Vascular Center of Mobile

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VASCULAR CENTER

Date: _____

Name: 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 Holder's Name: _____ Policy Holder DOB: _____

Marital Status: S M W D Spouse's 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 ad
❒ TV ad
❒ 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 / did you smoke? _____
When did you stop smoking? _____

List all 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 the box if yes.

❒ Stroke
❒ Dizziness / Blackouts / Seizures
❒ Vision loss
❒ Leg Pain
❒ Leg swelling
❒ Difficulty walking
❒ High blood pressure
❒ Diabetes
❒ Blood clots / DVTs
❒ Aneurysms
❒ Heart Disease
❒ Shortness of breath
❒ Bleeding disorders or Anemia
❒ Asthma
❒ COPD
❒ Back pain
❒ Bone or Joint problems
❒ Gallbladder / Colon / Stomach
❒ Prostate problems
❒ Gynecological problems
❒ HIV/AIDS
❒ Hepatitis
❒ Covid-19
❒ Cancer - Type: _____

❒ Please list any additional medical conditions you have that were not listed above:

_____

_____

_____

Family History:

Has anyone in your family ever had any of the following? (Please check the appropriate box):

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

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

Brother/Sister:
❒ Cancer ❒ Heart problems
❒ High blood pressure
❒ Aneurysm ❒ Diabetes
❒ Varicose veins ❒ Stroke

Medication Information

Pharmacy Name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Drug allergies: _____

Describe your reaction: _____

_____

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

Medication Name:	Milligrams	How often do you take it?

Authorization for Use and Disclosure of Protected Health Information (PHI)

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

Thank you for trusting your medical care to Vascular Center of Mobile. When you schedule your appointment, we set aside time to provide the highest quality care. We understand issues may arise and you must cancel your appointment. Should you have to cancel, please give our office a 24-hour notice prior to your appointment. This ensures adequate time to fill the time slot with another patient. Failure to cancel or reschedule within a 24-hour period, will be subject to the fee below. This is charged to you and not your insurance company.

Effective November 1, 2022, any established patient who fails to show or cancel/reschedule with a 24-hour notice period will be subject to a $50.00 **NO SHOW FEE**

If a third no show occurs within a 1-year period, a dismissal of services may occur

Any **NEW PATIENT NO SHOW** that occurs on initial visit, new patient forms for you will have to submitted before next appointment. If second no show occurs, we will not reschedule you.

$75.00 for any **MISSED ULTRASOUND** appointment

$300.00 for any **MISSED PROCEDURE** appointment

Privacy Agreement

By supplying my telephone 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, all care providers, time/date of my scheduled appointment, and other limited information, for the purpose of notifying me of a pending appointment/missed appointment, overdue exams, balances, lab results, or any other healthcare 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 receiving multiple messages per day from my healthcare provider, if 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 myself.

_____ _____

Please Print Full Name **Date**

_____

Signature

VASCULAR CENTER

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. If you do not have a referral for your visit, you are responsible for $150 office visit charge. Other charges could be applied if ultrasound is needed.
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.
7. For all in office procedures, deductibles are due at time of services. No payment arrangements can be made for deductibles. If you are needing more than one elective procedure, full financial balance must be paid prior to moving forward with another procedure.

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