PATIENT REGISTRATION

1) Patient Information:

Name: _____ **Sex:** Male / Female (circle one)

Social Security #: _____-_____-_____ **Birth Date:** _____/_____/_____

Address: _____

(CIRCLE ONE) Marital Status: Single / Married / Divorced / Widowed / Other

(CIRCLE ALL THAT APPLY) Race: Black or African American / White / Asian / American Indian or Alaska Native

Hawaiian or other Pacific Islander / Other Race_____ / Declines to specify

Home#: _____ Cell#:_____

Work# _____

Email Address _____

EMPLOYMENT STATUS: Full-time___ Part-time ___ **Are you enrolled in Hospice?** ( ) Y ( ) N

2) Spouse / Parent Information:

Name: _____ **Sex:** Male / Female

(If Primary Insured) Social Security # _____-_____-_____ **Birth Date** _____/_____/_____

Relationship: _____ **Employer:** _____

Address_____

Home #: _____ Work #: _____ Cell#:_____

3) Emergency Contact other than Spouse:

Name: _____ **Relationship:** _____ ( )M ( )F

Address _____

Home#: _____ Work#: _____ Cell#: _____

4) Insurance Information:

Primary insurance: _____ **Policy #** _____ **Group #** _____

Name of primary subscriber_____ **DOB** ____ /____ /____ **SSN** _____ - _____ - _____

Employer/Group Name _____

Secondary ins: _____ **Policy #** _____ **Group #** _____

Name of primary subscriber_____ **DOB** ____ / ____ / ____ **SSN** _____ - _____ - _____

Employer/Group Name _____

5) I hereby certify that all information given is true and correct to the best of my knowledge and ability and therefore hereby grant permission to East Texas Vascular Associtates to employ such medical, surgical, and x-ray procedures as my doctor may consider necessary in my diagnoses and treatment. Ii authorize the holder of medical or other information to release to my insurance carrier, governmental agency or its intermediary, any information needed for this or a related insurance claim. **I understand that insurance claims are filed as a courtesy and agree to pay any charges incurred by me to East Texas Vascular Associates, PA.**

Patient Signature_____ **Date** _____

Patient Name: _____

DOB - _____ Age - _____ Sex: M or F

Primary Care Physician: _____ Specialty Physician: _____

Referring Physician: _____ Phone# - _____

Primary Pharmacy: _____ Location/Phone #: _____

List Current Medications AND Dosages (**including** vitamins, supplements, and ASPIRIN:

MEDICATIONS	**DOSAGE**	**HOW MANY/HOW OFTEN**

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? YES _____ NO _____

If yes, please list: _____

Are you allergic to Iodine? YES _____ NO _____

Have ***you ever*** been diagnosed or experienced the following syndromes or conditions? **(Circle Y or N)**

Y N Claustrophobia
Y N Cancer - Where? _____
Y N Diabetes
Y N On Dialysis? Which Days? _____
Y N Hernia - Where? _____
Y N Hypertension (high blood pressure)
Y N Coronary Artery Disease (heart disease)
Y N Atrial Fibrillation (abnormal heart rhythm)
Y N Esophageal Reflux (acid reflux)
Y N Hyperlipidemia (high cholesterol)
Y N Hepatitis
Y N HIV/AIDS
Y N TB (tuberculosis)
Y N COPD (chronic obstructive pulmonary disease)
Y N CHF (congestive heart failure)
Y N Hypothyroidism (low thyroid)
Y N Hyperthyroidism (high thyroid)
Y N Coronary Artery Bypass of Heart?
Y N Cardiac Pacemaker?
Y N Other Surgical Implants? (Metal?) Y or N Where _____

Social History:

Y N Do you drink alcohol?
How much? _____

Family History:

Y N Cancer - Who? _____
Y N Diabetes - Who? _____
Y N Heart Disease - Who? _____
Y N Stroke? - Who? _____
Y N Other: _____

LIST ALL SURGERIES WITH DATES: _____

Do you CURRENTLY smoke? **Y N** If no, are you a FORMER smoker? **Y N**
Do you use SMOKELESS tobacco products? **Y N**

Have you had a Colonoscopy in the last 10 years? **Y N**
Have you had a Mammogram in the last 12 months? **Y N**
Have you had a **RECENT** flu shot during flu season? **Y N** (Flu Season: Sept 1 last year to March 1 this year)
Have you **EVER** had a pneumonia shot? **Y N**

REVIEW OF SYSTEMS - **(Please CIRCLE Y or N):**
*****CIRCLE Y or N if you have recently experienced or currently have any of the following?*****

Y N Fatigue
Y N Weight Loss
Y N Fever
Y N Chills
Y N Night Sweats

Y N Vision Problems
Y N Blurry Vision
Y N Seeing Double
Y N Eye Discharge

Y N Loss of Hearing
Y N Ringing in the Ears
Y N Earache
Y N Ear Discharge

Y N Nasal Discharge
Y N Nasal Congestion
Y N Sinus Pressure
Y N Sinus Pain
Y N Sore Throat
Y N PostNasal Drip
Y N Hoarseness
Y N Allergies

Y N Cough
Y N Coughing up Sputum
Y N Blood
Y N Shortness of Breath
Y N Wheezing

Y N Chest Pain
Y N Short of Breath/Coughing @ Night
Y N Edema (swelling)
Y N Palpitations (heart pounding/racing)

Y N Decrease in Appetite
Y N Heartburn
Y N Difficulty Swallowing
Y N Nausea
Y N Vomiting
Y N Diarrhea
Y N Constipation
Y N Abdominal Pain
Y N Epigastric Pain (upper abdomin)
Y N Right Upper Abdomin Pain
Y N Bloating
Y N Jaundice (yellowing in eyes)
Y N Anal Pain
Y N Rectal Pain
Y N Pain with Bowel Movement
Y N Anal Itching
Y N Perianal Burning
Y N Bright Red Blood/Rectum
Y N Bloody Stools
Y N Black Tarry Stools
Y N Perianal Crack/Fissure
Y N Perianal Wound
Y N Fecal Incontinence
Y N History of Pancreatitis

Y N Urinary Frequency
Y N Urinary Incontinence
Y N Painful Urination
Y N Blood in Urine
Y N Urinate at Night (>2 times)

Y N Joint Pain
Y N Muscle Aches
Y N Muscle Weakness

Y N Numbness
Y N Tingling
Y N Headache
Y N Dizziness
Y N Fainting

Y N Skin Lesions

Y N Breast Discharge
Y N Breast Lump

Y N Excessive Thirst
Y N Intolerance to Heat
Y N Intolerance to Cold
Y N Easy Bruising
Y N Swollen Glands in Neck

Y N Depression
Y N Anxiety
Y N Sleep Disturbances

FEMALES:
Y N Vaginal Discharge
Y N Irregular Periods
Y N Painful Periods
Y N Heavy Periods
Y N No Periods >6 months
Y N Painful Intercourse
Y N Decreased Libido (sex drive)

MALES:
Y N Penile Discharge
Y N Testicular Lump
Y N Inadequacy of Erection
Y N Terminal Dribbling
Y N Urinary Hesitancy

EAST TEXAS VASCULAR ASSOCIATES, PA

Patient Name: _____ **DOB:** _____
(Put your initials on the following FIVE spaces)

POLICIES REGARDING MEDICATION PRESCRIPTIONS

_____ ** Patients are given prescriptions for pain following surgery and dismissal from the hospital. These prescriptions are usually all that will be needed for pain. Tylenol can be used to relieve any residual pain. If additional medication is required, the patient should call our office and speak to a medical assistant who will answer most questions after consulting the physician when required. Your medication can only be managed by *one* physician. If another physician (including the physicians at ETVA) is prescribing pain medication for you, the on-call physician at ETVA will **NOT** provide additional medication.

_____ ** Telephone calls related to medications and/or refills must be called in to your pharmacy before 2:00 pm Monday through Thursday and by 1:00 pm on Friday. Your pharmacy will then contact our office. Otherwise, the telephone call will **not** be handled until the next business day.

_____ ** Pain medication will NOT be refilled or prescribed over the telephone after hours, or on weekends or holidays.

_____ ** Please observe the above Policies to avoid problems and expensive ER visits for treatment. In order to emphasize our position on the matter, we request that you sign the following statement: *As a patient of the physicians of ETVA, I realize that I will in all likelihood be given prescriptions for medications. I further am aware that all medications have potentially harmful side effects and complications. I will do my best to follow ETVA Medication Policies, and ask my doctor to explain the common side effects and complications of the medications I am receiving. I am further aware that many narcotic pain medications are addictive and that I will inform myself as to their addictive potential.*

HIPPA, Notice of Privacy Practices, and Meaningful Use

_____ ** This office's Notice of Privacy Practices which explains how my medical information will be used and disclosed is posted in our waiting room. I understand that I am entitled to receive a copy of this document. Please provide us with your email address so that you can be invited to access our Patient Portal. It is also available on our website: www.etva.net

My email address is : _____

Patient Signature _____ **Date** _____

MY PERSONAL INFORMATION MAY BE RELEASED TO THE FOLLOWING PERSONS:
****NAME AND INFORMATION MUST BE COMPLETED ON REGISTRATION FORM****
(CHECK ALL THAT APPLY)
_____SPOUSE (listed on paperwork)
_____PARENT (listed on paperwork)
_____EMERGENCY CONTACT (listed on paperwork)

ADDITIONAL INDIVIDUALS TO RELEASE INFORMATION:

NAME OF INDIVIDUAL	RELATIONSHIP TO PATIENT	PHONE NUMBER
NAME OF INDIVIDUAL	RELATIONSHIP TO PATIENT	PHONE NUMBER

(Updated 6-17-16)

EAST TEXAS VASCULAR ASSOCIATES, PA

(Put your initials in all FOUR spaces and sign at the bottom)

_____ **ASSIGNMENT OF BENEFITS:** In consideration of the services rendered and/or to be rendered, I hereby irrevocably assign and transfer to East Texas Vascular Associates, P. A. (hereinafter referred to as the "Physician") all right, title, and interest in all benefits payable for the health care rendered, which are provided in any and all insurance policies, employee benefit plans, and/or third party actions against any other person or entity from whom my dependents or I am entitled to recover (hereinafter referred to as "Benefits"). Assignment and transfer shall be for the purposes of granting the Physician an independent right of recovery against such Responsible Parties, but shall not be construed to be an obligation of the Physician to pursue any such right of recovery. I hereby authorize *all* Responsible parties to pay directly to the Physician all benefits and amounts due for services rendered by the Physician. I understand that insurance claims are filed as a courtesy and if the Physician is not paid in full by proceeds of any Benefits, then this assignment does not release my obligation and liability to the Physician for payment of all services and items provided to the above-referenced patient or me by the Physician. In the event no Benefits are paid by my insurance company or health benefit plan, then I agree to pay Physician for charges determined to be my responsibility. I have been informed that payment arrangements can be made by contacting the Business Office of East Texas Vascular Associates, PA at 903-595-2636.

_____ **AUTHORIZATION:** I hereby grant permission to East Texas Vascular Associates to employ such medical treatment as my doctor may consider medically necessary in my diagnosis and recovery. I authorize the holder of my medical chart to release to my insurance carrier, governmental agency, or its intermediary, any information needed for this or a related insurance claim.

_____ **FINANCIAL POLICY: T**he staff is not able to give an accurate estimate of our doctor's services/fees prior to the physician rendering service. A new patient visit without insurance could range up to $500, depending on the severity of the visit; this does not include labs, x-rays, ultrasounds, etc. Our expectation is that all charges will be paid in full the day of the visit. **At the time of office visits, all patients with insurance/healthcare coverage are required to pay their copays in full.** All patients are expected to present proper picture identification and insurance cards at each visit. Patients will not receive statements until after the insurance has paid their portion of the claim; therefore balances on statements reflect patient responsibility and are due upon receipt. Patients are required to provide requested information to insurance company representatives upon their request and are responsible to resolve all coverage issues with their insurance company. All East Texas Vascular Associates Physicians are contracted with Medicare. It is the responsibility of the patient to verify that the Physician is in network and to obtain all required referrals prior to the appointment. Certain non-covered items may still be the responsibility of the patient and will be subject to collection by the Physician. **All accounts left unpaid for 90 days could stop any future appointments with the physician until the account is paid in full.** Prior to scheduling surgical/diagnostic procedures, all patients without insurance/healthcare coverage are required to contact the Business Office to make arrangements. **Surgery deposits are to be received no later than 48 hours prior to surgery.** However, if not paid earlier than 48 hours before surgery, only cash or credit card will be accepted. Patients not able to present the required deposit 48 hours prior to service may have their procedure re-scheduled. Patients may also be required to sign a payment plan instituting monthly payments not to exceed six months.

_____ **Out-of-State Provider Access Bill, HB270 - Exclusive Forum Selection & Choice of Law Agreement**

By signing this form, I agree to all of the following on behalf the named patient and all of that patient's heirs and beneficiaries:

- I agree to all health care rendered (or not rendered) to the patient by the health care provider, including all employees, contractors, and representatives of the provider, shall be governed exclusively by Texas law, and not by the law of any other state or any foreign nation. In no event shall the law of any other state or any foreign nation apply to the health care rendered to the patient.
- I agree that any dispute, lawsuit, cause of action, or other claim that relates in any way to the health care rendered (or not rendered) to the patient shall be brought only in a Texas court in the county or district in which all or substantially all of the health care services were rendered (or should have been rendered).
- I agree not to file in the courts of any other state any dispute, lawsuit, cause of action, or other claim that relates to the health care rendered (or not rendered) to the patient.
- I understand that this Agreement applies to all claims arising out of or relating to the health care rendered (or not rendered) to the patient by the health care provider, including all employees, contractors, and representatives of the health care provider, whether the claim is brought by me or someone else.
- I understand that the choice of law and forum selection provisions of this Agreement are mandatory, not permissive.

BY SIGNING, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE ABOVE POLICIES OF EAST TEXAS VASCULAR ASSOCIATES, PA.

Signature: _____ **DATE:** _____

Print Name: _____ **DOB:** _____

Revised: 6/17/2016