**Vascular Center of Mobile**

**Glenn Esses, M.D., F.A.C.S**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_ Sex: M F SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ST \_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_

Home Ph. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( ) Cell Ph. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_( ) Check Primary Number (√)

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance #1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance #2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holders Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: S M W D Spouse Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason you came to the Vascular Center: Follow up care? Yes No

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why did you choose the Vascular Center? Please indicate all that apply:

□ Doctor Referral Doctor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Friend Referral Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Website

□ Radio

□ TV

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal History:**

Do you consume alcohol? Yes No How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever smoked? Yes No Do you smoke now? Yes No

How long have you smoked? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many packs per day do you smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you stop smoking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List surgeries (including dates) you have had in the past \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have, or have you had any problems with any of the following?

Please check any if yes.
□ Strokes □ Bleeding Disorders
□ Dizziness/Blackouts □ Asthma
□ Vision Loss □ COPD
□ Leg Pain/Swelling □ Back Pain
□ Difficulty walking □ Bone or Joint
□ High Blood Pressure □ Gallbladder/Colon
□ Diabetes □ Prostate(men)
□ Blood Clots □ HIV/AIDS
□ Aneurysms □ Hepatitis

□ Heart Disease □ Cancer; type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list additional medical conditions you have that were not listed above. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family History:

Has anyone in your family ever had: Please circle

Father: Cancer Diabetes High blood pressure Aneurysm Heart problems Stroke Varicose veins

Mother: Cancer Diabetes High blood pressure Aneurysm Heart problems Stroke Varicose veins

Bro/Sis: Cancer Diabetes High blood pressure Aneurysm Heart problems Stroke Varicose veins

**Medication Information**

Pharmacy Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_

Drug allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(If you brought your own medication list, let us make a copy)**

Medication Milligrams How taken daily

**Authorization For Use and Disclosure**

**of Protected Health Information**

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing below, you hereby authorize us to use or disclose information about yourself (or another person for whom you have authority to sign) that is protected under federal law, for the sole purpose and time period described below. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information.

Information to be used or disclosed must be identified in a specific and meaningful fashion and must reveal the purpose of the use and disclosure. Please check all that apply:

\_\_\_\_\_Medical Information \_\_\_\_\_Financial Information (Medical History)

\_\_\_\_\_Demographic Information \_\_\_\_\_Insurance Information

List individuals to whom information can be released (other than those required by law):

Please identify by name:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ indefinitely (no expiration)

 \_\_\_\_\_\_\_\_\_\_\_\_\_other (please specify)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient\Responsible Party Date

**Cancellation and No-Show Policy**

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide at least a 24 hour notice.

Patients who do not arrive for their appointment without a call to cancel will be considered a **NO-SHOW**. Patients who no-show two (2) or more times in a 12 month period, may be dismissed from the practice and thus will be denied any future appointments.

**Patients may also be subject to:**

**$25.00 fee for a missed office appointment**

**$50.00 fee for a missed ultrasound appointment**

**$300.00 fee for a missed procedure**

The cancellation and no-show fees are the sole responsibility of the patient and must be paid in full before the patient’s next appointment. We understand that special circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

**Privacy Agreement**

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other  healthcare related function.  I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events.  I consent to the receiving multiple messages per day from my healthcare provider, when necessary.  I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Responsible Party Signature Date



**Patient Responsibilities**

**To treat you at the highest professional level, we required the following from our patients.**

1. Notify us of any changes in your address, contact numbers, or insurance information at the time of change.
2. Be familiar with your insurance requirements regarding necessary referral or prior authorizations. If you need a referral, please notify us or your primary care physician before your office visit.
3. Provide us with copies of any testing done at another office or hospital.
4. Copayments must be made at the time service is rendered. (your insurance requires this) There could be separate copayment for an office visit and vascular laboratory testing.
5. The fee for a returned check is $30.00
6. The fee for completing any disability, life insurance, or health policy form is $12.00. Payment is due when the form is given to us to complete. Please allow our office 14 days to complete the forms.

**Assignment, Acknowledgement and Guarantee of Payment**

I authorize the release of my medical information to any pertinent party, in addition to any insurance companies for the processing of my claims. I authorize, by signing below, payment of medical benefits directly to Vascular Center of Mobile. I understand I am financially responsible for any deductibles, non-covered services, and balances not covered by any insurance carrier. I understand and accept the fee charged as legal and lawful and agree to pay said fee, including all collection agency fees(33.33%), attorney fees, and/or court costs, if such necessary.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient/Responsible Party Signature Date