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 Initial: ____ Race: ____ 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
- ☐ Burning pain/Numbness/Tingling
- ☐ Severe headaches
- ☐ Seizure
- ☐ 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

Cancellations and Missed Appointments

Our goal is to provide quality individualized medical care. "Late cancellations" and "No Shows" are barriers for individuals who need access to medical care in a timely manner. *We recognize that certain life events make it difficult to notify us of the need to cancel or reschedule an appointment.* If you must cancel an appointment, please follow the guidelines below.

Cancellation
In order to be respectful of the medical needs of other patients, please be courteous and notify Vascular Interventional Physicians when you are unable to show up for a scheduled appointment or procedure. We require that you notify the center 24 hours in advance. Two less than 24 cancellations will result in a full missed/no show appointment fee. This timely notification will allow another individual an opportunity to receive treatment. *Failure to cancel a scheduled appointment in a timely manner will be recorded in the medical record.

How to Cancel Your Appointment
To cancel appointments, please call 901-747-1007. If you do not reach the receptionist, you may leave a detailed message on our voicemail. If you would like to reschedule your appointment, please include a telephone number. A clinic coordinator will contact you to schedule another appointment that better meets your needs.

New Patients - Missed Appointment / No Show
Established Patients Missed Appointment/ No Show
Missed Procedure Appointment/ No Show for Procedures

A *no show* exists if you fail to appear for a scheduled appointment.
*Failure to appear for a scheduled appointment or procedure is recorded in the medical record.

- ***Missed appointment/ no show, will be followed up by a clinic coordinator.***
- ***Missed appointments and/or late cancellation will result in a $50.00 fee for clinic and imaging appointments.***
- ***Missed procedure appointment/ no show will result in $150.00 fee.***
- ***Two less than 24-hour cancellations will result in a full missed/no show appointment fee of $50.00.***

I do hereby acknowledge that I have received and read the guidelines above and have had any portion of the guidelines, which I do not understand, explained to me.

____ _________________________

Patient or Guardian Signature Date

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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: _____________________________

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 notification 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.

Any credits remaining after an insurance claim is paid will be applied to open balances for any account due to Mid-South Imaging & Therapeutics, P.A. or its subsidiaries. (Subsidiaries include: Desoto Imaging Specialist, East Memphis Imaging, & Vascular Interventional Physicians)

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:** ___________________