Artery and Vein Institute, LLC

Patient Medical History

Today's Date_____

Name_____ Date of Birth _____

Referring Physician_____ Primary Physician_____

Reason for Today's Visit: _____

List Medical History: (Any diagnosis given in the past/Reason for taking Medications)

_____

_____

List of Surgical History:

_____

_____

For Dialysis Patients Only:

Chair Time_____ Days_____ Left/Right-Handed_____

Facility_____ Location _____

Is there any family history of:

Vascular Disease?_____ Heart Disease?_____

Cancer?_____ Stroke?_____

If so, who? (Only Immediate Family...Mom, Dad, Brother, Sister)

_____

Do you have complications with anesthesia?_____

Artery and Vein Institute, LLC

Patient Information/HIPPA Documentation

Patient Name: Date of Birth:_____

_____

Home Phone:_____

Email:_____

Marital Status: M S W D

Emergency Contact Information: To whom may we speak regarding your medical condition? 18 years or older.

Name of contact:_____

Phone number: _____ May we leave a message?_____

Relationship of contact to patient:_____

May we leave a message on patients answering machine? _____

Pharmacy: Name_____ Phone _____

Workman's Comp Information: Claim #_____

Employer:_____

Adjustor's contact info; Name: _____

Phone #_____

Patient Financial Responsibility

Name of patient: _____

Military insured **ONLY** social security #:_____

Thank you for choosing Artery and Vein Institute, as your health care provider. Please review our financial Policy

The signature below authorized the release of any medical information necessary to process any claims submitted. I also request payment of benefits be made to ARTERY AND VEIN INSTITUTE, LLC, for any services rendered to me by this provider.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

This includes co-payments, non-covered services, "less amounts that exceed maximum coverage", co-insurance, deductibles, etc. Also, I give my consent to Artery and Vein Institute, LLC to keep a copy of my credit/debit card on file for these purposes. I understand that if my due amount is not paid after one (1) billing cycle my card on file will be charged. I further understand that nonpayment of any amount due will be sent to collections.

Payment of office visit (s) is due at the time of service, except for Medicare patients and for those insurances with which this office has a contractual agreement. CO PAYMENTS ARE DUE AT TIME OF SERVICE.

I authorize any holder of medical information about me to be released to my current medical insurance company, including Centers of Medicare and Medicaid, or my insurance benefits be made/assigned on my behalf to ARTERY AND VEIN INSTITUTE, LLC

We accept checks, cash, and all major credit cards

WE OFFER AN EXTENDED PAYMENT (BUDGET) PLAN. Contact our billing office at: (484) 370-8140

Insurance Policy:

Your insurance policy is a contract between you and your insurance company. Professional care is provided to you, our patient, and not to an insurance company. Thus, the insurance company is responsible for the patient and the patient is responsible to the doctor. We will gladly process your claim, but we request your estimated portion be paid at the time of services. To do so, we require your complete insurance information. In the event we do accept the assignment of benefits, please know that the balance of your bill is still your responsibility whether your insurance company pays or not. If your insurance company has not paid your account in full within 30 days, you will have 30 days to arrange payment of the balance due. Regarding insurance plans in which we are a participating provider, please understand that we do require payment of co-pays and deductibles prior to treatment.

Managed Care Insurance:

Patients enrolled in a managed care health plan are expected to receive appropriate co-payment upon arrival at the office for the appointment. After the practice receives payment from the insurance company and any discount adjustments have been posted, the patient is responsible for any balance due.

Insurance Authorization and Assignment

I request that payment of authorized insurance benefits be made on my behalf to Artery and Vein Institute, for any services furnished me. I hereby authorize Artery and vein Institute, LLC to release any medical information necessary to process my claim. I permit a copy of this authorization to be used in place of the original. The authorization may be revoked either by me or my insurance company at any time in writing.

I have read Financial Policy. I understand and agree with this Financial Policy. I have read all the information, and I certify that this information is true and correct to the best of my knowledge. I will notify the office of any changes in the above information.

Signature of patient or authorized representative:_____ Date:_____

AVI Ultrasound Agreement

I consent to have my imaging scheduled at Artery and Vein Institute. I understand that a $50.00 fee will be charged for appointments cancelled with less than 24hr prior notice. I understand this fee will be assessed by myself and it is expected to be paid prior to rescheduling it to the office. I agree to inform the office of cancellation as soon as possible so another patient may have the opportunity to have their imaging performed.

Patient:_____ Date:_____

DOB:_____

Artery and Vein Institute, LLC

MEDICATIONS:

List all Medications: (including over the counter)

Patient Name:________________________________ DOB:____________

Med:________________ Dosage:________________ Times per Day:____________

Reason for taking:____

Med:________________ Dosage:________________ Times per Day:____________

Reason for taking:____

Med:________________ Dosage:________________ Times per Day:____________

Reason for taking:____

Med:________________ Dosage:________________ Times per Day:____________

Reason for taking:____

Med:________________ Dosage:________________ Times per Day:____________

Reason for taking:____

Med:________________ Dosage:________________ Times per Day:____________

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Med:________________ Dosage:________________ Times per Day:____________

Reason for taking:____

Med:________________ Dosage:________________ Times per Day:____________

Reason for taking:____

Med:________________ Dosage:________________ Times per Day:____________

Reason for taking:____

Med:________________ Dosage:________________ Times per Day:____________

Allergies:

List all Allergies: (including environmental)

Patient Name:_____ DOB:_____

Allergy:_____ Reaction:_____

Allergy:_____ Reaction:_____

Allergy:_____ Reaction:_____

Allergy:_____ Reaction:_____

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