Anesthesia: Local or General	Complications (If any)

6. If you are a female, IS THERE ANY CHANCE THAT YOU COULD BE PREGNANT NOW? Yes No
   - Date of last menstrual period? _____ ☐ **Not Applicable**
7. Do you require antibiotics before a dental procedure? Yes No

   If yes, why? _____
8. Have you ever had a blood transfusion? Yes No
9. Do you have a religious objection to receiving blood transfusion? Yes No
10. Have you ever been treated for cancer with chemotherapy or radiation? Year:_____
11. Dialysis Center_____ Phone_____
12. Dialysis Days MWF TTS

PLEASE SIGN AND DATE: The information that I have provided is an accurate and current profile of my medical history and review of systems. I have disclosed all of my medical history known to me.

_____ _____

Patient or Guardian Signature Date

M.D.'s Initials:_____Date Reviewed:_____

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HIPAA Consents and Acknowledgements

Patient Name: _____ Date: _____

Please Initial

_____Medical History

The information that I have provided to the staff is an accurate and current profile of my medical history and review of systems. I have disclosed all of my medical history known to me.

_____Consent to Leave Message:

I wish to be called at home □**;** other □ (check all that apply) regarding my care and follow-up. The best telephone number(s) to reach me are: _____ home _____other

□ I do; □ I do not give permission to leave relevant medical information on my answering machine or voice mail.

□ I do; □ I do not want relevant medical information shared with the person who may answer the telephone. The name(s) of the individual(s) with whom you may leave pertinent information are: _____ _____.

_____ Privacy Practices

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____ Referral Policy

If you have HMO insurance coverage, your **referral must be in our office before your visit**. If our office does not receive a valid referral before your visit, you will have to reschedule your appointment.

THIS IS YOUR RESPONSIBILITY!!!!!

You can choose one of the 2 options:

1. Bring the referral to the office yourself. Please be sure that it is valid referral for the date of the visit.
2. Have it faxed to our office. In this case, you must check with our office to see that we have received the referral one day in advanced of your visit. Statements by the primary physicians' office that the referral was faxed or will be faxed do not guarantee that we will receive the fax.

Please be aware that many of the Primary Care Physicians' offices have their own policies regarding the issuance of referrals. Some require 5-7 days of advance notice. Others require re-evaluation by the primary physician prior to a request consultation.

_____Release of Information

I hereby authorize any physician, hospital, or medical facility to provide on my behalf all information on my medical history and treatment of the doctors at South Florida Vascular Associate. I hereby authorize South Florida Vascular Associates to release any information acquired in the course of my examination for the continuation of my treatment and care.

I have read and understand the above statements and agree to abide by the office policies outlined above. I hereby authorize and photocopy of the form to be as valid as the original.

Patient Signature: _____ Date:_____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on 03/02/2017 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR INSURANCE PAYMENT: We may use or disclose health information about you in order to bill and collect payment for the services and items you may receive from us.

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Office Policy for Financial Arrangements & Medical Insurance

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits.

- **Payment for service is due at the time services are rendered. We accept cash, checks, MasterCard, Visa, Discover & American Express.**
- **Filing of Insurance**
    1. **Surgery and diagnostic procedure**- As a courtesy to you, we will assist with your insurance for surgeries and diagnostic procedures. We will call to confirm benefits and when necessary written pre-authorizations will be prepared by our office. Insurance providers do not "guarantee" the amounts quoted over the phone. We must emphasize that as a medical provider, our relationship is with you; not your insurance company. Your active participation is necessary when denials occur or payments are delayed from your insurance provider. We will file claim forms with your primary insurer and you will be responsible for handling any secondary insurer.
    2. **Medicare**- Claim forms for covered Medicare procedures will be handled by the office.

As the Patient you have the ultimate financial responsibility: All charges are expected at the time services are rendered by this practice. In the case that private insurance may pay a portion of your charges, your estimated payment (considering expected insurance coverage) will be required to be paid at the time of service. In the event that your insurance provider denies payments or pays less than expected, you are ultimately responsible for all balances on accounts. The Insurance Company's decisions and payment amounts are not within our control; however, we are happy to assist you in the insurance appeal process. In the event of an unpaid account by your insurance provider, please understand that you are ultimately responsible for all charges. If it becomes necessary to collect you unpaid account using a collection agency, you will be responsible for any charges incurred as a result of involvement of the collection agency/attorney (usually 20-50% of unpaid amount) and any other legal or court fees incurred as a result.

Missed or Cancelled Appointments: The timeliness of treatments is important in getting the most effective results. We accommodate patient schedules as best we can. In consideration of this and other patients, this office requires a 48-business hour notice of cancellation of an appointment. This provides time to work other patients into the schedule. Failure to provide notice will result in a missed appointment charge ranging from $25 to $200 depending on the type of appointment that was scheduled. Policy strictly enforced.
{Please initial _____}

Returned Checks A $25 service fee will be charged for all returned checks. Repayment will need to be cash, money order or credit card only.

Lifetime Authorization I authorize this practice to provide any medical information about me to Medicare and/or insurance providers in order to determine payment for services received from South Florida Vascular Associates.

Agreement
I, (print name) _____, have read and understand the cancellation policy and the terms & conditions of my financial obligation and agree to abide by the office policies outlined above.

Patient Signature: _____ Date: _____

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Dear Patient,

Beginning June 1, 2015, SFVA will implement a Cancellation and No-Show policy. We understand that unplanned issues can come up and you may need to cancel an appointment.

If that happens, we respectfully ask for scheduled appointments to be cancelled ***at least 48 hours in advance.***

It is customary to contact you in advance to confirm your appointment as our staff and physicians want to be available for your needs and the needs of all of our patients however, when a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen.

Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of changing for no-show appointments and those appointments not cancelled within 48 hours.

Fees for missed appointments will be as follows:

Consults and Follow-ups	**$ 25.00**
Ultrasounds	**$ 50.00**
Dialysis Access Procedures	**$ 75.00**
All other Procedures	**$200.00**

By signing below, you acknowledge that you have read and understand the Cancellation and No-Show Policy for South Florida Vascular Associates as described above.

Thank you for you cooperation.

_____ _____
Printed Name Signature

_____
Date

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