



PATIENT INFORMATION

PATIENT NAME _____ DATE _____

DATE OF BIRTH _____ SSN _____ GENDER MALE FEMALE

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMAIL _____

CELL PHONE _____ HOME PHONE _____

MARITAL STATUS Married Single Widowed Other

MOBILITY STATUS Ambulatory Wheelchair Stretcher

ETHNICITY Non Hispanic or Latino Hispanic or Latino Other

RACE American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander
 Caucasian or White Other

EMPLOYMENT INFORMATION

Employed Unemployed Retired

DO YOU RECEIVE HEALTH INSURANCE FROM YOUR EMPLOYER? Yes No

EMPLOYER _____

OCCUPATION _____ WORK PHONE _____

EMERGENCY CONTACTS

NAME	RELATIONSHIP	PHONE
_____	_____	_____
_____	_____	_____

FORM COMPLETED BY (CHECK ONE): PATIENT (SELF) LEGALLY AUTHORIZED REPRESENTATIVE

PRINT NAME OF PATIENT/LEGALLY AUTHORIZED REPRESENTATIVE _____

SIGNATURE _____ DATE _____

PATIENT NAME _____	DATE _____
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PATIENT CARE TEAM INFORMATION

To better facilitate your care, we kindly ask for contact information for anyone involved in your support system, such as family members, friends, or caregivers who may assist with scheduling or driving you to appointments. This helps us keep everyone informed and ensures your appointments run smoothly. Thank you!

MOBILITY STATUS Ambulatory Wheelchair Stretcher

HOW DO YOU GET TO YOUR APPOINTMENTS? I drive myself Family/Friend Ride Service Public Transport

IF YOU SELECTED FAMILY/FRIEND, RIDE SERVICE, OR PUBLIC TRANSPORT, PLEASE PROVIDE DETAILS:

DO YOU HAVE A CARETAKER? YES NO

IF YES, PLEASE DESCRIBE RELATIONSHIP AND NAME _____

CONTACT 1

NAME _____ **RELATIONSHIP TO PATIENT** _____

MAIN PHONE _____ **TYPE** Home Cell Work Other _____

PHONE 2 _____ **TYPE** Home Cell Work Other _____

PHONE 3 _____ **TYPE** Home Cell Work Other _____

IS THIS CONTACT YOUR DRIVER? YES NO

THIS CONTACT HELPS WITH (CHECK ALL THAT APPLY) TRANSPORTATION SCHEDULING OTHER _____
 MEDICAL INFO BILLING

PERMISSION TO DISCUSS YOUR CARE WITH CONTACT 1? YES NO

CONTACT 2

NAME _____ **RELATIONSHIP TO PATIENT** _____

MAIN PHONE _____ **TYPE** Home Cell Work Other _____

PHONE 2 _____ **TYPE** Home Cell Work Other _____

PHONE 3 _____ **TYPE** Home Cell Work Other _____

IS THIS CONTACT YOUR DRIVER? YES NO

THIS CONTACT HELPS WITH (CHECK ALL THAT APPLY) TRANSPORTATION SCHEDULING OTHER _____
 MEDICAL INFO BILLING

PERMISSION TO DISCUSS YOUR CARE WITH CONTACT 2? YES NO

PRINT NAME OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE _____

SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE _____ DATE _____

PATIENT NAME	DATE
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PATIENT INSURANCE INFORMATION

SELF-PAY

PRIMARY INSURANCE _____ **STATE** _____

MEMBER ID _____ **GROUP** _____

POLICY HOLDER NAME _____ **POLICY HOLDER DOB** _____

RELATIONSHIP TO POLICY HOLDER Self Spouse Parent Other _____

SECONDARY INSURANCE _____ **STATE** _____

MEMBER ID _____ **GROUP** _____

POLICY HOLDER NAME _____ **POLICY HOLDER DOB** _____

RELATIONSHIP TO POLICY HOLDER Self Spouse Parent Other _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

**Please present all insurance and information to the receptionist for registration. I hereby authorize Premier Vascular, LLC (DBA: Premier Vascular) to provide any necessary medical or other information about me or my dependent to my insurance company, and/or its designated representatives, for the purpose of attaining payment. This authorization is valid as long as I am a patient of Premier Vascular. I hereby assign to the provider all payments for healthcare services, including behavioral and mental health treatment, rendered to myself or my dependent.

I understand that my insurance company may only cover a portion of my total bill, or may cover nothing at all. I understand I am responsible for all bills related to the provision of healthcare services and will be responsible for payment of any charges not covered under this assignment. If for any reason my or my dependent's account becomes delinquent, I agree to pay for any and all charges related to re-billing, cost of collections, reasonable legal fees, and any other charges permitted by law.

PRINT NAME OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE

SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE

DATE

MEDICARE ONE TIME SIGNATURE AUTHORIZATION

I hereby request that payment of authorized Medicare benefits be made on my behalf to Premier Vascular or any healthcare services provided to me or my dependent. I authorize Premier Vascular to provide any necessary medical or other information about me or my dependent to the Health Care Financing Administration and its agents as needed to determine these benefits or the benefits payable for related services.

PRINT NAME OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE

SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE

DATE

MEDIGAP ASSIGNMENT AUTHORIZATION

I request that payment of authorized Medigap benefits be made to Premier Vascular for any healthcare services provided to me or my dependent by Premier Vascular. I hereby authorize Premier Vascular to provide any necessary medical or other information about me or my dependent to the Medigap carrier as needed to determine these benefits or the benefits payable for related services.

PRINT NAME OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE

SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE

DATE

PATIENT NAME _____	DATE _____
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PATIENT MEDICAL HISTORY

AGE _____ HEIGHT _____ WEIGHT _____

PRIMARY CARE PROVIDER _____

REFERRING PROVIDER _____

DO YOU SEE A CARDIOLOGIST? YES NO **CARDIOLOGIST** _____

DO YOU SEE A NEPHROLOGIST? YES NO **NEPHROLOGIST** _____

DO YOU SEE AN ORTHOPEDIST? YES NO **ORTHOPEDIST** _____

ARE YOU A DIALYSIS PATIENT? YES NO **DIALYSIS DAYS** _____

DIALYSIS CENTER _____ PHONE _____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES NO IF YES, DID YOU HAVE A REACTION? YES NO

DESCRIBE REACTION _____

WILL YOU ACCEPT A BLOOD TRANSFUSION DURING SURGERY OR HOSPITALIZATION IF NECESSARY? YES NO

MEDICATIONS + DOSES

1.	9.
2.	10.
3.	11.
4.	12.
5.	13.
6.	14.
7.	15.
8.	16.

PREFERRED PHARMACY

PHARMACY NAME _____

PHARMACY ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHARMACY PHONE _____ FAX _____

PATIENT NAME	DATE
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PATIENT MEDICAL HISTORY

DO YOU TAKE ANY BLOOD THINNERS? YES NO IF YES, LIST THEM HERE _____

HAVE YOU EVER SEEN A VASCULAR SURGEON BEFORE? YES NO

VASCULAR SURGEON _____ PHONE _____

HAVE YOU EVER SEEN A VEIN SPECIALIST BEFORE? YES NO

VEIN SPECIALIST _____ PHONE _____

DESCRIBE YOUR SMOKING HABITS NEVER SMOKER
 CURRENT SMOKER PACKS PER DAY _____
 FORMER SMOKER START DATE _____ STOP DATE _____

DO YOU DRINK ALCOHOL? YES NO HOW MUCH? _____ HOW OFTEN? _____

HAVE YOU EVER USED STREET DRUGS? YES NO PAST PRESENT

DO YOU USE ANY OTHER FORM OF TOBACCO? YES NO TYPE: CIGAR PIPE SNUFF CHEWING TOBACCO

PATIENT ALLERGIES+REACTIONS

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

PATIENT SURGICAL HISTORY

SURGERY NAME	DATE	DOCTOR/FACILITY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

PATIENT NAME	DATE
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PATIENT MEDICAL HISTORY

DO YOU HAVE, OR HAVE YOU EVER HAD:

Abnormal bleeding	<input type="radio"/> YES <input type="radio"/> NO
Alcohol/drug abuse	<input type="radio"/> YES <input type="radio"/> NO
Aneurysm	<input type="radio"/> YES <input type="radio"/> NO
Angina/shortness of breath	<input type="radio"/> YES <input type="radio"/> NO
Arthritis	<input type="radio"/> YES <input type="radio"/> NO
Asthma	<input type="radio"/> YES <input type="radio"/> NO
Blood clotting disorder	<input type="radio"/> YES <input type="radio"/> NO
Blood clot in vein	<input type="radio"/> YES <input type="radio"/> NO
Blood clot in artery	<input type="radio"/> YES <input type="radio"/> NO
Cancer (Type):	<input type="radio"/> YES <input type="radio"/> NO
Chronic knee pain	<input type="radio"/> YES <input type="radio"/> NO
Chronic plantar fasciitis	<input type="radio"/> YES <input type="radio"/> NO
Congestive heart failure	<input type="radio"/> YES <input type="radio"/> NO
Coronary artery disease	<input type="radio"/> YES <input type="radio"/> NO
Diabetes type I	<input type="radio"/> YES <input type="radio"/> NO
Diabetes type II	<input type="radio"/> YES <input type="radio"/> NO
Depression	<input type="radio"/> YES <input type="radio"/> NO
DVT	<input type="radio"/> YES <input type="radio"/> NO
Emphysema	<input type="radio"/> YES <input type="radio"/> NO
Epilepsy	<input type="radio"/> YES <input type="radio"/> NO
Foot wound	<input type="radio"/> YES <input type="radio"/> NO

Heart attack	<input type="radio"/> YES <input type="radio"/> NO
Heart disease	<input type="radio"/> YES <input type="radio"/> NO
Head injury	<input type="radio"/> YES <input type="radio"/> NO
Hepatitis	<input type="radio"/> YES <input type="radio"/> NO
High blood pressure	<input type="radio"/> YES <input type="radio"/> NO
High cholesterol	<input type="radio"/> YES <input type="radio"/> NO
Hip pain	<input type="radio"/> YES <input type="radio"/> NO
HIV/Aids	<input type="radio"/> YES <input type="radio"/> NO
Hyperthyroidism	<input type="radio"/> YES <input type="radio"/> NO
Kidney disease	<input type="radio"/> YES <input type="radio"/> NO
Kidney stones	<input type="radio"/> YES <input type="radio"/> NO
Knee replacement	<input type="radio"/> YES <input type="radio"/> NO
Peptic Ulcer	<input type="radio"/> YES <input type="radio"/> NO
Phlebitis	<input type="radio"/> YES <input type="radio"/> NO
Pregnancy*	<input type="radio"/> YES <input type="radio"/> NO
Pulmonary embolism	<input type="radio"/> YES <input type="radio"/> NO
Sleep apnea	<input type="radio"/> YES <input type="radio"/> NO
Stroke	<input type="radio"/> YES <input type="radio"/> NO
Varicose veins	<input type="radio"/> YES <input type="radio"/> NO
Ulcer or wound	<input type="radio"/> YES <input type="radio"/> NO
Uterine fibroids	<input type="radio"/> YES <input type="radio"/> NO

HAVE YOU EVER GIVEN BIRTH? YES NO

HOW MANY TIMES? _____ **LIST DATES** _____

IF YOU HAVE ANY CONDITIONS NOT LISTED ABOVE, PLEASE LIST BELOW.

PATIENT NAME	DATE
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USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

Your protected health information will be used by Premier Vascular. It will be disclosed to others solely for the purposes of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

INITIALS OF PATIENT/LEGALLY AUTHORIZED REPRESENTATIVE _____ I HAVE READ, UNDERSTAND, AND AGREE TO THIS SECTION.

AUTHORIZATION TO RECEIVE AND RELEASE MEDICAL RECORDS

I hereby authorize for Premier Vascular to receive and release any medical records for my proper health care treatment. I give Premier Vascular permission to request, receive, and share my medical records as needed for my care and treatment. I understand that I have the right to look at and get a copy of any information shared under this authorization. I also understand that I do not have to sign this form in order to receive treatment. I may cancel this authorization at any time by putting it in writing, but any information already shared before that point cannot be taken back. I also understand that once my information is shared, it may be re-disclosed by the recipient and may no longer be protected by law. By signing below, I agree to the use and sharing of my health information as described above.

INITIALS OF PATIENT/LEGALLY AUTHORIZED REPRESENTATIVE _____ I HAVE READ, UNDERSTAND, AND AGREE TO THIS SECTION.

POLICIES

PAYMENT POLICY

Payment of Insurance and/or Medicare Benefits to: Premier Vascular, 1902 Forysth St, Macon, GA 31201
I request payments be made directly to the provider listed on the claim for services furnished to me during the effective period of this authorization. I authorize the above listed provider(s) to release to the Social Security Administration, its intermediaries or carriers any information required for any claim to be paid and processed. I authorize the release of any information necessary to determine these benefits or the benefits payable for related services.

CANCELLATION & NO-SHOW POLICY

If you are unable to keep your appointment, you are obligated to inform our office within 24 business hours of your scheduled office visit or ultrasound appointment and 48 business hours for an in-office surgery or hospital surgery. If you do not cancel your appointment within that time frame, you will be classified as a "no-show" and subject to a non-cancellation fee as follows: Office visits \$35.00, Ultrasounds \$50.00, In-office surgery \$150.00 and Hospital surgery \$200.00. Three appointment "no-shows" will result in being discharged from our practice. Your signature below acknowledges that you have read and understand our non-cancellation policy.

INITIALS OF PATIENT/LEGALLY AUTHORIZED REPRESENTATIVE _____ I HAVE READ, UNDERSTAND, AND AGREE TO THIS SECTION.

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Acknowledgement: I understand I am ultimately responsible for payment for the services I receive at Premier Vascular, regardless of my health insurance coverage, I understand Premier Vascular will not act as an administrator to resolve my personal financial agreements regarding my medical care. I have had the opportunity to read this Patient Financial Responsibility Agreement in its entirety and have had the opportunity to ask questions regarding the details of this Agreement. Any questions have been answered to my satisfaction. I consent and agree to the aforementioned policies of Premier Vascular and understand they may be changed without notice. Co-pays and outstanding patient balances are due at times of service. Failure to pay will result in patient not being seen.

INITIALS OF PATIENT/LEGALLY AUTHORIZED REPRESENTATIVE _____ I HAVE READ, UNDERSTAND, AND AGREE TO THIS SECTION.

ACKNOWLEDGEMENT AND AGREEMENT

**I acknowledge that I have read and understood all sections on this page, including: *Use and Disclosure of Your Protected Health Information, Authorization to Receive and Release Medical Records, Policies, and the Patient Financial Responsibility Agreement.* By signing below, I confirm that I understand and agree to the information and terms described herein.

PRINT NAME OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE _____

SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE _____ DATE _____

PATIENT NAME	DATE
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CONSENT FOR TREATMENT

The patient or authorized representative recognizes the need for care and consents to ANY and ALL medically necessary services as ordered by the physician and at the discretion of the patient. These services may include lab procedures, medical treatment, minor or emergency surgical treatment, exam or other services rendered under the specific instructions of the physician.

INITIALS OF PATIENT/LEGALLY AUTHORIZED REPRESENTATIVE _____ I HAVE READ, UNDERSTAND, AND AGREE TO THIS SECTION.

AUTHORIZATION FOR MULTIMEDIA IMAGING

Premier Vascular, LLC is committed to providing high-quality care. As part of your treatment, we may use photography, video, or audio recordings ("multimedia imaging") to help with diagnosis, treatment, and professional education.

These images are used only for medical purposes and will be stored securely in compliance with Premier Vascular policies, as well as state and federal laws. Images may include certain body parts to show their condition at a specific point in time. They will not include features that identify you. Multimedia images may be shared only for your medical care, billing, or other healthcare operations. Any other use will require your written permission.

I have read and understand this policy regarding the use of photography, video, or audio recordings as part of my treatment at Premier Vascular, LLC. I have had the opportunity to ask questions, and my questions have been answered. By signing below, I give permission for multimedia imaging to be used as described above.

INITIALS OF PATIENT/LEGALLY AUTHORIZED REPRESENTATIVE _____ I HAVE READ, UNDERSTAND, AND AGREE TO THIS SECTION.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been made aware of Premier Vascular, LLC "Notice of Privacy Practices" ("Notice"). I received a copy of this document on today's date, and I have a right to request additional copies in the future. The Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills, or in the performance of Premier Vascular, LLC healthcare operations. The Notice also describes my rights and responsibilities with respect to my protected health information.

I understand that copies of the Notice are available in the registration areas of each facility and on Premier Vascular, LLC system website at www.premiervascularsurgery.com. I understand that I may request a copy of the Notice at any time. Premier Vascular, LLC reserves the right to change the privacy practices that are described in the Notice at any time and will make a revised Notice available for review. I may obtain a revised Notice of Privacy Practices by requesting a copy or by accessing Premier Vascular, LLC website listed above.

INITIALS OF PATIENT/LEGALLY AUTHORIZED REPRESENTATIVE _____ I HAVE READ, UNDERSTAND, AND AGREE TO THIS SECTION.

TRANSPORTATION POLICY

Transportation providers must remain on-site with the patient at all times and depart the office no later than 4:30 p.m. If transportation leaves before the patient is discharged, the driver must complete a signed acknowledgment accepting full responsibility for returning to pick up the patient.

INITIALS OF PATIENT/LEGALLY AUTHORIZED REPRESENTATIVE _____ I HAVE READ, UNDERSTAND, AND AGREE TO THIS SECTION.

ACKNOWLEDGEMENT AND AGREEMENT

**I acknowledge that I have read and understood all sections on this page, including: *Consent For Treatment, Authorization for Multimedia Imaging, Acknowledgement of Receipt of Notice of Privacy Practices, and Transportation Policy*. By signing below, I confirm that I understand and agree to the information and terms described herein.

PRINT NAME OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE _____

SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE _____ DATE _____



HOW DID YOU HEAR ABOUT US?

DATE _____

NAME _____ AGE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMAIL _____ PHONE _____

PLEASE CHECK ALL THAT APPLY:

- FRIEND/FAMILY (HIS/HER NAME): _____
- FACEBOOK
- INSTAGRAM
- GOOGLE (SEARCH TERM USED): _____
- ADVERTISEMENT (DESCRIBE): _____
- INSURANCE
- WEBSITE
- LETTER
- WEBMD
- PHYSICIAN/NURSE: _____
- OTHER (DESCRIBE): _____