VASCULAR
INTERVENTIONAL &
VEIN
ASSOCIATES

PLEASE ATTACH
LIST OF MEDICATIONS
LIST OF CURRENT DOCTORS

Today's Date: _____

PATIENT INFORMATION

Name: **Date of Birth:** **SSN:**

Sex: **Marital Status:** **Language:**

Address (Street, Apt/Unit, City, State, Zip):

Primary Phone #: **Secondary Phone#:** **★Email: (To be web enabled):**

Employment Status: ☐ Full time ☐ Part Time ☐ Unemployed ☐ Retired ☐ Disabled **Name of Employer:**

Race: ☐ White ☐ African American ☐ Hispanic ☐ Asian ☐ American Indian ☐ Pacific Islander ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Check all that apply:
- ☐ I have an Advanced Directive/Living Will
- ☐ I have a Healthcare Surrogate
- ★ ☐ I have brought my documentation today
- ☐ I have a Power of Attorney
- ☐ I do not have any Health Care Plan
- ☐ I have **not** brought my documentation today

PHYSICIAN INFORMATION

★Primary Care Physician: **★Who referred you?**

★Please name all Physicians involved in your treatment:

INSURANCE INFORMATION

Primary Insurance: **Subscriber's Name/Relationship:**

Subscriber's Date of Birth: **Subscriber's SSN:**

Secondary Insurance: **Subscriber's Name/Relationship:**

Subscriber's Date of Birth: **Subscriber's SSN:**

PRIMARY EMERGENCY CONTACT

Name: **Relationship to Patient:** **Phone #:**

Address (Street, Apt/Unit, City, State, Zip)

Allow this person access to my condition/information: ☐ Yes ☐ No

★ **Pharmacy Name: _____ Location: _____**

RELEASE OF MEDICAL INFORMATION

Patient Name: _____Date of Birth: _____ Date: _____

I agree that Vascular, Interventional and Vein Associates (VIVA) may disclose certain portions of my health information to a relative, friend, and/or other caregiver because such person is involved with my health care or payment relating to my health care. In that instance, VIVA will disclose only information that is directly relevant to the person's involvement in my health care or payment relating to health care.

☐ I wish to make no designation at this time.

I designate the following persons listed below as persons involved in my health care or payment related to my health care for the purpose of VIVA making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

First and Last Name: _____

Phone #: _____ Relationship to Patient: _____

First and Last Name: _____

Phone #: _____ Relationship to Patient: _____

First and Last Name: _____

Phone #: _____ Relationship to Patient: _____

First and Last Name: _____

Phone #: _____ Relationship to Patient: _____

I request that my protected health information not be disclosed to the following individuals or entities [list individuals or entities to which information would **not** be disclosed]:

_____

_____

Signature of patient: _____

MEDICAL HISTORY (PAGE 1)

Patient Name: **DOB:** **★Height:** **★Weight:**

Please check the boxes next to any medical conditions you have now OR have had in the past.

Cardiovascular
- ☐ Heart Attack/Myocardial Infarction
- ☐ Coronary Artery Disease
- ☐ Congestive Heart Failure
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Murmur
- ☐ Atrial Fibrillation
- ☐ Pacemaker/Defibrillator

Bladder/Genitourinary:
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Urinary Incontinence
- ☐ Bladder Cancer
- ☐ Prostate Cancer
- ☐ **Dialysis**
  - ☐ **M, W, F** ☐ **T, T, S** ☐ **PD**

Hematological/Immune:
- ☐ Liver Disease/Condition
- ☐ Hepatitis
- ☐ Anemia
- ☐ Clotting Problems
- ☐ Fibromyalgia
- ☐ Multiple Sclerosis
- ☐ **Lupus**

Vascular:
- ☐ Abdominal Aortic Aneurysm
- ☐ Stroke/Paralysis
- ☐ TIA
- ☐ Phlebitis
- ☐ Deep Vein Thrombosis
- ☐ Pulmonary **Embolism**
- ☐ **Varicose Veins or Spider Veins**

Endocrine:
- ☐ **Diabetes**
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

Neurological:
- ☐ Parkinson's Disease
- ☐ Alzheimer's Disease
- ☐ Seizures
- ☐ Tremors
- ☐ Peripheral Neuropathy
- ☐ **Dementia**

Gastroenterology:
- ☐ GERD/Heartburn/Reflux Disease
- ☐ Ulcers
- ☐ Difficulty Swallowing/Dysphagia
- ☐ Cancer of the Mouth/Throat/Neck **Stomach/Intestines/Rectum**

Respiratory:
- ☐ Pneumonia
- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ Lung Cancer
- ☐ Chronic Cough

Musculoskeletal:
- ☐ Arthritis
- ☐ Osteoarthritis
- ☐ Degenerative Disc Disease
- ☐ Degenerative Joint Disease
- ☐ Osteoporosis
- ☐ **Rheumatoid Arthritis**

Visual:
- ☐ Macular Degeneration
- ☐ Cataracts
- ☐ Blurred/Double Vision
- ☐ Loss of Vision

Allergies: ★PLEASE LIST ALL ALLERGIES TO MEDICATIONS AND DESCRIBE REACTION: NONE: ____

I am allergic to: _____

_____

Other:

☐ **MRSA**
☐ **HIV/AIDS**

Do you need assistance to walk? ☐ Yes ☐ No
Are you an amputee? ☐ Yes ☐ No

MEDICAL HISTORY (PAGE 2)

Name: **DOB:**

Personal Habits

Caffeine	☐ Yes ☐No	**How many cups per day? _____**	
Exercise	☐ Yes ☐No	**How often?_____**	**What kind of Exercise?_____**
★Tobacco	**☐ Current Smoker ☐ Never Smoker ☐ Former Smoker** **☐ 1-9 cigarettes a day ☐ 10-19 cigarettes a day ☐ 20+ cigarettes a day** **For how many years did you smoke? _____** **How many years ago did you stop smoking?_____**		
★ Alcohol	**Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No** **If 'Yes': How often did you have a drink containing alcohol in the past year?** **☐ Never** **☐ Monthly or less** **☐ Two to four times a month** **☐ Two to three times per week** **☐ Four or more times a week** **If 'Yes': How many drinks did you have on a typical day when you were drinking in the past year?** **☐ 1 or 2** **☐ 3 or 4** **☐ 5 or 6** **☐ 7 to 9** **☐ 10 or more** **If 'Yes': How often did you have 6 or more drinks on one occasion in the past year?** **☐ Never** **☐ Less than monthly** **☐ Monthly** **☐ Weekly** **☐ Daily or almost daily**		

Name: **DOB:**

★ **Current Medications** ☐**See list**

Name of Medication	Dosage	Frequency

Family History: (Please write a check mark to all that apply)

	Alive	Deceased	Medical Conditions and/or Cause of Death
	Please Check		
Father			
Mother			
Siblings None: ____	**Male #____ Female #___**	**Male #____ Female #____**	
Children None:____	**Male #____ Female #___**	**Male #_____ Female #____**	

Surgical History	Date

Do you CURRENTLY have? If yes, please check appropriate boxes.

Hematologic
- ☐Anemia
- ☐Bleed or Bruise Easily
- ☐Blood Clots

Skin
- ☐Discoloration
- ☐Skin Ulcers
- ☐Open Wounds

Ear, Nose, Throat, Mouth
- ☐Dry Mouth
- ☐Hearing Aid
- ☐Nose Bleeds
- ☐Vertigo

Endocrine
- ☐Excessive Hunger
- ☐Excessive Thirst
- ☐Excessively Cold

General
- ☐Chills
- ☐Depression
- ☐Fatigue
- ☐Fever
- ☐Weakness

Cardiovascular
- ☐Chest Pain
- ☐Irregular Heart Beat
- ☐Murmur
- ☐Tachycardia

Immune/Allergies
- ☐Seasonal Allergies
- ☐Frequent Infections
- ☐Itching
- ☐Rashes
- ☐Swollen Glands

Neurologic
- ☐Headaches
- ☐Dizziness
- ☐Memory Loss
- ☐Numbness
- ☐Seizures

Musculoskeletal
- ☐Back Pain
- ☐Herniated Disc
- ☐Leg Pain
- ☐Joint Stiffness/ pain
- ☐Muscle Cramps/ pain
- ☐Sciatica
- ☐Knee pain
- ☐Neck Pain
- ☐Joint Swelling
- ☐Muscle Weakness

Digestive
- ☐Abdominal Pain
- ☐Heartburn
- ☐Bloody Stool
- ☐Constipation
- ☐Diarrhea
- ☐Loss of Appetite
- ☐Nausea/Vomiting

Respiratory
- ☐Cough
- ☐I Use Oxygen
- ☐Shortness of Breath
- ☐Wheezing

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Consent for Treatment and Authorization to Release Information

- I request the services of Pranay T. Ramdev, M.D, duly licensed in the State of Florida, and all staff personnel. I consent to examination, diagnostic procedures, and treatment, which may need to be performed on my behalf.
- Dr. Ramdev may, at his discretion, disclose all or part of my patient medical records to any referring physicians, employer, or insurance companies to identify me to carry out my treatment, payment and healthcare operations. Such disclosure shall include furnishing copies of said records. I authorize fax transmittal of my medical records as necessary.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which in the judgment of the attending physician or their assigned designees may be considered medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly VIVA of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury to my employer or designee understand that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

- I give VIVA permission to review my prescription history for verification of my medications.
- I understand that my prescription refills must be requested at least one week before my medication runs out.
- A photocopy of this consent shall be considered as valid as the original.
- I have received a copy of VIVA's Notice of Privacy Practice for my record. I understand that if I have questions or complaints that I should contact the Facility Privacy Official.

    - Patient Initial: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature: _____DOB: _____ Date: _____

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Assignment of Benefits/Financial Policy

Vascular, Interventional & Vein Associates wants to assist you in the financial management of our relationship. Benefit verification will be provided as a courtesy and is not a guarantee of payment. Be assured that we will be ethical and fair concerning any billing or collection concerns you may have. Please be advised that this policy is subject to change. If you have any questions, please contact our billing department.

Participating Plans

- Our billing department will file your insurance for services rendered.
- The patient is responsible for presenting all current available insurance cards at the time of service.
- The patient is responsible for co-pays, deductibles, and co-insurance at the time of service, before services are rendered (If you have Medicare and a supplemental, we will file Medicare and a supplemental; then transfer balance to you after your supplemental has paid on the claim. If you do NOT have a supplemental insurance, you will be responsible for the 20% of Medicare allowable for each service plus any deductible.)
- The patient is responsible for knowing their policy coverage, deductibles, coinsurance, etc.
- The patient is responsible for insurance follow-up with their plan regarding student status forms, annual employer claim forms, accident/injury information, and terminated insurance plans.
- If we participate with your insurance, we must collect any deductible, coinsurance and/or co-pay at the time of service. If you are unable to provide that payment, we reserve the right to re-schedule your appointment.

Non-Participating Plans

- The patient is responsible for all "out of network" patient responsibility at time of service unless other payment arrangements have been made. This would include any co-insurance, deductible, and the difference between carriers allowable and our standard fee.
- Our billing department will file the patient's insurance as a courtesy.

Self-Pay

- Patient with no insurance coverage will be considered Self Pay.
- Self-Pay patients will sign this form indicating that they have NO health insurance.
- Payment is due at time service is rendered or arrangements must be made in advance.
- Self-Pay patients must speak with billing manager BEFORE SERVICES ARE RENDERED.

Collections

- Collection notices begin if the patient balance has not been paid in full
- All unpaid balances will be sent to an outside collection agency after all practice efforts have been exhausted.

Return Check Fee

- A fee of $25.00 will be charged to the patient account for Return Check from the bank.

No Shows

- Any patient that does not show to an office procedure will have a $50 fee added to their account

Medicare Lifetime Authorization

I authorize holder of medical or other information about me to release any information needed for this or a related Medicare Claim to the Social Security Administration and Center for Medicare and Medicaid Services, its intermediaries or carriers. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider or any other party who may be responsible for paying or treatment. (Section 1128B of the Social Security Act and 31 USC 3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply. (Signature retained on file).

I assign the benefits payable for services to VIVA. Patient Initials: _____
I request this authorization also apply to all other insurance. Patient Initials: _____

I, the undersigned, have read and understand the above information. I agree to be responsible for any charges incurred by me or not payable by my insurance company. I also agree to be responsible for any legal fees and/or court costs incurred as a result of my failure to pay services rendered.

Patient Signature: _____DOB: _____ Date: _____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date: _____

To: _____
(Physician/Name/Hospital/Facility)

_____
(Address)

_____
(City) (State) (Zip)

_____
(Phone Number) (Fax Number)

I hereby request that:
_____ A full and complete copy of my medical records be released to:
_____ A copy of the following medical records

_____
be released to:

Pranay T. Ramdev, M.D.
960 37th Place
Vero Beach, Florida 32960
Fax: 772-567-8478

I understand and direct this authorization remain in effect for twelve (12) months or until I revoke it in writing. I hereby release the originating office/facility and its employees from any liability that may arise from the release of this information as I have directed.

_____
(Print Patient Name) (DOB)

_____
(Patient's Signature)