ADVANCED VASCULAR ASSOCIATES
AdvancedVascular.com

Main Phone: 973-540-9700
Fax: (973) 540-9717

(Please print)

Today's Date: _____

Patient Information

Name: _____
First Name Middle Last Name

Date of Birth: _____ Age: _____ Social Security #: _____

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other _____

Home Phone: _____ Cellular: _____

E-Mail: _____

Home Address:

Address: _____ Bldg/Apt #: _____

City: _____ State: _____ Zip Code: _____

Employer Information

Employer: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Work Phone: _____

Emergency Notification

In case of emergency, who should be notified? _____

Relationship to patient: _____

Email: _____

Phone Numbers:

Home: _____ Work: _____ Cellular: _____

Reviewed by: _____ Date: _____

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MEDICAL HISTORY

Today's Date: _____

Patient Name: _____ **DOB:** _____

Physicians

1. Primary Care Physician _____ Phone# _____

Address: _____

2. Physician who referred you today _____ Phone# _____

Address: _____

3. Cardiologist (if applicable) _____ Phone# _____

Address: _____

4. Nephrologist (if applicable) _____ Phone# _____

Address: _____

5. Other Physician _____ Phone# _____

Address: _____

Dialysis Information (if applicable)

Type: ☐ HEMO-DIALYSIS ☐ PERITONEAL (PD)

Shift/Time of Dialysis: _____

Days: ☐ MON ☐ TUES ☐ WED ☐ THUR ☐ FRI ☐ SAT

Dialysis Center: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____

Nephrologist: _____

ADVANCED VASCULAR - Medical History

Patient Name: _____ DOB: _____

Please CHECK all that apply to your history and add any conditions not listed

General:
- ☐ High Blood Pressure
- ☐ High Cholesterol

Vascular:
- ☐ Aneurysm (Body Location _____)
- ☐ Blood Clots (Body Location _____)
- ☐ Carotid Artery Disease
- ☐ Peripheral Artery Disease / ☐ Leg bypass surgery or stents
- ☐ Varicose Veins

Cardiac:
- ☐ Atrial Fibrillation / ☐ Other Heart Rhythm Problem /
- ☐ Pacemaker / Defibrillator (Chest Location: ☐Right ☐Left)
  Brand: _____
- ☐ Coronary Artery Disease / ☐ Heart Attack
- ☐ Heart Bypass Surgery / ☐ Cardiac Stents
- ☐ Congestive Heart Failure
- ☐ Congestive Heart Disease
- ☐ Heart Valve Disease / ☐ Heart Murmur
- ☐ Heart Valve Surgery

Pulmonary:
- ☐ Asthma / ☐ COPD / ☐ Emphysema
- ☐ Oxygen Dependence
- ☐ Pneumonia
- ☐ Sleep Apnea

Neurological:
- ☐ Migraine Headache (Aura: Yes or No)
- ☐ Peripheral Neuropathy
- ☐ Seizures
- ☐ Stroke
- ☐ TIA or Mini Stroke (Stroke-like symptoms that typically resolve in minutes)

Endocrine:
- ☐ Diabetes: ☐ Type I ☐ Type II
- ☐ Thyroid Disease

Renal:
- ☐ Dialysis Dependence
- ☐ Kidney Failure
- ☐ Kidney Disease (Type _____)

Hematologic / Lymphatic:
- ☐ Anemia
- ☐ Blood or Clotting Disorder
- ☐ Cancer (Body Location _____)
- ☐ Lymphedema

Gastrointestinal:
- ☐ Diverticular Disease
- ☐ GERD / Heartburn
- ☐ Hepatitis / Liver Disease (Type _____)
- ☐ History of Stomach Ulcer
- ☐ Pancreatic Disease

Other:
- ☐ Arthritis / ☐ Spine Disease / ☐ Back Pain
- ☐ Autoimmune (Rheumatoid Arthritis, Lupus, Vasculiis)
- ☐ Chronic Pain / Fibromyalgia
- ☐ Depression / Anxiety
- ☐ Enlarged Prostate
- ☐ Gout
- ☐ HIV / AIDS

☐ Additional: _____

_____

_____

_____

_____

SURGICAL HISTORY - (Please list all previous surgeries and year)

Date: _____ Procedure: _____

Date: _____ Procedure: _____

Date: _____ Procedure: _____

Date: _____ Procedure: _____

Date: _____ Procedure: _____

ADVANCED VASCULAR - Medical History

Patient Name: _____ DOB: _____

SOCIAL HISTORY

CIGARETTE SMOKING: CURRENT : # PACKS PER DAY_____ # YEARS SMOKING _____
QUIT: # YEARS SINCE QUITTING _____ # YEARS SMOKING _____
☐ NEVER
CHEWING TOBACCO: ☐ YES ☐ NO ☐ PAST
ALCOHOL CONSUMPTION: ☐ NONE ☐ RARE
DRINKS / DAY_____ #DRINKS / WEEK _____ #DRINKS / MONTH _____

FAMILY HISTORY

Please check if applicable / provide relative:

☐ Aneurysm_____ ☐ Stroke_____ ☐ Blood clots_____ ☐ Blood Disorder_____
☐ Heart Disease_____ ☐ Sudden Death_____ ☐ Diabetes_____ ☐ Varicose Veins _____

Please list any other family medical history:

_____

_____

_____

LIVING WILL OR ADVANCE DIRECTIVE: ☐ YES ☐ NO

SYSTEM REVIEW
(CHECK ANY SYMPTOMS OCCURRING NOW OR WITHIN THE PAST MONTH)

Constitutional
- ☐ Fever
- ☐ Chills
- ☐ Weight loss
- ☐ Weight gain
- ☐ None

Cardiovascular
- ☐ Chest pain
- ☐ Leg / ankle swelling
- ☐ None

Respiratory
- ☐ Cough
- ☐ Shortness of breath
- ☐ Pain with breathing
- ☐ Coughing up blood
- ☐ None

Gastrointestinal
- ☐ Abdominal pain
- ☐ Abdominal pain after meals
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ None

Genitourinary
- ☐ Difficulty urinating
- ☐ Blood in urine
- ☐ None

Integumentary
- ☐ Dry skin
- ☐ Skin discoloration
- ☐ Skin ulcers
- ☐ Itching
- ☐ Rash
- ☐ None

Neurological
- ☐ Sudden muscle weakness
- ☐ Sudden paralysis or loss of feeling
- ☐ Sudden visual disturbance
- ☐ Sudden difficulty speaking or swallowing
- ☐ Dizziness / Vertigo
- ☐ Syncope (fainting spells)
- ☐ None

Musculoskeletal
- ☐ Leg pain with walking
- ☐ Leg pain at rest
- ☐ Back pain
- ☐ Joint pain
- ☐ None

Hematologic / Lymphatic
- ☐ Easy bleeding
- ☐ Enlarged lymph nodes
- ☐ None

Allergic / Immunologic
- ☐ Hives
- ☐ None

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MEDICATION RECONCILIATION

Name: _____ ALLERGIES: REACTION:

DOB: _____ (EX. DRUGS, FOOD, CONTRAST, NICKEL)

Today's Date: _____ _____

Pharmacy Name: _____ _____

Pharmacy Town: _____ _____

Pharmacy Phone #: _____ _____

Facility: _____ _____

_____ ☐ NO KNOWN DRUG ALLERGIES

MEDICATION:	**DOSAGE:**	**TIMES:**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

UPDATED:

DATE: _____ DATE: _____

DATE: _____ DATE: _____

DATE: _____ DATE: _____

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INSURANCE

Name: _____ **Date of Birth:** _____

Insurance Information

1. Primary Insurance Carrier _____ Subscriber Name _____

   Subscriber Date of Birth _____ ID # _____

   Relationship to Patient _____

2. Secondary Insurance Carrier _____ Subscriber Name _____

   Subscriber Date of Birth _____ ID # _____

   Relationship to Patient _____

CLAIM AUTHORIZATION FOR HEALTH INSURANCE AND MEDICARE PATIENTS

HEALTH INSURANCE COMPANY:

"I hereby authorize any physician, health care practitioner, hospital, clinic, or other medically-ralated facility to furnish any and all records, medical history, services rendered, or treatment given to me or any dependent for purposes of review, investigation, or evaluation of any claim submitted to the Health Insurer

If my coverage is under Group Contract held by an employer, an association trust fund, union, or similar entity, this authorization also permits disclosure to them for the purposes of utilization review or audit.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with the insurer including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon me, my dependents and or heirs, executors and administrators"

MEDICARE:

"I request the payment of authorized Medicare benefits be made either to me or on my behalf to this office for any services furnished by that Physician to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

AUTHORIZATION TO PAY:

"I request payment of this claim and, if the payor accepts assignment, authorize payment direct to the physician or supplier for the services described."

AUTHORIZATION TO APPEAL CLAIM:

I authorize Advanced Vascular Associates, to act on my behalf in pursuing a benefit claim. As my authorized representative, Advanced Vascular Associates shall have full authority to act and receive notices on my behalf. Claims appeals cannot be initiated without my written consent.

_____ _____

Signature of Insured/Guardian Date

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PAYMENT POLICY AND FINANCIAL AGREEMENT

Thank you for choosing Advanced Vascular Associates as your healthcare provider. We are committed to providing you with the best possible care. The medical services you seek imply a financial responsibility on your part. If you have medical insurance, we will do our best to ensure you receive the maximum allowable benefits. In order to achieve these goals, we need your assistance in understanding our payment policy. We are happy to help with any questions regarding your financial responsibility.

1. You acknowledge and agree to the established policies and procedures of Advanced Vascular Associates, including but not limited to this PAYMENT POLICY AND FINANCIAL AGREEMENT. These policies may be periodically changed, without notice.
2. You are ultimately responsible for all payment obligations arising out of your treatment and guarantee payment for these services. Such responsibilities include deductibles, co-payments, co-insurance, noncovered cosmetic services, or any other balance indicated by your insurance carrier. If you are not prepared to make your co-pay or other patient responsibility amount, your visit may be rescheduled by Advanced Vascular Associates.
3. You are responsible for understanding your insurance policy. The policy is a contract between you, your employer and your insurance company. You will be required to follow our registration procedures, including updating your personal information and presenting current insurance cards every six months. If we do not have your card on file or are unable to verify your benefits, you will be treated as a self-pay patient. As a self-pay patient, you are required to pay for all services.
4. Your insurance company may require a referral to see a specialist. In this case, you must initiate the request with your primary care provider. Several insurance plans require pre-authorization for certain services. Our office will obtain the authorization if necessary.
5. Advanced Vascular Associates will comply with the No Surprises Act protocol. If we do not participate with your insurance, you will receive our fees in writing prior to your visit. You agree to sign the disclosure and pay in full.
6. Cosmetic procedures are not covered by your insurance policy. Our Billing Department will discuss fees and payment arrangements.
7. You will receive an itemized billing statement that contains the total cost of your services. You may receive this statement within twenty (20) days after your insurance company has responded to the claim . You must notify us of any errors or objections within thirty (30) days or the fees and services will be deemed accurate. If there is a problem with your account, it is your responsibility to contact our Billing Department.
8. Payment of any account balance is due within thirty (30) days of receipt of your billing statement. If any balance on your account is over ninety (90) days past due, your account will be in default and referred to a collection agency. We encourage our patients to contact our Billing Department to discuss payment options.
9. We accept payment by cash, check, credit card, money order or Care Credit (interest free financing). You may pay via our online patient portal.

I have read and understand this financial agreement, and realize that all fees regardless of insurance coverage, are ultimately my responsibility.

Patient Signature | Patient Name | Date

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Name: _____ **Date of Birth:** _____

GENERAL CONSENT AND AUTHORIZATION

By signing this form, I consent to and authorize the staff and physician(s) at Advanced Vascular Associates to treat me or my dependent. I understand this could include tests, medication prescription and/or administration, education, or other medical health interventions. I understand that this consent will be valid and remain in effect as long as I attend any of the offices at Advanced Vascular Associates.

To the extent permitted by applicable law, I authorize Advanced Vascular Associates (or their designees) to collect information about my prescription history from my pharmacy and insurers and give my pharmacy and insurers permission to disclose such information.

I give consent to All employees, agents, and members of the medical staffs of Advanced Vascular Associates to access All my electronic health information through various organizations, providers, programs and Carequality, in connection with my health care services.

VALUABLES

I understand that Advanced Vascular Associates recommends that all personal belongings and valuables be given to a family member or a friend . I assume all risk for loss or damage to any personal belongings retained by me. Advanced Vascular Associates will not replace or reimburse me for any personal belongings which are lost, broken, or stolen during my visit.

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

By signing this form, I acknowledge that I have received a copy of the Notice of Privacy Practices for Protected Health Information (PHI) for Advanced Vascular Associates. This notice provides a complete description of the uses and disclosures of my PHI. By Signing this form, I consent, Advanced Vascular Associates, to use and disclose protected health information about me to conduct treatment, payment, and healthcare operations (TPO). I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Advanced Vascular Associates may decline to provide treatment to me. With my consent, Adyanced Vascular Associates may call, email, or mail to my home or other designated loca~on any items that assist the. practice in conducting TPO.

Is there a person that you authorize to receive/ discuss your PHI? ☐ YES ☐ NO

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Release Information From:
Medical Facility (Name, Address, Phone):

_____

_____

_____

_____

Release Information To:

ADVANCED VASCULAR ASSOCIATES

131 Madison Avenue, Second Floor

Morristown, New Jersey 07960

PURPOSE OF RELEASE: ☒ Treatment / Continued Care

INFORMATION TO BE RELEASED: _____

Patient's Names (print) _____ Date _____

Signature of Patient or Legal Guardian _____ Parent/Legal Guardian Name (print) _____