The Vascular Group of Bradenton

Woodrow W. Yeaney III, MD
4502 Cortez Road West
BMO Harris Bank Bldg, Suite 200
Bradenton, FL 34210
www.tvgbradenton.com

New Patient Registration

Today's date: _____

Name: _____ **DOB:** _____ **Age:** _____

Nickname/ Maiden Name: _____ **Gender (circle one):** Male Female

Marital Status (circle one): Single Married Divorced Other **Social Security #:** _____

Mailing Address: _____ **Apt/Unit #:** _____

City: _____ **State:** _____ **Zip:** _____

Email: _____

Phone number: Home _____ Cell _____ Work _____

May we leave general messages about appointments and test results at above numbers? _____

Race: Caucasian African American Asian Hispanic Other Declined

Preferred Language: English Spanish Other (specify): _____

Employer: _____ **Occupation:** _____

Primary Care Physician: _____ **Phone:** _____

Referring Physician: _____ **Phone:** _____

Pharmacy: _____ **Address:** _____ **Phone:** _____

Emergency contact:

Name _____ Phone _____ Relationship _____

Do you have a living will or advance directive? Yes No (If yes, please bring a copy for our records)

Healthcare Proxy, if one named:

Name _____ Phone _____ Relationship _____

How did you hear about us? (circle one)

Friend Relative Doctor Insurance directory Hospital visit Internet Advertisement(specify): _____

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Insurance Information

Primary Insurance Company _____ Employer _____

Member/Policy # _____ Group # _____

Policyholer: **Self (if self, skip to next section)** **Other (complete next section)**

Policyholder Name _____ Relationship to patient _____

Social Security #_____ DOB _____ Employer _____ Phone _____

Address (if different from patient) _____

Secondary Insurance Company _____ Employer _____

Member/Policy # _____ Group # _____

Policyholer: **Self (if self, skip to next section)** **Other (complete next section)**

Policyholder Name _____ Relationship to patient _____

Social Security #_____ DOB _____ Employer _____ Phone _____

Address (if different from patient) _____

INSURANCE AUTHORIZATION, RELEASE AND ASSIGNMENT OF BENEFITS

I hereby authorize The Vascular Group of Bradenton to furnish and/or release any information necessary to insurance carriers concerning my illness and treatment, and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. It may be used to process my insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from The Vascular Group of Bradenton on behalf of myself and/or my dependents, and I understand by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original. I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) including Medicare, Medigap, private insurance and any other health/medical plan to issue payment directly to The Vascular Group of Bradenton, for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand I am responsible for any amount not covered by insurance, regardless of insurance coverage.

_____ _____

Patient signature (or guardian if patient is a minor) **Date**

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Patient Medical & Social History

Patient Name: _____ **DOB:** _____ **Age:** _____ **Date:** _____

Reason for today's visit: _____

Do you have any known allergies? No Yes (please list with type of reaction): _____

_____

Are you allergic to: Lidocaine Yes No **Penicillin** Yes No **IV Dye** Yes No

Have you ever been diagnosed with any of the following? If yes, please circle

Heart Disease	Diabetes	High Cholesterol	Bleeding Disorder
Heart Attack	Kidney Disease	PAD or PVD	Blood clots in leg or lung
Stroke	Aneurysm	Non healing wounds	Varicose Veins
Cancer	High Blood Pressure	Other:	

Are you experiencing any of the following? Please circle all that apply

Pain in legs after exertion	Purplish/reddish skin on legs	Leg swelling
Cramping in legs after exertion	Achy legs at end of day	Cold or numb legs
Varicose veins	Leg pain at night wakes you up	Pain in foot at rest

Please list all previous surgical procedures: Continue on back if necessary

Procedure	**Where Performed / Surgeon**	**Date**

Has anyone in your family been diagnosed with any of the following? If yes, circle and indicate relative

Heart Disease	Diabetes	Bleeding Disorder
Stroke	Aneurysm	Blood clots in leg or lung
Heart Attack	PAD or PVD	Varicose Veins
Cancer	Other:	

Office Use Only:

Height: _____ Weight: _____ BP: Left _____ Right _____ Pulse: _____ Resp Rate: _____

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Patient Name: _____ **DOB:** _____ **Age:** _____ **Date:** _____

Do you currently use or have you previously used tobacco? Yes No

If current use: How many years have you smoked? _____ How many packs per day _____

If former use: How many years did you smoke? _____ How many packs per day _____

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

Have you had a recent influenza vaccination? No Yes If yes, please give date: _____

Have you had a recent pneumonia vaccination? No Yes If yes, please give date: _____

_____ _____

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Medication List

Patient Name: _____ DOB: _____ Age: _____ Date: _____

Please list all prescriptions and over-the-counter medications, including herbal products and vitamins, you are currently taking. If you have a medication list, you may skip this section if you bring that list with you to your appointment. **Please be sure dose and frequency is listed for all medications. This form will need to be updated before every physician visit.**

	Medication	Dose	Frequency
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

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Patient Name: _____ DOB: _____ Age: _____ Date: _____

NOTICE OF PRIVACY

I acknowledge I have received a copy of The Vascular Group of Bradenton "Notice of Privacy Practices". I have read and understand all of the above and agree to comply.

_____ _____
Patient signature (or guardian if patient is a minor) **Date**

PROTECTED HEALTH INFORMATION DISCLOSURE

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list the below the name(s) of the individual(s) you authorize us to discuss your care with. Your PHI will be disclosed to the individual(s) listed below until you notify us otherwise in writing. **Please list your spouse or significant other and any family, friends and agents you authorize us to discuss your PHI with.**

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

This authorization will remain in effect for one year unless otherwise specified. I understand this authorization extends to all or any part of my medical record, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse and/or AIDS (Aquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above. I understand this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on the authorization. I understand that my PHI used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my PHI may no longer by protected by law.

_____ _____
Patient signature (or guardian if patient is a minor) **Date**

CONSENT TO TREAT

The purpose of medical care is to facilitate the treatment of disease, injury and disability. Medical services are provided through examination, testing and use of procedures to aid the diagnosis or treatment of a medical condition or conditions. I request and authorize The Vascular Group of Bradenton to provide me with medical services as described above. I agree to cooperate fully and to participate in all medical procedures and to comply with the plan of medical care/services that is established.

_____ _____
Patient signature (or guardian if patient is a minor) **Date**

Responsible party – adult or guardian present signing consent to treat:

Last Name _____ First Name _____ Relationship to Patient _____

Social Security # _____ Date of Birth _____ Gender (circle one) Male Female

Address (if different from patient) _____

Phone Number: Home _____ Cell _____ Work _____

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AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS

Authorization to obtain, release or review protected health information (PHI):

I hereby authorize The Vascular Group of Bradenton to obtain or release a copy of all medical information and reports for the purpose of my treatment. I understand that this authorization extends to all or any part of my medical record, which may include psychiatric information and/or genetic counseling/testing, and/or alcohol/drug abuse and/or HIV/AIDS test results, and imaging. I expressly consent to the release of this information.

I understand this authorization will remain in effect for one year unless otherwise specified. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer by protected by law.

Please **send** a copy of my medical record to:

The Vascular Group of Bradenton
4502 Cortez Road West
Suite 200
Bradenton, FL 34210
Fax: 941-243-3953

Please **release** a copy of my medical record to: (please list any doctors you would like us to send records to following any physician visit)

_____ _____

_____ _____

_____ _____

_____ _____

Patient signature (or guardian if patient is a minor) **Date**

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FINANCIAL POLICY

Welcome to our practice! We strive to provide you with excellent medical care and our goal is to make your visit as convenient as possible.

By signing this agreement, you confirm that you have read the policies below and understand that:

- It is your responsibility to inform our office of any address or phone number changes
- Your account needs to be kept current. Accordingly, all self-pay or insurance co-payments, co-insurances and deductibles will be collected at the time of service, unless other arrangements have been made in advance, and are payable by cash, check, Visa, Mastercard, Discover or American Express
- If you do not have your payment(s), your appointment may be rescheduled
- You may be asked to schedule another appointment for issues other than the reason for your original appointment
- A returned check will result in a $25 service charge **and** all future payments will be required in the form of cash or credit card
- You will only be sent a statement if your balance exceeds $5 and you will only receive a credit upon request and if the amount is over $10. Refunds will be issued within 4-6 weeks from the date requested, if there are no pending insurance claims
- There is a $25 charge for the completion of paperwork (Disability, FMLA, etc)
- Any unpaid balances older than 30 days may be subject to 1.5% interest per month
- If your account is turned over to a collection agency, you will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 35% of your outstanding balance, court costs and attorney fees.

If you have health insurance coverage:
We will submit your claims on your behalf. However, we must emphasize that, as medical providers, our relationship is with you, not your insurance company. Although we attempt to verify your healthcare benefits with your insurance policy, please be advised this is only an estimate of your coverage based on the information given to us at the time of inquiry.
By signing below, you confirm that you understand:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment
- If your insurance policy requires a referral from your primary care physician, it is your responsibility to have that referral faxed to our office prior to your appointment
- No all services are a covered benefit with all insurance plans
- It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance policy
- Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibility from the date services are rendered

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, please do not hesitate to ask us. We are here to help you.

I have read and understand the above Financial Policy and agree to meet all financial obligations.

_____	_____	_____
Patient Name (please print)	**Patient Signature**	**Date**
_____	_____	_____
Responsible Party Name (if other than patient)	**Patient Signature**	**Date**

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PHOTOGRAPHY CONSENT

In order to ensure accurate patient identification and obtain all necessary information for some insurance companies, photographs may be taken and/or scanned and saved into your medical records. This includes but is not limited to your driver's license photo for identification purposes and images of current wounds or visible medical conditions your insurance may require prior to authorizing medical procedures.

By signing this form, you are consenting to medical photographs to be made of yourself or for a person whom you are a legal guardian. You understand that the information may be used in your medical record and for insurance purposes at The Vascular Group of Bradenton. By consenting to these medical photographs, you understand that you will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care you receive. If your insurance company requires the photographs be submitted prior to authorization of medical procedures, you will be given the option to consent to the photographs or waive insurance benefits for such procedure.

If you have any questions or wish to withdraw your consent in the future, please contact the staff at The Vascular Group of Bradenton at 941-243-3991.

By signing this form below, you confirm that this consent form has been explained to you in terms which you understand.

_____ _____

Patient signature (or guardian if patient is a minor) **Date**

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OFFICE POLICIES & AGREEMENT

Your medical care is of utmost importance to us. We strive to deliver quality care in an efficient manner with a comfortable experience. To ensure we are delivering this experience to every patient, we have developed the following office policies.

Appointments in our office: We require you to provide your medical insurance card(s), photo identification, date of birth, social security number, address and phone number. If you receive health benefits through a spouse or parent, we require you to provide their date of birth, address and phone number. Our staff will obtain your insurance information when scheduling a new patient appointment and will verify this information prior to any future appointments. We ask that you bring your insurance card to **every** appointment and notify us **prior** to your appointment of any changes.

Keeping your appointments: Every appointment is important to your health and care. If you fail to keep your scheduled appointment, your physician may fail to detect and/or treat serious health conditions. In addition, failing to keep scheduled appointments creates significant hardship for your physician and is not fair to other patients who would like access to vascular service's offered by your physician's practice. Every effort should be made to keep any scheduled appointment. If you are unable to keep your appointment, please notify our staff **at least 48 hours in advance**.

We understand that emergencies may come up that keep you from keeping your appointment. In the case of an emergency, no cancellation fee will apply provided you supply written documentation or proof of the emergency. In all other instances, a **$25.00** no show cancellation fee will apply for any appointment not cancelled **at least 48 hours** in advance.

Health insurance: It is your responsibility to understand the provisions of your health insurance plan and coverage and to contact your carrier prior to receiving services to verify your coverage and responsibilities. You are responsible for verifying if a referral is required for your appointment and to obtain such referral prior to your appointment. If our staff determines a referral is required by your plan and one was not obtained, your appointment will be rescheduled.

Co-payments, deductibles and previous balances: It is our responsibility, as detailed by the terms of our contracts with health insurance companies, to collect any co-payments, deductibles, co-insurances and patient responsibilities that your health insurance companies designates as your responsibility. Co-payments, co-insurances and deductibles are due at the time of service. Any amount your health insurances designates as your responsibility after the date of service is expected to be paid in a reasonable time period.

Self-pay patients: If you opt to self-pay for your medical care services, payment is due, in full, at the time of service unless other arrangements have been made in advance with our office staff.

Prescription refills: Please call your pharmacy to request a refill on your prescriptions. If there are no remaining refills available, the pharmacy will contact us to process a refill. Please allow 48 hours for your request to be completed. Controlled substances require an original prescription from the physician and cannot be processed electronically. You will need to come to our office to pick up any prescription for a controlled substance.

I have read and understand the above office policies and agree to abide by them.

_____ _____

Patient signature (or guardian if patient is a minor) **Date**

Revised 2/2018