MIDDLE TENNESSEE VASCULAR

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☐ **4601 Carothers Parkway, Suite 375**
Franklin, TN 37067
(615) 791-4790

☐ **808 Hatcher Lane**
Columbia, TN 38401
(931) 388-6256

☐ **120 Frank Martin Rd, 101**
Shelbyville, TN 37160
(931) 685-0986

Appointment:

Doctor: _____

Date and Time:_____

Welcome!

We appreciate that you have chosen us for your healthcare needs. Enclosed is your new patient paperwork. It is ***very important*** that you complete it as ***thoroughly*** as possible and bring to your appointment along with:

- Insurance Cards
- Medication List (if you wish for us to make a copy)

Please note, our office provides a variety of services including doctor visits, ultrasound services, and procedures. Because our patients have differing needs, your wait time may be different than other patients in our lobby. It is possible that patients who arrive in our office after you, may be called back sooner than you, simply because they require different services than you. There are times when, for a variety of reasons, our schedules can run behind. If that happens, we appreciate your patience and will do our best to treat all of our patients' appointment times in a fair and consistent manner.

Please call if you have any questions or need to change your appointment. We look forward to seeing you in our office!

Sincerely,

The Office Staff of Middle Tennessee Vascular

Directions to Franklin Office from US-65 going North:

- Take the TN-96 exit, EXIT #65, toward Murfreesboro
- Turn RIGHT onto Murfreesboro Rd. / TN-96.
- At the second stoplight, turn LEFT onto Carothers Pkwy.
- Go 0.7 miles (if you cross over Liberty Pike, you've gone too far) and turn LEFT onto Physicians Way. **Our office building is at corner of Physicians Way and Carothers Parkway.**

Directions to Franklin Office from US-65 going South:

- Take EXIT #67 toward McEwen Dr.
- Keep left on the E McEwen Dr ramp and turn LEFT onto E McEwen Dr.
- In 0.4 miles, turn RIGHT onto Carothers Pkwy.
- Go 1.1 miles and The Carothers Tower will be on your RIGHT. **Our office building is at corner of Physicians Way and Carothers Parkway.**

Patient Information

Date:_____

Last Name: _____ **First Name**: _____ **MI**: _____

Address: _____

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

Home Phone (____)_____ **Work Phone** (____)_____ **Cell Phone** (____)_____

Date of Birth: _____ **Age**: _____ **Social Security Number**: _____

Check Appropriate Box:

☐ Male ☐ Female

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr.

☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

- **Race**:

☐ White ☐ Hispanic ☐ African American ☐ Asian ☐ Other ☐ Refuse to Report

- **Ethnicity**:

☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Refuse to Report

- **Language**:

☐ English ☐ Spanish ☐ Russian

Whom may we thank for referring you? _____

Primary Care Physician: _____

Insurance Information (**Not necessary** to complete this section if you have presented cards at the front desk)

Primary Insurance_____ **Policy Holder's Name**_____ **Birthdate**_____

Member ID_____ **Group#**_____ **Relationship to Patient**_____

Secondary Insurance_____**Policy Holder's Name**_____ **Birthdate**_____

Member ID_____ **Group#**_____ **Relationship to Patient**_____

Do we have your permission to use email to communicate with you? Y N

Email address:_____

WARNING: Email may not protect your confidential medical information. I recognize any confidential medical information transmitted by email is not secure and sent at my own risk. I will not hold the Physicians, Providers or staff of Middle Tennessee Vascular Associates responsible for the loss of any confidential medical information transmitted by email. The Physicians, Providers & staff of Middle Tennessee Vascular Associates will limit the use of unencrypted email to prevent disclosure of protected health information.

Please list an emergency contact person (relative or friend not living with you):

Name: _____

Relationship: _____ **Phone**: _____

I acknowledge all of the above information is correct. I authorize the Physicians, Providers & staff of Middle Tennessee Vascular Associates to use the contact information above in treatment of my medical conditions.

Signature: _____ **Date:** _____

Patient History Form

Today's Date_____

Name: _____ Date of Birth: _____ Age: _____

What health concern has brought you to our office today? Please Explain.

_____

_____

How long have you had this problem? _____ Height: _____ Weight: _____

Occupation: _____ Retired: Y N

Preferred Pharmacy: _____ City: _____ State: _____

Address: _____

➢ Medications

(If you have a written list of your medications, we will gladly make a copy for our records)

Current Medication	**Strength (ml or mg)**	**Frequency**	**Form (tab, spray, etc.)**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

➢ Medical History

Please check all that apply:

- ☐ Peripheral Artery Disease
- ☐ Aneurysm
- ☐ Stroke
- ☐ Varicose Veins
- ☐ Deep Vein Thrombosis/Blood Clot
- ☐ Heart Arrhythmias/Atrial Fibrillation
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Alzheimer Disease
- ☐ COPD
- ☐ Dialysis – If so, at what facility do you dialyze?

  Facility Name:_____

  Facility Phone Number:_____
- ☐ High Blood Pressure
- ☐ Congestive Heart Failure
- ☐ Heart Disease
- ☐ Thyroid Problems
- ☐ Arthritis
- ☐ Cancer – Type

  _____
- ☐ Parkinson Disease
- ☐ Hepatitis (A, B, C)
- ☐ HIV/AIDS
- ☐ Other:

  _____

  _____

  _____

➢ Immunizations

Pneumonia Vaccine ☐ Yes ☐ No If yes, month and year? _____

Flu Vaccine ☐ Yes ☐ No If yes, month and year? _____

➢ Allergies

☐ NONE

Please check all that apply:

- ☐ Latex
- ☐ Penicillin
- ☐ Iodine
- ☐ Sulfa
- ☐ Codeine
- ☐ Other: _____

➢ Surgical History

Please check any of the following Surgeries or Procedures that you have had:

- ☐ Aneurysm Repair
- ☐ Leg Bypass
- ☐ Varicose Vein Surgery
- ☐ Abdominal: _____
- ☐ Pacemaker/Defibrillator
- ☐ Gallbladder
- ☐ Tonsillectomy
- ☐ Carotid Surgery
- ☐ Leg Stents/Angioplasty
- ☐ Heart Stents/Angioplasty
- ☐ Hysterectomy
- ☐ Heart
- ☐ Appendectomy
- ☐ Other: _____

➢ Family Medical History

Heart Disease?	Y	N	Mother	Father	Sister	Brother	Son	Daughter
Peripheral Artery Disease?	Y	N	Mother	Father	Sister	Brother	Son	Daughter
Stroke?	Y	N	Mother	Father	Sister	Brother	Son	Daughter
Diabetes?	Y	N	Mother	Father	Sister	Brother	Son	Daughter
High Cholesterol?	Y	N	Mother	Father	Sister	Brother	Son	Daughter
High Blood Pressure?	Y	N	Mother	Father	Sister	Brother	Son	Daughter
Blood Clots?	Y	N	Mother	Father	Sister	Brother	Son	Daughter
Cancer?	Y	N	Mother	Father	Sister	Brother	Son	Daughter

Other: _____

➢ Social History

Do you smoke? _____ Packs per day? _____

Have you quit? _____ When did you quit? _____

Drink Alcohol? _____ If so, how often? _____

Use Drugs? _____ If so, how often? _____

Please check all that apply:

Respiratory:

- ☐ Chest Pain
- ☐ Cough
- ☐ Shortness of Breath at Rest
- ☐ Shortness of Breath with Exertion

Peripheral Vascular:

- ☐ Cold extremities
- ☐ Decreased sensation in extremities
- ☐ Pain/Cramping in Legs
- ☐ Ulcers (sores) on Skin

General/Constitutional:

- ☐ Change in appetite
- ☐ Fever/Chills
- ☐ Unexplained Weight Loss
- ☐ Fainting/Passing Out

Endocrine:

- ☐ Intolerant to Cold
- ☐ Intolerant to heat
- ☐ Weakness

Neurologic:

- ☐ Difficulty Speaking
- ☐ Dizziness/Confusion
- ☐ Sudden Headaches
- ☐ Loss of Use of Extremity
- ☐ Tingling/Numbness
- ☐ Sudden Vision Loss
- ☐ Doubled/Blurred Vision
- ☐ Memory Loss
- ☐ Loss of Balance/Coordination

Skin:

- ☐ Discoloration of Skin
- ☐ Rash
- ☐ Skin Lesions

Psychiatric:

- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty Sleeping

Cardiovascular:

- ☐ Chest Pain
- ☐ Chest Pain with Exertion
- ☐ Sudden Difficulty Walking
- ☐ Shortness of Breath with Exertion
- ☐ Rapid/Skipped Heart Beat
- ☐ Shortness of Breath

Gastrointestinal:

- ☐ Abdominal Pain/Swelling
- ☐ Blood in Stool/Change in Bowel Habits
- ☐ Nausea/Vomiting
- ☐ Unexplained Weight Loss

Hematology:

- ☐ Dizziness
- ☐ Bruise/Bleed Easily

Ophthalmologic:

- ☐ Blurred Vision
- ☐ Diminished Visual Activity
- ☐ Itching/Redness

ENT:

- ☐ Difficulty Swallowing
- ☐ Nosebleed
- ☐ Sore Throat

Genitourinary:

- ☐ Abdominal Pain/Swelling
- ☐ Blood in Urine
- ☐ Urination Difficulty/Pain

Musculoskeletal:

- ☐ Joint Stiffness
- ☐ Leg cramps
- ☐ Weakness

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize that my medical information may be released to the above mentioned physicians or their staff. This includes medical history, mental or physical conditions, diagnosis, prognosis, and reviewing of necessary x-rays**.**

A copy of this is as valid as the original. I have the right to receive a copy.

Printed Name _____

Signature _____

Date of Birth _____

Date _____ **Witness** _____

General Consent For Treatment

As the patient, you have the right to be informed about your conditions and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify appropriate treatment and/or procedure for any identified condition(s).

I request and authorize medical care as my provider, his assistant or designees (collectively called "the providers") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care. I authorize my provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my provider(s) and that other personnel render care and services to me (the patient) according to the provider(s) instructions.

I understand that I have the right and the opportunity to discuss alternative plans of treatment with my provider and to ask and have answered to my satisfaction any questions or concerns.

In the event that a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus or hepatitis C, I consent to the testing of my blood and/or bodily fluids for these infections and the reporting of my test results to the healthcare worker who has been exposed. _____ **(initial)**

I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT; I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED.

Name of Patient: _____

Signature of Patient: _____ Date: _____

☐ Consent of Legal Guardian, Patient Advocate or Nearest Relative **if patient is unable to sign**

☐ Consent Caregiver **if patient is unable to sign**

Name of Legal Guardian, Patient Advocate, Nearest Relative or Other: _____

Relationship: _____ Telephone: _____

Address: _____

Signature of the above: _____ Date: _____ Time: _____

Signature of Witness: _____ Date: _____

AdvancedHEALTH

Release Of Medical Information

NAME *(Please print)*: _____

By Signing Below, I Authorize (Practice Name) To Release My Medical And Billing Information To:

RELATIONSHIP			**NAME OF DESIGNATED PERSON**
SPOUSE	☐ YES	☐ NO	_____
CHILDREN	☐ YES	☐ NO	_____
IN-LAWS	☐ YES	☐ NO	_____
CAREGIVERS	☐ YES	☐ NO	_____
PARENTS	☐ YES	☐ NO	_____

OTHERS _____

PATIENT SIGNATURE _____ DATE _____

PARENT SIGNATURE _____ DATE _____

We ask that if you have any change in this request, that you please inform the receptionist.

(PRACTICE NAME) MAY LEAVE APPOINTMENT INFORMATION ON MY VOICEMAIL:

HOME	☐ YES	☐ NO
WORK	☐ YES	☐ NO
RELATIVE	☐ YES	☐ NO

PATIENT SIGNATURE _____ DATE _____

I AUTHORIZE THE FOLLOWING TO PICK UP PRESCRIPTIONS, X-RAYS, ETC.

RELATIONSHIP

SPOUSE	☐ YES	☐ NO	_____
RELATIVE	☐ YES	☐ NO	_____
CAREGIVER	☐ YES	☐ NO	_____

PATIENT SIGNATURE _____ DATE _____

I UNDERSTAND THAT (PRACTICE NAME) WILL ASK FOR IDENTIFICATION OF THE PERSON PICKING UP PATIENT MEDICAL INFORMATION OR PRODUCTS.

AdvancedHEALTH

Patient Financial Policy

This is an agreement between AdvancedHEALTH, as creditor, and the Patient/Debtor named on this form and indicated by patient/debtor signature below.

In this agreement the words "you", "your" and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us" and "our" refer to AdvancedHEALTH. By executing this agreement, you are agreeing to pay for all services that are rendered.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. A copy of your signed financial agreement will be provided to you.

HEALTH INSURANCE - It is YOUR responsibility to:

- Ensure we have been provided with the most current insurance information relative to filing your claim including insurance card, ID number, employer, birth date and patient address. This information will be located on our patient registration form.
- Ensure we are contracted with your insurance carrier to receive maximum benefits.
- Pay your co-payment or patient portion at the time of service.
- Inform us of any insurance changes made after this signed agreement/date of service. Insurance carriers have specific timely filing guidelines and pre-authorization requirements for certain services. If revised insurance information is not provided to us within your insurances' timely filing limits, you will be required to pay for services in full. If prior authorization was required for services already received and your claim is denied for lack of authorization, you will be required to pay for services in full.
- Contact your insurance company if no correspondence is received by you within 45 days of the date of service.

It is OUR responsibility to:

- Submit a claim to your health insurance carrier based on the information provided by the patient/debtor at the time of service or as updated information is provided.
- Provide your health insurance carrier with information necessary to determine benefits. This may include medical records and/or a copy of your insurance card.
- Provide MVA patients a courtesy health insurance claim form for their records upon request.

PAYMENT OPTIONS: Per our contracted agreement with your insurance carrier, we are required to collect your co-payment on the day of service. If you do not have insurance, you are required to pay for treatment at the time of service unless other arrangements have been formally made. A separate self-pay financial agreement will be provided to you.

We accept the following: Cash Check Credit Card *(Visa, MasterCard, Discover, American Express)*

A twenty-five dollar ($25.00) returned check fee will be assessed to the patient account per incident.

For convenience, payments may be made online at **www.ePayItOnline.com.** To utilize this service you will need your account number, access code, and Code ID. This information can be found on the patient statement you will receive reflecting your balance. ***Patients who no-show may be subject to a no-show fee.***

PENDING APPROVALS FOR SERVICES: In the event we are unable to obtain approval for services and you wish to proceed, we will not bill your insurance. Services will be reduced to the in-network insurance allowable amount and will apply to the patient's responsibility.

Patient and/or Debtor Signature: _____ Date _____/_____/_____

Additional financial explanations are continued on the back side of this page

AdvancedHEALTH

WORKERS' COMPENSATION INJURIES: Written approval/authorization by your employer and/or workers' compensation carrier prior to your initial visit is needed. We will contact your case manager and/or supervisor to confirm your workers' compensation injury. If this claim is denied, for any reason by your employer or your employer's workers' compensation carrier, you will be responsible for payment in full. If denial is made by workers' compensation, health insurance can be filed for these denied services and you will be held responsible for the account.

MOTOR VEHICLE ACCIDENTS (MVA's) – Yes, I was involved in a MVA on _____/ _____/ _____. Unless prior agreement has been reached or I am a Medicare recipient, my **health insurance** will be filed for services related to this accident. In the event I do not provide insurance information upon initial visit, I understand insurance denials may occur depending on type of service(s) received or carrier specific filing requirements. I agree, as the patient or patient's guardian, I am ultimately responsible for all balance(s) due to this facility and/or its physician(s) for services rendered regardless of insurance denial(s) or unfavorable case outcomes. If I have chosen an attorney to oversee my case, this financial agreement will serve as a Letter of Protection to my attorney. I further understand my account may be handled by an outside entity that specializes in attorney lien accounts at the facilities discretion.

_____ Yes, I have chosen to retain an attorney. Signed: _____ Date: _____/_____/_____

Attorney Name: _____ Phone: _____

BILLING INFORMATION

STATEMENTS:
A statement of account will be provided to you if insurance has paid leaving a patient portion, denied or no response is received. Due to the type of service we provide, you may receive billing from more than one practice, otherwise known as split billing. The balance on your statement is due and payable within 30 days of receipt unless other arrangements are made with our billing department. The statement will be sent to the address provided at the time of service. In the event your mailing address changes after your service date and your account has not been paid in full, you are required to notify our billing office of this change by calling 615.851.6033 ext. 2067. In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child at time of service will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, court documentation is required for any guarantor address changes, otherwise, it is the authorizing/custodial parent's responsibility to collect from the other parent. Any account with a credit balance of less than <$5.00> will not be refunded without specific request from the patient/debtor.

DELINQUENT ACCOUNTS:
We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If we have to refer your account to a collection agency, you agree to pay all of the collection costs, which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs. In case of suit, you agree the venue shall be Davidson County, Tennessee. In addition, we reserve the right to deny future non emergency treatment for any and all debtor-related unpaid account balances.

WAIVER OF CONFIDENTIALITY:
You understand if your account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

MEDICAL RECORDS:
You will be required to request in writing or sign a medical authorization form for the release of your medical records to any organization or physician. If the request is for a party other than the originally billed insurance and/or party, a **$20.00 medical records fee** will be required on each occasion.

Notice Of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

Patient Name or Legal Guardian: _____

Signature: _____

Date: _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date: _____ Initials:_____

Reason: _____

_____

AdvancedHEALTH