Patient Intake Form

VASCULAR INTERVENTIONAL PHYSICIANS

The following questionaire is intended to help us better evaluate and treat your medical problems. We appreciate you filling it out in its entirety. Should you have any questions about what information to include don't hesitate to ask the office staff.

1. Date of Appointment:

Last Name: | First Name: | Middle Initials: | Date of Birth:

Age: | Sex: ○ Male ○ Female | Social Security No.: | Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed

Home Address: | Apt./Unit #: | City: | State: | Zip Code:

Home Phone: | Cell Phone: | Preferred Phone: ○ Home ○ Cell

May we contact you via text message? ○ Yes ○ No

Email Address:

Would you like to be contacted by email? ○ Yes ○ No

2. **In Case of Emergency:**

Contact Name: | Relationship: | Phone:

3. Preferred Pharmacy (Local): | Phone:

Primary Care Physician: | Phone:

4. Primary Insurance: | ID Number:

Secondary Insurance: | ID Number:

5. Please list allergies (medications or food) and type of reaction (rash, difficulty breathing, etc.):

	Allergy	Reaction
1		
2		
3		

6. Please list all medications (including over the counter, vitamins and herbals):

	Medication	Strength and Frequency	Reason for Use
1			
2			
3			

7. Please list all implants (penile, breast, pacer, etc.):

_____

_____

_____

_____

8. Please check any of the following syptoms you have experienced in the past 6 months. General:

- ☐ Easily fatigued
- ☐ Fatigued only after exercise
- ☐ Fatigued upon walking
- ☐ Excessive weight gain
- ☐ Excessive weight loss
- ☐ Night sweats
- ☐ Fever

9. Blood:

- ☐ Anemia (low blood count)
- ☐ Bleeding disorders
- ☐ Taking Coumadin
- ☐ Easy clotting
- ☐ Blood clot
- ☐ DVT

10. Skin:

- ☐ Bleeding
- ☐ Easily bruising
- ☐ Sores
- ☐ Itching
- ☐ Scaling
- ☐ Varicose veins
- ☐ No healing leg/foot wounds

11. Glands:

- ☐ Enlargement
- ☐ Pain
- ☐ Drainage
- ☐ Lymphoma

12. Eyes:

- ☐ Glasses
- ☐ Cataracts
- ☐ Trauma
- ☐ Infection
- ☐ Temporary blindness
- ☐ Visual loss
- ☐ Glaucoma

13. Ear:

- ☐ Infection
- ☐ Loss of hearing
- ☐ Pain

14. Nose:

- ☐ Sinus infection
- ☐ Nose bleeds
- ☐ Runny nose

15. Mouth/Throat:

- ☐ Difficulty chewing
- ☐ Excessive tongue movement
- ☐ Pain
- ☐ Dentures
- ☐ Frequent sore throat
- ☐ Hoarseness
- ☐ Pain or difficulty swallowing

16. Neck:

- ☐ Limitation of movement
- ☐ Pain
- ☐ Stiffness
- ☐ Trauma
- ☐ Weakness
- ☐ Swelling

17. Respiratory:

- ☐ Asthma
- ☐ Coughing
- ☐ Lung infections
- ☐ Coughing up mucus
- ☐ Coughing up blood
- ☐ Shortness of breath at rest
- ☐ Shortness of breath after excertion

18. Heart/CV:

- ☐ Irregular heart beat
- ☐ Chest pain
- ☐ Cold hand and/or feet
- ☐ Pain in legs after walking
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Swelling of hands and/or feet

19. GI:

- ☐ Nausea
- ☐ Indigestion
- ☐ Vomiting
- ☐ Abdomen pain
- ☐ Vomiting blood
- ☐ Jaundice (yellow skin)
- ☐ Blood in stool

20. Genitourinary:

- ☐ Change in color or urine
- ☐ Decreased urination
- ☐ Painful urination
- ☐ Frequent urination at night
- ☐ Increaed urination
- ☐ Change in menstual cycle
- ☐ Erectile dysfunction/Impotence

21. Skeletal:

- ☐ Genralized weakness of muscles
- ☐ Muscle paralysis
- ☐ Decreased in muscle size
- ☐ Decrease in muscle strength
- Involuntary movement
- ☐ Arthritis
- ☐ Joint pain

22. Neurological:

- ☐ Dizzness
- ☐ Falls/Balance difficulty
- ☐ Slurred speech
- ☐ Severe headaches
- ☐ Seizure
- ☐ Burning pain/Numbness/Tingling
- ☐ Low back pain

23. Psychiatric:

- ☐ Memory loss
- ☐ Difficulty focusing
- ☐ Depression
- ☐ Mood swings
- ☐ Sleep disturbance
- ☐ Black outs
- ☐ Light headedness

Patient

_____

Signature

6286 Briarcrest Ave. Ste 300
Memphis, TN 38120
FAX 901.531.7199

55 Physician's Lane
Southaven, MS 38671
FAX 662.996.2214

VASCULAR INTERVENTIONAL PHYSICIANS

John Braun, M.D.
Aron Chary, M.D.
David Cohen, M.D.
Henry Dalsania, M.D.
W. Woodruff, M.D.
Katrina Gates, ACNP
Tyson Stone, FNP-C
Jenna Scruggs, FNP-C

901.747.1007

A Division of Mid-South Imaging & Therapeutics, P.A.

www.vipphysiciansmemphis.com

To our patients: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY.

VASCULAR INTERVENTIONL PHYSICIANS
NOTICE OF PRIVACY PRACTICES
(Summary Notice- Patient Copy)

PLEASE REVIEW THIS PAGE, SIGN BELOW, AND RETURN THIS COVER PAGE TO THE STAFF PERSON WHO GAVE IT TO YOU.

Upon request, you may receive a longer notice document, please request one from our staff who provided this page to you.

Please keep longer notice document and take it home with you. You may review the long form notice either now or later. In either case, let us know if you have any questions after reviewing it.

UNDERSTANDING YOUR MEDICAL RECORD/ HEALTH INFORMATION:

Each time you visit a health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. The doctors and staff of our practice use and maintain this health information relating to the care you receive from us.

The longer notice contains information to help you understand what is in your medical record and how your health information is used. This helps you ensure the accuracy of such information, and helps you better understand who, what, when, where, and why others may have access to your health information.

Signature of Patient: _____

Patient Name (please print) _____

If personal representative, please list relationship: _____

(For office use only)

VIP staff person's name: _____ Date: _____

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Friends and Family Designation Form

FIRST AND LAST NAME OF PATIENT: _____

PATIENTS DATE OF BIRTH: _____

I understand that Vascular Interventional Physicians, a division of Mid- South Imaging & Therapeutics, P.A. ("VIP"), may disclose information about my care or payment for my care to family member(s) or close personal friend(s) whom I designate below:

1. Name: _____ Relationship: _____
2. Name: _____ Relationship: _____
3. Name: _____ Relationship: _____

I understand that VIP is subject to the federal HIPAA privacy rules and may only disclose to any person I designate above the information that is relevant to that person's involvement in my care or payment for my care. In the event of an emergency or if I am incapacitated, VIP may, in the exercise of its professional judgment, determine whether a disclosure is in my best interests and, if so, disclose information directly relevant to the person's involvement with my care or as needed for notification purposes.

I understand that designation family and friends on this form is voluntary. I understand that I have the right to revoke this designation, in writing, at any time, by contacting Vascular Interventional Physicians. I understand that such revocation is not effective to the extent that VIP has already relied on this form for the use or disclosure of my information.

This designation will be effective from the date signed below until the date on which I am no longer receiving services from VIP (unless sooner revoked by me writing, as described above).

Signature: _____ Date: _____

Print name of patient: _____
Or personal representative, if applicable

Relationship to patient: _____

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Authorization to Release / Obtain Medical Records

I hereby authorize the disclosure of information from the health records of:

Patient's First Name_____ Patient's Last Name: _____

Phone Number_____ DOB: _____

Health information to disclose:

- All information
- Progress notes
- Treatment summary
- Labs
- Imaging studies
- Other (specify)_____
- None

Method of Disclosure: Doctors Name or Facility Name, if more than one doctor please leave it blank.

- Release medical records from Vascular Interventional Physicians to:

  Name: _____

  Phone or fax number: _____

- Release medical records to Vascular Interventional Physicians from:

  Name: _____

  Phone or fax number: _____

Expiration: unless otherwise revoked by you, this authorization shall remain in effect until such time as your relationship as a patient of Vascular Interventional Physicians is officially ended.

Signature of patient or personal representative_____

Printed Name of patient or personal representative_____

Relationship to patient (if representative) _____

MIDSOUTH IMAGING

VASCULAR INTERVENTIONAL PHYSICIANS

EAST MEMPHIS IMAGING

BILLING NOTIFICATION

Please expect to receive a bill for your medical imaging services. This bill will be for both technical and radiology reading fee (Global Billing).

You will receive a text message with a link to your bill from our billing company and a hard copy will be sent to you via the mail.

If you have labs or pathology completed during your visit, you will receive a separate bill from the lab and/or pathology company.

I hereby expressly consent to allow the Facility and/or Provider (and/or business associates/third party collection agencies of the Facility and/or Provider) to contact me (including, but not limited to, through the use of contact information and/or telephone numbers that I have provided to the Facility and/or Provider) via telephone, text message, cellular phone, electronic mail and/or any other form electronic communication using pre-recorded messages, auto-dialers, and /or other forms of automated/electronic communication. Electronic communication can be intercepted in transmission or misdirected. Your use of electronic communication to us indicates that you acknowledge and accept the possible risks associated with such communication.

Billing Contact: Call 800-475-3698

This form has been explained to me. I have been given the opportunity to ask questions. My questions have been answered to my satisfaction, and I do understand my financial responsibility.

Patient Name _____

Guardian if Patient is under 18 _____

Patient/ Guadian Signature _____

Date _____

Employee Initials _____

VASCULAR INTERVENTIONAL PHYSICIANS

Name: _____ Date: _____

Address: _____ City, State, Zip: _____

Date of Birth: _____Home Phone: _____ Mobile Phone_____

Email address: _____ Referring Physician: _____

Emergency Contact: _____Contact phone: _____

Would you like to authorize someone other than yourself to have access to your protected health information including all items of care, testing, and billing? Yes _____ No _____

If yes, please list their name: _____ Their date of birth: _____

Patient Registration and Consent for Treatment

Authorization for Treatment

I hereby consent to and permit the attending physician and other medical staff to provide treatment and care as may be deemed necessary and available to me during my office visit or outpatient procedure, including but not limited to tests, examinations, administration of medications, local anesthetics, x-rays and medical and surgical treatments, and other necessary procedures. With this consent, I authorize Mid-South Imaging and Therapeutics, P.A./ Vascular Interventional Physicians ("VIP") to obtain and review my medical records from any external healthcare providers, including doctors, clinics, hospitals, and pharmacies, as necessary for my treatment and care.

Release of Medical Information

With this consent, Mid-South Imaging and Therapeutics, P.A./ Vascular Interventional Physicians ("VIP") may use and disclose my protected health information for treatment, payment, and healthcare operations as explained in the Vascular Interventional Physicians Notice of Privacy Practices. I also authorize release of my protected health information to Mid-South Imaging and Therapeutics, P.A. / Vascular Interventional Physicians ("VIP"), government agencies (such as Medicare and Medicaid), insurance carriers, and other providers for treatment purposes. I understand that I may authorize a personal representative to have access to my protected health information as well.

Financial Responsibility

With this consent, I authorize Mid-South Imaging and Therapeutics, P.A. / Vascular Interventional Physicians ("VIP") and/or their representatives to review my insurance coverage with my insurance company. I request that payment of authorized benefits be made directly to Mid-South Imaging and Therapeutics, P.A. / Vascular Interventional Physicians ("VIP") on my behalf. I fully understand that I am financially responsible for any and all amounts not otherwise paid by my insurance carrier or worker's compensation. I also certify the information on this form, given by me for payment under Title XVIII (Medicare) is correct and complete.

Notice of Privacy Practices

With this consent, Mid-South Imaging and Therapeutics, P.A. / Vascular Interventional Physicians ("VIP") may call, text or email my home or other alternative location and leave messages or voicemail in reference to any items that assist them in carrying out treatment, payment and health care operations. I understand that I may revoke my consent in writing except to the extent that Mid-South Imaging and Therapeutics, P.A. / Vascular Interventional Physicians ("VIP") has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Mid-South Imaging and Therapeutics, P.A. / Vascular Interventional Physicians ("VIP") may decline to provide treatment to me.

I acknowledge that I had the opportunity to review the Notice of Privacy Practices. I understand I may request a paper or electronic copy of this policy to keep. Initial here _____

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

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____