Cary W. Pulliam, M.D.
Paul S. Fleser, M.D.
Sina Iranmanesh, M.D.
Caroline Royalty, PA-C
Ellen Sexton, PA-C

☐ **4601 Carothers Parkway, Suite 375**
Franklin, TN 37067
(615) 791-4790

☐ **808 Hatcher Lane**
Columbia, TN 38401
(931) 388-6256

Appointment:

Doctor: ___________________________________

Date:_____________________________________

Time:_____________________________________

Welcome!

We appreciate that you have chosen us for your healthcare needs. Enclosed is your new patient paperwork. It is ***very important*** that you complete it as ***thoroughly*** as possible and bring to your appointment along with:

- Insurance Cards
- Medication List (if you wish for us to make a copy)

Please call if you have any questions or need to change your appointment. We look forward to seeing you in our office!

Sincerely,
The Office Staff of Middle Tennessee Vascular

Directions to Franklin Office from US-65 going North:

- Take the TN-96 exit, EXIT #65, toward Murfreesboro
- Turn RIGHT onto Murfreesboro Rd. / TN-96.
- At the second stoplight, turn LEFT onto Carothers Pkwy.
- Go 0.7 miles (if you cross over Liberty Pike, you've gone too far) and turn LEFT onto Physicians Way. **Our office building is at corner of Physicians Way and Carothers Parkway.**

Directions to Franklin Office from US-65 going South:

- Take EXIT #67 toward McEwen Dr.
- Keep left on the E McEwen Dr ramp and turn LEFT onto E McEwen Dr.
- In 0.4 miles, turn RIGHT onto Carothers Pkwy.
- Go 1.1 miles and The Carothers Tower will be on your RIGHT. **Our office building is at corner of Physicians Way and Carothers Parkway.**

Patient Information

Date: _______________

Last Name: ____________________________ **First Name**: _____________________________ **MI**: ________

Address: ____

City: ____________________ **State**: _________ **Zip**: ___________

Home Phone (____)___________ **Work Phone** (____)_____________ **Cell Phone** (____)_______________

Date of Birth: __________________ **Age**: ______ **Social Security Number**: _________________________

Check Appropriate Box:

☐ Male ☐ Female

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr.

☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

- **Race**:

☐ White ☐ Hispanic ☐ African American ☐ Asian ☐ Other ☐ Refuse to Report

- **Ethnicity**:

☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Refuse to Report

- **Language**:

☐ English ☐ Spanish ☐ Russian

Name of Employer: ____

Address: ____

City: ____**State**: ______________**Zip**: _______________

Spouse *or* Guardian's Name: ______________________________________**Date of Birth**:_______________

Phone: (___) ____________________**Employer**: ____

Whom may we thank for referring you? ____

Primary Care Physician: ____

Additional Questions:

Do we have your permission to:

Call you at work with medical information? Y N

Leave a voice mail or answering machine message at home? Y N

Leave a voice mail or answering machine message at work? Y N

Leave a message with your spouse or someone who lives with you? Y N

Use e-mail to communicate with you? Y N

E-mail address: ____

WARNING: E-mail may not protect your confidential medical information. I recognize any confidential medical information transmitted by e-mail is not secure and sent at my own risk. I will not hold the Physicians, Providers or staff of Middle Tennessee Vascular Associates responsible for the loss of any confidential medical information transmitted by e-mail. The Physicians, Providers & staff of Middle Tennessee Vascular Associates will limit the use of unencrypted e-mail to prevent disclosure of protected health information.

Do you have an Advance Directive (Living Will)? Y N

May we discuss your medical information with anyone other than you? Y N

Name: ____

Relationship: _________________________________

Phone: ______________________________________

Please list an emergency contact person (relative or friend not living with you):

Name: ____

Relationship: ____

Phone: ____

I acknowledge all of the above information is correct. I authorize the Physicians, Providers & staff of Middle Tennessee Vascular Associates to use the contact information above in treatment of my medical conditions.

Signature: ____ **Date:** ____________________

Patient History Form

Today's Date________________________

Name: _______________________________ Date of Birth: ______________ Age: _________

What health concern has brought you to our office today? Please Explain.

____

____

How long have you had this problem? ______________ Height: ________ Weight: ________

Occupation: ____________________________ Retired: Y N

Preferred Pharmacy: _____________________ City: ________________ State: ___________

Address: ____

➢ Medications

(If you have a written list of your medications, we will gladly make a copy for our records)

Current Medication	Strength (ml or mg)	Frequency	Form (tab, spray, etc.)
________________	________________	_________	__________________
________________	________________	_________	__________________
________________	________________	_________	__________________
________________	________________	_________	__________________
________________	________________	_________	__________________
________________	________________	_________	__________________
________________	________________	_________	__________________
________________	________________	_________	__________________
________________	________________	_________	__________________

Medical History

Please check all that apply:

- ☐ Peripheral Artery Disease
- ☐ Aneurysm
- ☐ Stroke
- ☐ Varicose Veins
- ☐ Deep Vein Thrombosis/Blood Clot
- ☐ Heart Arrhythmias/Atrial Fibrillation
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Alzheimer Disease
- ☐ COPD
- ☐ High Blood Pressure
- ☐ Congestive Heart Failure
- ☐ Heart Disease
- ☐ Thyroid Problems
- ☐ Arthritis
- ☐ Cancer – Type ______________________
- ☐ Parkinson Disease
- ☐ Hepatitis (A, B, C)
- ☐ HIV/AIDS
- ☐ Other: ____________________________ ____________________________

Immunizations

Pneumonia Vaccine ☐ Yes ☐ No If yes, month and year? ____________________

Flu Vaccine ☐ Yes ☐ No If yes, month and year? ___________________________

Allergies

☐ NONE

Please check all that apply:

- ☐ Latex
- ☐ Penicillin
- ☐ Iodine
- ☐ Sulfa
- ☐ Codeine
- ☐ Other: _________________

➢ Surgical History

Please check any of the following Surgeries or Procedures that you have had:

- ☐ Aneurysm Repair
- ☐ Leg Bypass
- ☐ Varicose Vein Surgery
- ☐ Abdominal: _______________
- ☐ Pacemaker/Defibrillator
- ☐ Gallbladder
- ☐ Tonsillectomy
- ☐ Carotid Surgery
- ☐ Leg Stents/Angioplasty
- ☐ Heart Stents/Angioplasty
- ☐ Hysterectomy
- ☐ Heart
- ☐ Appendectomy
- ☐ Other: ______________________________

➢ Family Medical History

Heart Disease?	Y	N	Mother	Father	Sister	Brother	Son	Daughter
Peripheral Artery Disease?	Y	N	Mother	Father	Sister	Brother	Son	Daughter
Stroke?	Y	N	Mother	Father	Sister	Brother	Son	Daughter
Diabetes?	Y	N	Mother	Father	Sister	Brother	Son	Daughter
High Cholesterol?	Y	N	Mother	Father	Sister	Brother	Son	Daughter
High Blood Pressure?	Y	N	Mother	Father	Sister	Brother	Son	Daughter
Blood Clots?	Y	N	Mother	Father	Sister	Brother	Son	Daughter
Cancer?	Y	N	Mother	Father	Sister	Brother	Son	Daughter

Other: ____

➢ Social History

Do you smoke? ________________ Packs per day? ___________________

Have you quit? ________________ When did you quit? _______________

Drink Alcohol? ________________ If so, how often? _________________

Use Drugs? ___________________ If so, how often? ________________

Please check all that apply:

Respiratory:

- [ ] Chest Pain
- [ ] Cough
- [ ] Shortness of Breath at Rest
- [ ] Shortness of Breath with Exertion

Peripheral Vascular:

- [ ] Cold extremities
- [ ] Decreased sensation in extremities
- [ ] Pain/Cramping in Legs
- [ ] Ulcers (sores) on Skin

General/Constitutional:

- [ ] Change in appetite
- [ ] Fever/Chills
- [ ] Unexplained Weight Loss
- [ ] Fainting/Passing Out

Endocrine:

- [ ] Intolerant to Cold
- [ ] Intolerant to heat
- [ ] Weakness

Neurologic:

- [ ] Difficulty Speaking
- [ ] Dizziness/Confusion
- [ ] Sudden Headaches
- [ ] Loss of Use of Extremity
- [ ] Tingling/Numbness
- [ ] Sudden Vision Loss
- [ ] Doubled/Blurred Vision
- [ ] Memory Loss
- [ ] Loss of Balance/Coordination

Skin:

- [ ] Discoloration of Skin
- [ ] Rash
- [ ] Skin Lesions

Psychiatric:

- [ ] Anxiety
- [ ] Depression
- [ ] Difficulty Sleeping

Cardiovascular:

- [ ] Chest Pain
- [ ] Chest Pain with Exertion
- [ ] Sudden Difficulty Walking
- [ ] Shortness of Breath with Exertion
- [ ] Rapid/Skipped Heart Beat
- [ ] Shortness of Breath

Gastrointestinal:

- [ ] Abdominal Pain/Swelling
- [ ] Blood in Stool/Change in Bowel Habits
- [ ] Nausea/Vomiting
- [ ] Unexplained Weight Loss

Hematology:

- [ ] Dizziness
- [ ] Bruise/Bleed Easily

Ophthalmologic:

- [ ] Blurred Vision
- [ ] Diminished Visual Activity
- [ ] Itching/Redness

ENT:

- [ ] Difficulty Swallowing
- [ ] Nosebleed
- [ ] Sore Throat

Genitourinary:

- [ ] Abdominal Pain/Swelling
- [ ] Blood in Urine
- [ ] Urination Difficulty/Pain

Musculoskeletal:

- [ ] Joint Stiffness
- [ ] Leg cramps
- [ ] Weakness

Middle Tennessee Vascular

Patient Agreement

Limitations of Practice
Patient understands that the practice of Middle Tennessee Vascular Associates is limited to Vascular Surgery.

Patient Consent
Patient hereby gives consent, if needed, for drawing blood samples for diagnosis or in case of accidental puncture or exposure to medical personnel during my course of treatment either in the office or in the hospital. This test may include HIV/AIDS testing.

In order to provide an accurate and updated medical record, patient gives consent to query outside resources to obtain a list of your current medications.

Tennessee Controlled Substance Monitoring Database (CSMD)
Middle Tennessee Vascular Associates abides by the rules and regulations set forth by the State of Tennessee regarding the CSMD as required by law. Patient herby gives consent for the practice to access any and all records held by the Department of Health relating to Schedule II-V controlled substance dispensed to the patient.

Privacy Policy

All patients have the right to review our Notice of Privacy practices. Any employee of the practice can provide you a copy of the Notice of Privacy Practices. If you would like to restrict access or request modifications be made to your Personal Health information, please request the required form from a member of our staff.

Collection Policy

Insurance Claims Filing
In all cases, the patient is responsible for payment of their account. As a courtesy, Middle Tennessee Vascular Associates will file a claim to the patient's insurance.

Assignment and Release
Patient hereby authorizes and assigns applicable insurance benefits to be paid directly to the physician; Patient is financially responsible for non-covered services. Patient authorizes release of information necessary to process insurance claims. Patient authorizes photographs to be restricted for medical, education or insurance purposes and information released to other practitioners in good faith effort for my medical care.

Medicare
Patient requests that payment of authorized Medicare benefits be made on the patient's behalf to Middle Tennessee Vascular Associates and their associates for any services furnished to the

patient by that physician. Patient authorizes any holder of medical information about the patient to release to the Center for Medicare and Medicaid Services (CMS) or its agents any information needed to determine benefits payable for related services.

Managed Care Plans and Referrals

Managed care plans (e.g. HMO's) required specialist and sub-specialists to obtain a referral number before the physician can see a patient. **The patient is responsible for obtaining a referral number, not this office.** Failure to have a referral number prior to service will result in reduced benefits by the managed care plan. Therefore, the patient is responsible for any balance not paid by the coverage plan.

Co-Payments

In all cases, the patient is responsible for making co-payments at the time of the patients visit in the form of cash, check or card. If a co-payment is not made at the time of the patients visit, Middle Tennessee Vascular Associates reserves the right to require co-payment to be made prior to all future visits.

Unpaid Balances

We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If we refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs. In case of suit, you agree the venue shall be Williamson County, Tennessee. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

Patient Signature____ Date____________________

ALL QUESTIONS CONCERNING THESE POLICIES SHOULD BE DIRECTED TO THE ADMINISTRATOR

<u>Middle Tennessee Vascular</u>

RELEASE OF MEDICAL INFORMATION

Date: _______________

I______________________________________, authorize the Physicians and Providers of Middle Tennessee Vascular Associates or their staff to release information on file regarding my medical bills and/or my medical treatment (any and all medical information relating to me) to the person(s) listed below. I understand that by signing this release that the designated person(s) will be able to speak with a staff member of Middle Tennessee Vascular Associates regarding my protected healthcare information (PHI).

Furthermore, I understand that the physician's office cannot be held liable for any information the below stated person(s) may obtain regarding my medical care. I understand that revocation of this authorization must be provided to Middle Tennessee Vascular Associates in writing. I understand that unless I revoke the authorization earlier, this authorization will automatically expire twelve (12) calendar months after the date this authorization is signed. I understand that I may refuse to sign this Authorization and that the Medical Group will not condition treatment on whether I sign this Authorization.

Please list designated person(s) below, if there is no designated person(s) – write "PATIENT ONLY". You can choose to designate a class of individuals such as "immediate family members", which will include your spouse and children.

Name: ______________________________________ Phone: ______________________

Relation: ____________________________________

Name: ______________________________________ Phone: ______________________

Relation: ____________________________________

I certify that I am:

- ☐ The patient and the identification that I provided is true and correct.
- ☐ The patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct.
  My relationship to the patient is that of: _________________________

Signature: ____ Date ____________

Print Name: ____ Date ____________

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize that my medical information may be released to the above mentioned physicians or their staff. This includes medical history, mental or physical conditions, diagnosis, prognosis, and reviewing of necessary x-rays**.**

A copy of this is as valid as the original. I have the right to receive a copy.

Printed Name ______________________________

Signature __________________________________

Date of Birth _______________________________

Date ______________ **Witness** ___________________