ADVANCED • VASCULAR • SOLUTIONS

NEW PATIENT REGISTRATION

DEMOGRAPHICS

Patient Information: *Need help with Forms? [ ] Y [ ] N* | Preferred Language: [ ]English[ ]Spanish

Name: (LAST) _____ (FIRST)_____ (MI)_____

Date of Birth: _____ /_____/ _____ Social Security (Optional) _____-_____-_____ Sex: [ ]Male [ ] Female

Street Address: _____ (Apt #) _____

(City) _____ (State)_____ (Zip) _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Best Form of Contact: [ ] Home [ ] Work [ ] Cell Phone |May *we leave a detailed voice message? [ ] Y [ ] N*

Email: _____

Primary Care Physician: (Name) _____ (Phone)_____

Preferred Pharmacy: (Name) _____ (Location) _____

Emergency Contact: (Name) _____ (Phone) _____

(Relationship)_____

Name of Primary Insurance _____ Primary Insurance ID: _____

Name of Secondary Insurance :_____ Secondary Insurance ID: _____

Patient Authorization to Release Medical Records (Family Member)

Patient Authorization to Release Medical Records: I authorize the custodian of records or other person/entity (specifically describe) to disclose/release the following information* Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse or STDs, you are hereby authorizing disclosure of this information.

To (Name): _____ Relationship: _____

To (Name): _____ Relationship: _____

Signature of Patient (or Guardian):_____Date: _____ / _____ / _____

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Please initial and sign to select your current method of coverage, and to complete the acknowledgement and consent for Medical Treatment, Notice of Privacy Practices, and Payment Policy.

___SELF-PAY PATIENT VISIT

By signing below, I acknowledge that I have been informed of my responsibility to pay for the professional services or supplies provided to me today by David Ladden, MD. DBA/Advanced Vascular Solutions. I understand that these costs must be paid prior to the provision of such services through its authorized representatives. I acknowledge and fully understand that the service(s) requested today will not be billed to any insurance carrier(s) at my request. I also understand that today's service(s) will be provided at a discounted rate and waive any right that I may have to require Advanced Vascular Solutions to attempt to bill any insurance carrier for these services. I further acknowledge that if I choose to submit an itemized receipt to any insurance carrier(s) for evaluation of partial or full reimbursement for these services that Advanced Vascular Solutions is exempt from any subsequent dispute regarding reimbursement but retains the option to submit these services for payment under the non-discounted insurance rates and guidelines upon mutual agreement by both parties when appropriate insurance information has been provided to Advanced Vascular Solutions.

___HEALTH INSURED PATIENT VISIT

I request that payment of authorized insurance benefits, including Medicare, be made on my behalf for any professional services or supplies provided to me by David Ladden, dba "Advanced Vascular Solutions".

I acknowledge that I have provided my insurance information today and authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related professional services or supplies by Advanced Vascular Solutions to the Health Care Financing Administration, my insurance company or other entity upon request to secure payment of my benefits. I understand that I am financially responsible to Advanced Vascular Solutions for any charges not covered by health care benefits. It is my responsibility to notify Advanced Vascular Solutions of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I understand that I am responsible for the entire bill including any unpaid balance of the professional services or supplies as determined by Advanced Vascular Solutions and/or my health care insurer should the submitted claim or any part of the claim be denied for payment or apply to my co-pay, deductible or coverage limitations.

___CONSENT TO MEDICAL TREATMENT

I voluntarily present for treatment and consent to the Advanced Vascular Solutions provider to provide my care. Such care may include, but is not limited to, diagnostic procedures, x-rays, blood draws, laboratory tests, medication administration, and other procedures considered advisable in my diagnosis, treatment and course of care.

I acknowledge that my treatment is intended to address specific, episodic illnesses or injuries and is not intended as a substitute for a primary care physician or other specialized physician and that no guarantee can be made or has been made as to the results of treatments or examinations at Advanced Vascular Solutions.

___ NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge review of Advanced Vascular Solutions's Notice of Privacy Practices, with a copy available upon request, as required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

___OFFICE POLICY ON PAYMENT

It is our policy to require all copayments to be made at the time of service. In the event any balance is not paid as agreed, the undersigned agrees to pay all costs charged by the Collection Company and reasonable attorney fee. I understand that by signing this form I am accepting full financial responsibility as explained above for all professional services and supplies received. I understand this original authorization will be kept on file by Advanced Vascular Solutions and does not expire unless written notice is provided by me.

Name of person signing below (print): _____

Signature of Patient or Guardian: _____

Today's (Visit) Date: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ **Date of Birth:** _____

Phone: H) _____ **Phone: W)** _____

Address: _____ **City/State/Zip:** _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ **Facility Phone:** _____

Facility Address: _____ **Facility Fax:** _____

City, ST, Zip: _____

Dates and Type of information to disclose:

☐ 2 years prior from last date seen
☐ Dates Other: _____
☐ Specific Information Requested:
_____

The purpose of disclosure is:

☐ Change of Insurance or Physician
☐ Continuation of Care (e.g., VA Med Ctr)
☐ Referral
☐ Other _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: Advanced Vascular Solutions

Address: 1801 N. Ed Carey Suite E

City, State, Zip: Harlingen, TX 78550

☐ **Please mail records.**

Fax: 956-594-8182 **Phone:** 956-887-8898

☐ **Please fax records.**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:** _____. **If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____ _____

Signature of Patient / Parent / Guardian or Authorized Representative **Date**
(Guardian or Authorized Representative must attach documentation of such status.)

_____ _____

Printed name of Authorized Representative Relationship / Capacity to patient

_____

Address and telephone number of authorized representative