SOUTH ATLANTA
VASCULAR INSTITUTE

# Patient Registration

Please complete all sections below

**1) Patient Information**

Name: _____

Last First Middle

Date of Birth : _____ /_____ /_____ Social Security Number: _____-_____-_____

Driver's License Number: _____ State Issued: _____

Sex: Female Male Marital Status: Single Married Widowed Divorced

Residence Address: _____ Home Phone: (_____) _____ - _____

_____ Cell Phone: (_____) _____ - _____

Email Address: _____

May we leave a message for you at home: Yes _____ No _____

May we leave a message on your cell phone: Yes _____ No _____

May we leave a message for you at work: Yes _____ No _____

Employer: _____ Work Phone: (_____) _____ - _____ Ext:_____

Employers Address: _____

_____

Employment Status: Full Time Part Time Retired Not Employed

Occupation: _____

If Student, Name of School: _____ Student Status: Full Time Part Time

**2) Spouse Information**

Name: _____

Last First Middle

Date of Birth : _____ /_____ /_____ Prior Military Service: Yes No

Employer: _____ Work Phone: (_____) _____ - _____ Ext:_____

Employers Address: _____

_____

Employment Status: Full Time Part Time Retired Not Employed

Occupation: _____

**3) Guarantor/Responsible Person** (If not covered by insurance)

Name: _____

Last First Middle

Relation to patient: Self Spouse Other: _____

If Other – Please complete the following (Otherwise skip to the next section)

Date of Birth : _____ /_____ /_____ Social Security Number: _____-_____-_____

Driver's License Number: _____ State Issued: _____

Sex: Female Male Marital Status: Single Married Widowed Divorced

Residence Address: _____ Home Phone: (_____) _____ - _____

_____ Cell Phone: (_____) _____ - _____

Employer: _____ Work Phone: (_____) _____ - _____ Ext:_____

Employers Address: _____

_____

Employment Status: Full Time Part Time Retired Not Employed

Occupation: _____

**4) Insurance Information (Please present insurance copy to receptionist)**

Primary Insurance: _____ Insurance ID number: _____

Name of Insured: _____

Last First Middle

Relationship to Patient: Self Spouse Other: _____
Sex: Male Female

Insured's Social Security Number: _____ - _____ - _____

Insured's Date of Birth: _____ /_____ /_____

*If the patient is covered by another insurance policy, please complete the following*

Secondary Insurance: _____ Insurance ID number: _____

Name of Insured: _____

Last First Middle

Relationship to Patient: Self Spouse Other: _____
Sex: Male Female

Insured's Social Security Number: _____ - _____ - _____

Insured's Date of Birth: _____ /_____ /_____

**5) Referral Information**

Referred by: _____

Name of Other Physician(s) who are taking care of you

1: _____ 3: _____

2: _____ 4: _____

**6) Pharmacy Information**

Pharmacy Name: _____

Pharmacy Phone: (_____) _____ - _____

Pharmacy Address: _____

_____

**7) Emergency Contact**

Name of Emergency Contact: _____

Last First Middle

Relationship: _____ Home Phone: (_____) _____ - _____

Residence Address: _____ Cell Phone: (_____) _____ - _____

_____ Work Phone: (_____) _____ - _____

Patient's Signature: _____

Date: _____ /_____ /_____

**Notices of Privacy Practices**

Patient's Protected Health Information (PHI) will be requested and disclosed in accordance with HIPAA and South Atlanta Vascular Institute's Privacy Practices. I hereby acknowledge Receipt of such and if I have any questions or concern, I may contact the Practice Administrator.

Patient's Signature: _____

Date: _____ /_____ /_____

**Notices of Financial Acknowledgement and Payment Policies**

I have received a copy of South Atlanta Vascular Institute's Financial Acknowledgement and Payment Policies. If I have any concerns, I may contact the Practice Administrator.

Patient's Signature: _____

Date: _____ /_____ /_____

SOUTH ATLANTA VASCULAR INSTITUTE

# Medical History Questionnaire

**NAME:** _____ **DOB:** _____

**Reason for Visit:** _____

**Other Physicians providing care and phone number:** **Reason for seeing physician:**

PCP: _____ _____

Specialist: _____ _____

Specialist: _____ _____

## Past Medical History

**Are you currently being treated or been treated in the past for any of the following medical conditions:**

| Medical Condition | ✓ | Medical Condition | ✓ |
|---|---|---|---|
| Aneurysm | | High Cholesterol | |
| Arthritis | | HIV/AIDS | |
| Asthma | | Hepatitis | |
| Blood clots/ DVT/PE | | Kidney Disease | |
| Cancer | | Dialysis | |
| Carotid Stenosis | | Peripheral Vascular disease | |
| COPD | | Stroke | |
| Diabetes | | Thyroid disease | |
| Heart Disease/MI | | Varicose veins | |
| Heart failure | | Wounds/Sores | |
| High blood pressure | | Bleeding disorder | |
| Anemia | | Seizures | |
| Sleep Apnea | | | |

**Please list any other disease or medical condition not listed above:**

| |
|---|
| |
| |
| |
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| |

If you are receiving dialysis, who is your dialysis center: _____

What days do you receive dialysis? MWF or TTS

SOUTH ATLANTA VASCULAR INSTITUTE

# Medical History Questionnaire

**NAME:** _____ **DOB:** _____

## Prior Surgeries or Hospitalizations

**Please list any prior surgeries and/or procedures that you have had:**

| DATE | SURGERY OR PROCEDURE |
|---|---|
| | |
| | |
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| | |

## Allergies

**List any drug allergies:**

| Allergy | What is your reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Nickel allergy?** Yes or No **Contrast dye?** Yes or No **Eggs?** Yes or No **Heparin?** Yes or No

**Latex?** Yes or No

## Family History

**Please mark an X to indicate if any immediate relatives (mother, father, grandfather, grandmother, sister, or brother) have had any of the following conditions:**

| Condition | Mother | Father | Grandmother | Grandfather | Sister | brother |
|---|---|---|---|---|---|---|
| **Diabetes** | | | | | | |
| **High blood pressure** | | | | | | |
| **Heart disease/heart attack** | | | | | | |
| **Aneurysm** | | | | | | |
| **Blood clots** | | | | | | |
| **Cancer** | | | | | | |
| **Kidney disease** | | | | | | |
| **Stroke** | | | | | | |
| **Peripheral vascular disease** | | | | | | |
| **Varicose veins** | | | | | | |

SOUTH ATLANTA VASCULAR INSTITUTE

# Medical History Questionnaire

**NAME:** _____ **DOB:** _____

## Social History

Do you currently smoke? Yes or No Former Smoker? Yes or No If yes; how long? _____

How many packs per day? _____ Do you vape? Yes or No Chew Tobacco? Yes or no

Do you drink alcohol? Yes or No If yes how many drinks per week? _____

Any history of illicit drug use? Yes or No

Have you traveled outside the U.S. in the last 3 months? Yes or No If yes; where? _____

Do you have an Advance Care Directive? Yes or No

## Medications

Please list your current Medications/Vitamins/Supplements:

| Medication/Vitamin/Supplement | Dosage | Times per day |
|---|---|---|
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**Patient/Guardian signature:** _____

**Date:** _____ /_____ /_____ **Relation to the patient:** _____

SOUTH ATLANTA VASCULAR INSTITUTE

Appointment Date: _____

Patient Date of Birth: _____

Patient Name: _____

**OFFICE POLICY - 2021**

***Signatures and Initials are Required Prior to Services***

***This signed form remains in effect for the current 2021 calendar year.***

It is South Atlanta Vascular Institute's (SAVI's) goal to provide high quality medical care and maintain good physician-patient relationships. Providing patients with the "Office Policy", prior to services, is intended to be communicative and serve as a patient resource tool which will help achieve the best healthcare experience possible._ ***Please read each section carefully and initial. If you have questions, please ask a SAVI team member.***

**APPOINTMENTS**

1. SAVI values the time that is set aside to see and care for our patients.
2. If you are not able to keep an appointment; SAVI respectfully requests and would appreciate a 24-hour notice or minimally one hour prior to your appointment.
    a. Patients will be charged a ($25.00) "**Missed Appointment Charge";** should a patient miss their appointment and not provide advance notice to SAVI.
        i. Please be aware that the "Missed Appointment Charge" is not billable/payable to your insurance plan. The charge will be your personal self-pay liability.

**LATE ARRIVALS**: If you arrive late to your appointment, (greater than 15 minutes); SAVI will do their best to accommodate you***. Please note: Ultrasounds and Procedures are time contingent services therefore cannot easily accommodate late arrivals. These services require planning for equipment and resource use. If you are beyond 20 minutes late your procedure and/or ultrasound may have to be rescheduled and you will be charged the "Missed Appointment Charge" if you have not notified SAVI in advance.*** We strive to minimize wait times; however, emergencies do occur and will take priority over a scheduled appointment. Your patience and understanding are greatly appreciated.

**INSURANCE**

1. Your insurance plan is a contract that exists between you and the insurance company. SAVI participates in as many insurance networks as possible for our geographical location; however, that does not make SAVI a party to the contract, nor does it guarantee benefit coverage.
2. Your insurance plan determines your policy's deductible, co-pay, and coinsurance amounts.
3. It is your responsibility to provide and keep SAVI up to date with your correct insurance information (policy, ID, Group Number etc.)
4. SAVI is a vascular specialist clinic and therefore **insurance deductible/copays will be** classified by insurance as a "specialist amount".
    a. SAVI is required by insurance contracts to collect deductibles and copay payments at the time of appointment check-in. If you are unable to pay in full, please speak with a billing team member.
5. Familiarize yourself with your insurance benefits prior to all medical services is a good practice in general.
    a. It is your responsibility to know if your insurance plan requires any form of referral to obtain services at SAVI.

INITIAL HERE: _____

*South Atlanta Vascular Institute, LLC Office Policy*

**PRIOR AUTHORIZATION AND REFERRALS**

1. Advance notice is requested for all non-emergent referrals, typically 1 to 3 business days are acceptable.
    a. ALL insurance referrals MUST be obtained prior to scheduling.
    b. SAVI will be unable to schedule services until required Prior Authorization or Referral forms are obtained.
    c. VA Community Care- patient responsibility to get referral for servicing provider and provide at first Visit. Patient must have it available, or appointment will have to be rescheduled.
2. It is patient responsibility to know if SAVI providers are "in-network" and what insurance benefits you may have for specialty vascular services.
    a. SAVI will also verify benefits prior to the appointment and make the patient aware of their in-network or out of network (OON) status.
    b. A patient being OON affects SAVI's ability to obtain insurance approvals.

INITIAL HERE: _____

**FORMS AND PAPERWORK**

1. There is no charge for return-to-work instructions.
2. There is a $25.00 dollar charge for completion of disability, FMLA, or other leave related paperwork and forms.
3. There is no charge for filing insurance claim.
    a. Your insurance plan may be required to pay for copies of your medical records.
4. There is no charge for prescription refill requests and processing.
    a. NOTE: Requests for prescription refills require 24- 48 hours processing time (turn-around-time can be impacted by your insurance approval process).
    b. NOTE: If you are away from home and require prescription refills you will need to call the office and provide the local pharmacy phone number. This pharmacy information will not be added to your permanent file unless instructed to do so by you.
5. If there are other relatable requests that are not listed here, please speak with one of our team members.

INITIAL HERE: _____

*South Atlanta Vascular Institute, LLC Office Policy*

**FINANCIAL RESPONSIBILITY**

1. Network contracts require that deductibles, co-pays, and coinsurances be collected at the time of service. Please be prepared to pay your co-pay/deductible at the time of your appointment.
    i. Full Accounting Statements are available upon request.
    ii. Monthly balance statement reminders are generated and mailed automatically.
2. SAVI will bill your insurance and generally the insurance pays provider direct. In the event your insurance plan sends payment directly to the patient/insured – your account will be transferred to self-pay, and you become liable for full charges.
    a. Provided you turn over insurance checks and corresponding explanation of benefits (EOB); SAVI will accept the insurance payment and make necessary contractual adjustments if applicable.
3. Immediately following insurance payment posting – your account will be moved to patient responsibility, and you will be sent a balance due statement.
4. Unless you have a payment arrangement on file, any account balance outstanding longer than 90 days will move to a third-party collection company.
    a. The 90-day period begins at the time an account moves to self-pay responsibility.
5. Your insurance deductible, co-pay, and coinsurance amounts will be requested at appointment check-In.
    a. If you are an established patient and carry a balance from prior services, you will be requested to pay that full balance or enter a formalized payment plan for amounts owed
    b. Payment plans require a credit/debit card be on file for scheduled withdrawals.
    c. Payment plan terms vary based on amounts and not all balances qualify.
    d. A patient can only be on one payment plan at a time.
    e. Payment plans can NOT extend past one year.
    f. Payment plans are established at the claim level not accumulated account balance(s).
    g. No payment plans for amounts owed less than $50.00.

INITIAL HERE: _____

***I have read and understand SAVI' s office policies and agree to comply and accept the responsibility for payment for services. I also understand and agree my insurance plan will be billed and insurance payment will indemnify my payment responsibility to deductible, co-pay, and coinsurance amounts. If I am uninsured, I fully understand and agree that I am 100% liable to pay for services.***

**Signature Date: _____**

**PATIENT NAME: _____ PATIENT SIGNATURE: _____**

**(Print)**

**OFFICE WITNESS: _____ Office Witness Signature: _____**

**(Print)**


# Notice of Privacy Practices

This notice describes how medical information about you collected by this practice may be used and disclosed and how you may access your medical information.

The Health Insurance Portability and Accountability Act (HIPAA) grants rights to individuals, on request, to access their protected health information (PHI). Your PHI will include medical records, billing records held by a provider. Insurance enrollment, payment, claims adjudication, case and medical management record systems maintained by a health plan. This also includes records used to make decisions about individuals.

**South Atlanta Vascular Institute may use and disclose your information for each of the following purposes:**

**Treatment:** We may use protected health information about you to provide your medical care. This information will be disclosed to our employees and others involved in providing your medical care. An example of others would include pharmacists and referring clinicians.

**Payment:** We may disclose protected health information about you to receive reimbursement for services, to certify coverage, to preform billing and collection and utilization review. Additionally, we may disclose information to other providers to assist them in obtaining payment for your medical care.

**Health Care Operations:** We my use your protected health information about you to run our practice. Examples may include quality review, referral authorization, medical reviews, legal services, audits, fraud and abuse programs as well as compliance programs.

**Appointments:** We may use and disclose protected health information to contact you for appointments. This includes answering machines, email and text. Additionally, we may use PHI when you sign in or we call out your name at your appointment. Occasionally, your PHI may be used to disclose information for alternative treatment options.

**Special Situations:** There are time when we may disclose either with or without your permission on a cases by case basis as required to by law, to public health authorities, to healthcare oversite agencies, for administrative or judicial review, to law enforcement, to coroners, for organ or tissue donation for public safety, for workman's compensation or to notify you in case of an information breach.

**When South Atlanta Vascular Institute may not use or disclose your information:**

Except as described in this Notice of Privacy Practices, South Atlanta Vascular Institute will not use or disclose your protected health information without your written authorization. If you do authorize South Atlanta Vascular Institute to use or disclose your protected health information for another purpose, you revoke your authorization in writing at any time.

**Your Health Information Rights:**

Right to Request Special Privacy Provisions: You have the right to request restrictions on certain uses and disclosures of your protected health information by written request specifying what information you want to limit and what limitations you wish to impose. We reserve the right to accept or reject any request and will notify you of our decision.

**Right to Request Confidential Communications:**

You have the right to request that you receive your protected health information in a specific way or at a specific location. We will comply with all reasonable requests submitted in writing.

**Right to Inspect and Copy:**

You have the right to inspect and copy your protected health information with limited exception. To access your protected health information, you must submit a written request. Detailing what information, you want access to. We will provide copies to you or any other person you designate in a format acceptable and producible to both parties. We will charge a reasonable fee for these services. If we are unable to process your request, we will inform you, and you will have the right to appeal our decision.

**Right to Amend or Supplement:**

You have the right to amend your protected health information that you believe to be inaccurate or incomplete. You must make your request in writing and inform us of the reason you believe your protected health information is inaccurate or incomplete. We are not required to change your protected health information and will inform you of our decision.

**Right to Accounting Disclosures:**

You have a right to receive an accounting of your disclosures of your protected health information made by south Atlanta Vascular Institute except as legally protected by either your written authorization or as required by law.

**Right to Paper or Electronic Copy of this Notice:**

You have a right to notice of our legal duties and privacy practices including a paper copy of our Notice of Privacy Practices.

**Changes to this Notices of Privacy Practices:**

We reserve the right to change the termsof our Notices of Privacy Practices and to make new provisions at any time. We will post and you may request a written Notice of Privacy Practices at any time.

**Complaints:**

Complaints about how your protected health information is handled should first be directed to the Practice administrator and/or Managing member. If you are not satisfied with the manner in which your complaint is handled, you may lodge a formal complaint with:

The U.S Department of Health and Human Services

Office of Civil Rights

61 Forsyth Street, SW, Suite 3B70

Atlanta, Ga 30303-8909

Phone: (404) 562-7886

OCRMail@hhs.gov

www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf