MIDDLE TENNESSEE VASCULAR

MIDDLE TENNESSEE VEIN CLINIC

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☐ **120 Frank Martin Rd, 101**
**Shelbyville, TN 37160**
**(931) 685-0986**

**Appointment:**

Doctor/Provider: _____

Date and 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 note, our office provides a variety of services including doctor visits, ultrasound services, and procedures. Because our patients have differing needs, your wait time may be different than other patients in our lobby. It is possible that patients who arrive in our office after you, may be called back sooner than you, simply because they require different services than you. There are times when, for a variety of reasons, our schedules can run behind. If that happens, we appreciate your patience and will do our best to treat all of our patients' appointment times in a fair and consistent manner.

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***

# 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 ☐ Black/African American ☐ Asian ☐ Other ☐ Refuse to Report

- **Ethnicity**:

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

- **Language**:

☐ English ☐ Spanish ☐ Russian

**Whom may we thank for referring you?** _____

**Primary Care Physician**: _____

**Insurance Information** (**Not necessary** to complete this section if you have presented cards at the front desk)

**Primary Insurance**_____ **Policy Holder's Name**_____ **Birthdate**_____

**Member ID**_____ **Group#**_____ **Relationship to Patient**_____

**Secondary Insurance**_____**Policy Holder's Name**_____ **Birthdate**_____

**Member ID**_____ **Group#**_____ **Relationship to Patient**_____

**Do we have your permission to use email to communicate with you? Y N**

**Email address:**_____

**WARNING: Email may not protect your confidential medical information. I recognize any confidential medical information transmitted by email is not secure and sent at my own risk. I will not hold the Physicians, Providers or staff of Middle Tennessee Vascular Associates or Middle Tennessee Vein Clinic responsible for the loss of any confidential medical information transmitted by email.**

**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
- ☐ Dialysis – If so, at what facility do you dialyze?

  Facility Name:_____

  Facility Phone Number:_____
- ☐ 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

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*Phone: (615) 791-4790*
*Fax: (615) 791-4531*

## 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** _____

# General Consent For Treatment

***As the patient, you have the right to be informed about your conditions and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify appropriate treatment and/or procedure for any identified condition(s).***

I request and authorize medical care as my provider, his assistant or designees (collectively called "the providers") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care. I authorize my provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my provider(s) and that other personnel render care and services to me (the patient) according to the provider(s) instructions.

I understand that I have the right and the opportunity to discuss alternative plans of treatment with my provider and to ask and have answered to my satisfaction any questions or concerns.

In the event that a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus or hepatitis C, I consent to the testing of my blood and/or bodily fluids for these infections and the reporting of my test results to the healthcare worker who has been exposed. _____ **(initial)**

**I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT; I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED.**

Name of Patient: _____

Signature of Patient: _____ Date: _____

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☐ Consent of Legal Guardian, Patient Advocate or Nearest Relative **if patient is unable to sign**

☐ Consent Caregiver **if patient is unable to sign**

Name of Legal Guardian, Patient Advocate, Nearest Relative or Other: _____

Relationship: _____ Telephone: _____

Address: _____

Signature of the above: _____ Date: _____ Time: _____

Signature of Witness: _____ Date: _____

AdvancedHEALTH

# Release Of Medical Information

NAME *(Please print)*: _____

By Signing Below, I Authorize (Practice Name) To Release My Medical And Billing Information To:

| **RELATIONSHIP** | | | **NAME OF DESIGNATED PERSON** |
|---|---|---|---|
| SPOUSE | ☐ YES | ☐ NO | _____ |
| CHILDREN | ☐ YES | ☐ NO | _____ |
| IN-LAWS | ☐ YES | ☐ NO | _____ |
| CAREGIVERS | ☐ YES | ☐ NO | _____ |
| PARENTS | ☐ YES | ☐ NO | _____ |

OTHERS _____

PATIENT SIGNATURE _____ DATE _____

PARENT SIGNATURE _____ DATE _____

**We ask that if you have any change in this request, that you please inform the receptionist.**

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(PRACTICE NAME) MAY LEAVE APPOINTMENT INFORMATION ON MY VOICEMAIL:

| | | |
|---|---|---|
| HOME | ☐ YES | ☐ NO |
| WORK | ☐ YES | ☐ NO |
| RELATIVE | ☐ YES | ☐ NO |

PATIENT SIGNATURE _____ DATE _____

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I AUTHORIZE THE FOLLOWING TO PICK UP PRESCRIPTIONS, X-RAYS, ETC.

RELATIONSHIP

| | | | |
|---|---|---|---|
| SPOUSE | ☐ YES | ☐ NO | _____ |
| RELATIVE | ☐ YES | ☐ NO | _____ |
| CAREGIVER | ☐ YES | ☐ NO | _____ |

PATIENT SIGNATURE _____ DATE _____

I UNDERSTAND THAT (PRACTICE NAME) WILL ASK FOR IDENTIFICATION OF THE PERSON PICKING UP PATIENT MEDICAL INFORMATION OR PRODUCTS.

AdvancedHEALTH

# Patient Financial Policy

*This is an agreement between AdvancedHEALTH, as creditor, and the Patient/Debtor named on this form and indicated by patient/debtor signature below.*

*In this agreement the words "you", "your" and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us" and "our" refer to AdvancedHEALTH. By executing this agreement, you are agreeing to pay for all services that are rendered.*

*Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. A copy of your signed financial agreement will be provided to you.*

**HEALTH INSURANCE - It is YOUR responsibility to:**

- Ensure we have been provided with the most current insurance information relative to filing your claim including insurance card, ID number, employer, birth date and patient address. This information will be located on our patient registration form.
- Ensure we are contracted with your insurance carrier to receive maximum benefits.
- Pay your co-payment or patient portion at the time of service.
- Inform us of any insurance changes made after this signed agreement/date of service. Insurance carriers have specific timely filing guidelines and pre-authorization requirements for certain services. If revised insurance information is not provided to us within your insurances' timely filing limits, you will be required to pay for services in full. If prior authorization was required for services already received and your claim is denied for lack of authorization, you will be required to pay for services in full.
- Contact your insurance company if no correspondence is received by you within 45 days of the date of service.

**It is OUR responsibility to:**

- Submit a claim to your health insurance carrier based on the information provided by the patient/debtor at the time of service or as updated information is provided.
- Provide your health insurance carrier with information necessary to determine benefits. This may include medical records and/or a copy of your insurance card.
- Provide MVA patients a courtesy health insurance claim form for their records upon request.

**PAYMENT OPTIONS:** Per our contracted agreement with your insurance carrier, we are required to collect your co-payment on the day of service. If you do not have insurance, you are required to pay for treatment at the time of service unless other arrangements have been formally made. A separate self-pay financial agreement will be provided to you.

**We accept the following: Cash Check Credit Card *(Visa, MasterCard, Discover, American Express)***

***A twenty-five dollar ($25.00) returned check fee will be assessed to the patient account per incident.***

For convenience, payments may be made online at **www.ePayItOnline.com.** To utilize this service you will need your account number, access code, and Code ID. This information can be found on the patient statement you will receive reflecting your balance. ***Patients who no-show may be subject to a no-show fee.***

**PENDING APPROVALS FOR SERVICES:** In the event we are unable to obtain approval for services and you wish to proceed, we will not bill your insurance. Services will be reduced to the in-network insurance allowable amount and will apply to the patient's responsibility.

Patient and/or Debtor Signature: _____ Date _____/_____/_____

*Additional financial explanations are continued on the back side of this page*

AdvancedHEALTH

**WORKERS' COMPENSATION INJURIES:** Written approval/authorization by your employer and/or workers' compensation carrier prior to your initial visit is needed. We will contact your case manager and/or supervisor to confirm your workers' compensation injury. If this claim is denied, for any reason by your employer or your employer's workers' compensation carrier, you will be responsible for payment in full. If denial is made by workers' compensation, health insurance can be filed for these denied services and you will be held responsible for the account.

**MOTOR VEHICLE ACCIDENTS (MVA's)** – Yes, I was involved in a MVA on _____/ _____/ _____. Unless prior agreement has been reached or I am a Medicare recipient, my **health insurance** will be filed for services related to this accident. In the event I do not provide insurance information upon initial visit, I understand insurance denials may occur depending on type of service(s) received or carrier specific filing requirements. I agree, as the patient or patient's guardian, I am ultimately responsible for all balance(s) due to this facility and/or its physician(s) for services rendered regardless of insurance denial(s) or unfavorable case outcomes. If I have chosen an attorney to oversee my case, this financial agreement will serve as a Letter of Protection to my attorney. I further understand my account may be handled by an outside entity that specializes in attorney lien accounts at the facilities discretion.

_____ Yes, I have chosen to retain an attorney. Signed: _____ Date: _____/_____/_____

Attorney Name: _____ Phone: _____

## BILLING INFORMATION

**STATEMENTS:** A statement of account will be provided to you if insurance has paid leaving a patient portion, denied or no response is received. Due to the type of service we provide, you may receive billing from more than one practice, otherwise known as split billing. The balance on your statement is due and payable within 30 days of receipt unless other arrangements are made with our billing department. The statement will be sent to the address provided at the time of service. In the event your mailing address changes after your service date and your account has not been paid in full, you are required to notify our billing office of this change by calling 615.851.6033 ext. 2067. In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child at time of service will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, court documentation is required for any guarantor address changes, otherwise, it is the authorizing/custodial parent's responsibility to collect from the other parent. Any account with a credit balance of less than <$5.00> will not be refunded without specific request from the patient/debtor.

**DELINQUENT ACCOUNTS:** 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 you fail to pay on time and we refer your account(s) to a third party for collection, a collection fee will be assessed and will be due at the time of the referral to the third party. The fee will be calculated at the maximum percentage permitted by applicable law, not to exceed 18 percent. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

**WAIVER OF CONFIDENTIALITY:** You understand if your account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

**MEDICAL RECORDS:** You will be required to request in writing or sign a medical authorization form for the release of your medical records to any organization or physician. If the request is for a party other than the originally billed insurance and/or party, a **$20.00 medical records fee** will be required on each occasion.

**CONSENT TO CONTACT:** I grant permission and consent to AdvancedHEALTH and its agents, assignees, and contractors (which may include third party debt collectors for past due obligations): (1) to contact me by phone at any number associated with me, if provided by me or another person on my behalf; (2) to leave messages for me and include in any such messages amounts owed by me; (3) to send me text message or emails using any email address I provided or any phone number associated with me, if provided by me or another person on my behalf; and (4) to use prerecorded/artificial voice messages and/or an automated telephone dialing system (an auto dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to me as provided herein or any related scheduled services and my account. I understand that my refusal to provide the consent described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services.

AdvancedHEALTH

# Notice Of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

Patient Name or Legal Guardian: _____

Signature: _____

Date: _____

## PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date: _____ Initials:_____

Reason: _____

_____

AdvancedHEALTH