

Premier Vascular Care P. C. And Premier Veins, Michigan
1701 South Blvd E Suite B-75 Rochester Hills MI 48307
Tel: (248) 243-3935 Fax: (248) 243-3939

PATIENT INFORMATION

Name: _____
(Last) (Middle) (First)

Date of Birth: ____/____/____ Social Security Number: _____
(month) (date) (year)

Email Address: _____

- Sex:**
- Male
 - Female
 - Transgender Male
 - Transgender Female
 - Patient declines to specify

- Sexual Orientation:**
- Straight or Heterosexual
 - Lesbian, Gay, or Homosexual
 - Bisexual
 - Patient declines to specify

- Marital Status:**
- Single
 - Married
 - Divorced
 - Widowed

- Ethnicity/Race Group:**
- White
 - American Indian or Alaska Native
 - Hispanic or Latino
 - Asian
 - Black or African American
 - Native Hawaiian or other Pacific Islander
 - Middle Eastern
 - Indian
 - Other:
- _____

- Language:**
- English
 - Arabic
 - Chaldean
 - French
 - Hindi
 - Spanish
 - Italian
 - Chinese
 - Other:
- _____

Address of Residence: _____
(Street)

(City) (State) (Zip)

Phone Numbers: (Home):(_____) _____ - _____
(Cell):(_____) _____ - _____

Emergency Contact: _____
(Last) (First)

Phone Number: _____

Relationship: _____

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Family Physician: _____

Phone Number:(_____) _____ - _____ Fax Number:(_____) _____ - _____

Referring Physician (IF DIFFERENT THAN FAMILY PHYSICIAN):

Phone Number:(_____) _____ - _____ Fax Number:(_____) _____ - _____

Insurance Information:

Primary Insurance: _____ Secondary Insurance: _____

ID Number: _____ ID Number: _____

Group Number: _____ Group Number: _____

Co-Pay For a Specialist: \$ _____ Co-Pay For a Specialist: \$ _____

Pharmacy Information:

Pharmacy Name: _____

Address: _____
(Street)

(City) (State) (Zip)

Phone Number:(_____) _____ - _____

Medical Data

Reason you were referred to Dr. Kadakol: _____

Past medical history (Check all that apply):

- | | | |
|--|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney failure | <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> Heart Attacks | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Anaemia |
| <input type="checkbox"/> Heart Stent | <input type="checkbox"/> Strokes/Mini-strokes | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Heart Bypass | <input type="checkbox"/> Problems with Stomach & Intestines | <input type="checkbox"/> Varicose Veins/Venous Insufficiency |
| <input type="checkbox"/> Irregular Heart Rhythm (AFIB) | <input type="checkbox"/> Operations on Abdomen | <input type="checkbox"/> Other |
| <input type="checkbox"/> Heart Valve Operations | <input type="checkbox"/> Other Operations | |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Cancer | |

Allergies (Please list all Drugs, Food and Environmental Allergies):

<u>Drug</u> ↓	<u>Food</u> ↓	<u>Environmental</u> ↓

Social History:

Smoking Status:

- Never smoker
 Current every day smoker
 Current some day smoker
 Heavy Tobacco smoker
 Light tobacco smoker
 Former smoker;
 Quit Date: _____
 # of years of smoking: _____

Alcohol Use Status

- No Alcohol Use
 Current everyday alcohol use
 Current someday alcohol use
 Heavy alcohol use
 Light Alcohol Use
 Former Alcohol Use
 Quit Date: _____
 # of years of Alcohol: _____

Smokeless Tobacco Status:

- Yes
 No

Recreational Drug Status:

- Yes
 Type: _____
 No

Family History (Please list any major illness you know of):

Mother: Alive Deceased

Father: Alive Deceased

Grand Mother: Alive Deceased

Grand Father: Alive Deceased

GENERAL CONSENT FOR TREATMENT

I freely consent to medical care by the doctors and designees of Premier Vascular Care P.C. I understand that by consenting I agree to give any and all information about my illness and factors that may contribute to or alter the course of the illness. I also understand that such information constitutes part of my medical record and will be charted and maintained as a permanent document with the doctors and their designees. Such records are a property of the practice. I am, hereby, also advised that I have the right to obtain a copy of such records on written request. I also consent to any and all necessary physical examination by the doctors and their designees. I also understand that I may be asked to undergo, treatments/tests/transfusions/procedures, etc., that are determined to be necessary by my doctor as part of my medical care and I consent to the same. I understand that this consent to medical care will be considered as valid indefinitely from my first medical encounter with the practice. I am also, hereby, advised that I have the right to withdraw this consent at any time.

Name of Patient (Or Representative with relationship to Patient)

Signature of Patient (Or Representative)

Today's Date

INSURANCE AGREEMENT

I authorize and consent to the treatments deemed necessary by the physician/nurse, to the release of information necessary to process my medical claims. I authorize all payments to be made directly to PREMIER VASCULAR CARE P.C. This includes Blue Cross Blue Shield, Medicare, Medicaid, and all private insurance payments.

I understand that I am responsible to procure any and all referrals necessary from my primary care physician. If I fail to do so, I will be responsible for any and all costs incurred for treatment regardless of any contract or contracts, between the provider and insurance company. I understand that I am financially responsible for all non-covered services including those not covered due to failure to provide referrals (HMO), and that co-pays and deductibles are my responsibility. I understand that it is my responsibility to communicate to the practice if there is any change in my insurance coverage or carrier.

I understand that I am financially responsible for all Medicaid charges, if applicable

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RECORD RELEASE AUTHORIZATION/ASSIGNMENT OF BENEFITS

I hereby authorize Premier Vascular Care P.C., to release complete or partial records in their possession regarding my illness and/or treatment to Medicare/my private insurance company/any agency that pertains to payment. I hereby authorize assignment of benefits from Medicare/my insurance company/agency to be remitted directly to Premier Vascular Care P.C. I understand that Premier Vascular Care P.C. has the right to release any or all records to legal representation in the case of a legal claim/litigation.

I understand that I will be responsible for any unpaid balance that Medicare/my private insurance agency/carrier does not cover. I also understand that it is mandatory that I notify my healthcare provider of any party/parties that may be responsible for paying for services rendered. (Section 1128B of the Social Security Act and 31 U.S.C 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

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Signature of Patient (Or Representative)

Today's Date

APPOINTMENT REMINDER CONSENT

In accordance with and to be compliant with the Telephone Consumer Protection Act (TCPA), we seek your consent to send you appointment reminders. Three appointment reminders will be sent to you prior to an appointment: 1-week prior (via email), 36-hours prior (via email), and 24-hours prior (via voice or text message).

If you cannot make it to the appointment, it is your responsibility to call and cancel your appointment more than 48 hours prior to the date and time of the appointment. Otherwise, we will treat such cancellation without informing the office as a "No-show".

Name of Patient (Or Representative with relationship to Patient)

Signature of Patient (Or Representative)

Today's Date

No-Show Policy

By signing here I agree to pay a "No-show" fee of \$35 if I do not show for my scheduled appointment

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HIPAA NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of health information and provide individuals with this notice of our legal duties to protect the privacy of health information. If you have any questions about this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 248-243-3935.

Standard Authorization of Use and Disclosure of Protected Health Information

Information to be Used or Disclosed

The information covered by this authorization includes; chart documentation, information regarding health status, test results, prognosis, future plan of care, and other information as needed to provide patient care.

Organizations to Whom Information May be Released

The information described above may be released to other physicians and their medical offices, any insurance companies and or any other health organizations directly involved in the patient's care.

Individuals to Whom Information May Be Disclosed

The patient agrees that our practice is authorized to disclose his/her/their health information to his/her/their spouse/partner/significant-other/children/parents/healthcare proxy unless he/she/they specifically instructs us otherwise. The patient may list any other individual/agency as authorized to receive his/her/their health information.

Individuals Authorized to Use or Disclose Information

The patient's health information may be disclosed by Dr. Ajith Kadakol or employee/designee to individuals/organizations listed above.

Expiration Date of Authorization and Termination

This authorization is effective indefinitely from the date and time it is signed until it is revoked by the patient or the patient's personal representative/legal healthcare proxy. The patient may revoke or terminate this authorization by submitting a written revocation to Premier Vascular Care P.C. The patient should contact the Practice Manager/Designee to terminate this authorization.

Potential for Re-Disclosure

Information that is disclosed under this authorization may be disclosed again to the Individuals listed in this authorization after it has been revoked only if the patient sends formal, written consent to the Practice Manager. Otherwise information will not be released until such consent is received.

The privacy of this information may not be protected under the federal privacy regulations. Signature below is only acknowledgement that you have read this Notice of Privacy Practices.

Name of Patient (Or Representative with relationship to Patient)

Signature of Patient (Or Representative)

Today's Date