

Advanced Vascular and Vein Center

4242 Farnam Street, Suite 490
Omaha, NE 68131



Patient Demographics

Name: _____
(First) (M.I) (Last)

DOB: ____/____/____ Age: _____ SS#: _____-_____-_____

Address: _____

_____, _____
(City) (State) (Zip)

Home Phone: () _____-_____ Cell Phone: () _____-_____

Email Address: _____

Preferred Language: _____ Preferred Name: _____

Sex: Male Female Marital Status: Single Married Widowed Divorced Separated

Race: White American Indian Alaska Native Asian Black/African American Hispanic
Native Hawaiian/Pacific Islander Other

Employer Information

Employment Status: Full time Part time Retired Unemployed Other: _____

Patient Employer: _____ Occupation: _____

Work Address: _____

_____, _____
(City) (State) (Zip) Work Phone: () _____-_____

Emergency Contact Information

Name: _____ Relationship: _____

Contact Number: () _____-_____

Name: _____ Relationship: _____

Contact Number: () _____-_____

Name: _____ Relationship: _____

Contact Number: () _____-_____

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Patient Name: _____ DOB: _____

Reason for today's visit: _____

Referring Doctor or Office: _____ Primary Care Doctor: _____

Please check any of the following health problems you have had or have now:

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Stroke or Mini Stroke	<input type="checkbox"/> Emphysema (COPD)	<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> Pain in legs with walking	<input type="checkbox"/> Stomach Reflux/Heartburn	<input type="checkbox"/> Aneurysm Location: _____
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Kidney Problems/Failure	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Angina/Chest Pain	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Diabetes Type: _____
<input type="checkbox"/> Congestive Heart Failure (CHF)	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Pacemaker/ICD	<input type="checkbox"/> Bleeding or Clotting Problems	<input type="checkbox"/> Anemia
<input type="checkbox"/> Varicose Veins/Vein Stripping	<input type="checkbox"/> Abnormal Heart Rhythm/Atrial Fibrillation	<input type="checkbox"/> Other: _____

List previous surgeries/procedures and when:

Year	Surgery	Year	Surgery

Family History: Please check if the following health problems affect your family and identify their relationship to you, ie: mother, father, brother, sister, grandparent, child

<input type="checkbox"/> Asthma/Chronic Lung Disease _____	<input type="checkbox"/> High Cholesterol _____
<input type="checkbox"/> Bleeding Problem _____	<input type="checkbox"/> Kidney Disease _____

Do you take any of the following: Coumadin/Warfarin Who manages lab work? _____
 Clpidogrel/Plavix Apixaban/Eliquis Aspirin Pradaxa Other: _____

Preferred Pharmacy: _____ **Location:** _____

Are you currently on dialysis? No Yes (If yes, please complete the information below)

Name of dialysis center: _____ Dialysis Doctor: _____

Dialysis center address: _____

Dialysis Days: M/W/F T/Th/Sa

Please check if you have experienced any of the following symptoms:

	Endocrine	
<input type="checkbox"/> Intolerant to Heat or Cold	<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Sweating (Night Sweats)
	Cardiovascular	
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Ankle Swelling
If yes, please specify:	<input type="checkbox"/> Fainting	
<input type="checkbox"/> with exercise <input type="checkbox"/> at rest		
	Eyes, Ears, Nose & Throat	
<input type="checkbox"/> Blindness in one eye	<input type="checkbox"/> Change in vision	<input type="checkbox"/> Lack of vision in visual field
	Gastrointestinal	
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Change in appetite	<input type="checkbox"/> Weight loss
	Hematological	
<input type="checkbox"/> Blood clotting	<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Prolonged bleeding
If yes, please specify:		
<input type="checkbox"/> Artery <input type="checkbox"/> Vein		

Musculoskeletal/Skin		
<input type="checkbox"/> Back pain	<input type="checkbox"/> Cramping with exercise	<input type="checkbox"/> Heaviness/Achiness in Legs
<input type="checkbox"/> Numbness and/or Tingling	<input type="checkbox"/> Skin color changes	<input type="checkbox"/> Sores on legs and/or feet
<input type="checkbox"/> Leg pain at rest and/or night	<input type="checkbox"/> Arm discomfort with activity	

How far can you walk? _____ feet, _____ yards, _____ blocks

Location of your leg pain? Buttock Thigh Calf Foot

Neurological (Dominant Side: <input type="checkbox"/> Right <input type="checkbox"/> Left)		
<input type="checkbox"/> Difficulty moving a side or limb	<input type="checkbox"/> Numbness of a side or limb	<input type="checkbox"/> Paralysis
If yes, please specify:	If yes, please specify:	<input type="checkbox"/> Slurred Speech
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	<input type="checkbox"/> Seizures
Respiratory		
<input type="checkbox"/> Cough	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Snoring
	If yes, please specify:	
	<input type="checkbox"/> At rest <input type="checkbox"/> with exertion	
Psychological		
<input type="checkbox"/> Change in sleeping patterns	<input type="checkbox"/> Depression	<input type="checkbox"/> Difficulty concentrating
<input type="checkbox"/> Hearing voices		
Urological		
<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Pain with urination

GYN (Females Only)

Date of last menses: _____

Menses: Regular Irregular

Date of last mammogram: _____

Hormone Therapy: Current Past

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Insurance Information

PLEASE HAVE YOUR PHOTO ID & INSURANCE CARDS AVAILABLE FOR COPYING AT EACH VISIT. ALL COPAYS ARE DUE AT THE TIME OF THE SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

Primary Insurance

Insurance Carrier:	Effective Date:
Member ID:	
Group:	
Policy Holder Name:	Policy Holder DOB:
Policy Holder SSN:	Policy Holder Employer:

Secondary Insurance

Insurance Carrier:	Effective Date:
Member ID:	
Group:	
Policy Holder Name:	Policy Holder DOB:
Policy Holder SSN:	Policy Holder Employer:

Tertiary Insurance

Insurance Carrier:	Effective Date:
Member ID:	
Group:	
Policy Holder Name:	Policy Holder DOB:
Policy Holder SSN:	Policy Holder Employer:

**Information Release and Consent to Treatment
Private Insurance Authorization for Assignment of Benefits**

I, the undersigned, authorize payment of medical services to Advanced Vascular and Vein Center for any services furnished to me by the physician/s. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

I, knowing that I have a condition requiring diagnosis, treatment, or related medical care do hereby consent to such care, medical examinations, operations, procedures, therapy sessions, photographs, and/or treatment by my attending physician, their assistants, or designees as may be necessary in their professional judgment. I further acknowledge that no guarantees have been made to me as to the results of such care, medical examinations, operations, procedures, therapy sessions and/or treatments.

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Patient Financial Policy

We are committed to providing you with the best possible care, and will help you receive your maximum allowable insurance benefits. However, we need your assistance and your understanding of our payment policy. Your insurance contract is between YOU/YOUR INSURANCE COMPANY/YOUR EMPLOYER. (Please refer to enclosed document-“Understanding Your Insurance Coverage”) Not all services are covered by all contracts.

We participate and accept assignment from most major payers, which means covered charges, will be paid directly to us. If we do not participate in your insurance plan, you may still choose to be seen by the practice. As a courtesy to you, we will file a claim with your insurance carrier on your behalf. Any remaining balance will be billed to you once we have received a remittance from your insurance carrier.

Due to current federal and insurance regulations, ALL co-payments, co-insurance and deductibles are collected at the time of service. We accept cash or checks, and for your convenience, Visa, MasterCard, and Discover. Additional fees, which typically are not covered by insurance plans, will be charged for services such as copying of medical records and completion of disability forms. A fee of \$35.00 will be charged for checks returned for insufficient funds. An additional monthly fee may be charged on all past due accounts and co-pays not paid at time of visit. We encourage you to contact our **Billing Company** promptly for assistance in the management of your account. We are here to help you and will be happy to answer any questions you may have about your treatment or insurance coverage.

Billing Company:
USMD Billing
13036 SE Kent-Kangley Rd, Suite 360
Kent, WA 98030
Toll Free (844) 218-1178 (Option #5)

Patient Financial Agreement

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for ANY professional services rendered. I have read the above Patient Financial Policy and have provided the Practice with true and correct insurance information. I will notify you of any changes in my health insurance coverage.

A copy of this agreement may be used in place of the original.

(Signature of Patient, Policy Holder or Legal Guardian)

(Date)

(Printed Name)

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Understanding Your Insurance Coverage

Your insurance policy is an agreement between you and your insurance company. The policy lists a package of medical benefits such as tests, drugs, and treatment services. The insurance company agrees to cover the cost of certain benefits listed in your policy. These are called “covered services”.

Your policy also lists the kinds of services that are not covered by your insurance company. You have to pay for any uncovered medical care that you receive. Keep in mind that a medical necessity is not the same as a medical benefit. A medical necessity is something that your doctor has decided is necessary. A medical benefit is something that your insurance plan has agreed to cover. In some cases, your doctor might decide that you need medical care that is not covered by your insurance policy.

Insurance companies determine what tests, drugs and services they will cover. These choices are based on their understanding of the kinds of medical care that most patients need. Your insurance company’s choices may mean that the test, drug or service you need isn’t covered by your policy.

Your doctor will try to be familiar with your insurance coverage so he/she can provide you with covered care. However, there are so many different insurance plans that it is not possible for your doctor to know the specific details of each plan. By understanding your insurance coverage, you can help your doctor recommend medical care that is covered in your plan.

- ✓ Take the time to read your insurance policy. It’s better to know what your insurance company will pay for before you receive a service, get tested or fill a prescription. Some kinds of care may have to be approved by your insurance company before your doctor can provide them.
- ✓ If you still have questions about your coverage, call your insurance company and ask a representative to explain it.
- ✓ Remember that your insurance company, not your doctor, makes the decisions about what will be paid for and what will not.
- ✓ Remember that your doctor, not your insurance company, makes medical decisions and recommendations about what will benefit your health status.

Most of the things your doctor recommends will be covered by your plan, but some may not. When you have a test or treatment that isn’t covered, or you get a prescription filled for a drug that isn’t covered, our insurance company won’t pay the bill. This is often called “denying the claim”. You can still obtain the treatment your doctor recommended, but you will have to pay for it yourself.

If your insurance company denies your claim, you have the right to appeal (challenge) the decision. Before you decide to appeal, know your insurance company’s appeal process. This should be discussed in your plan book.

(Patient Initials)

(Date)

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Notice of Health Information Practices

Notice of Privacy Policies

Acknowledgement of Understanding Statement

I, _____, have had access to the Advanced Vascular and Vein Center, LLC, Notice of Privacy Policies.

I understand:

Each time I visit Advanced Vascular and Vein Center, LLC, a record of my visit is made. Typically, this record contains my symptoms, examination, test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as my health or medical record, serves as:

- Basis for planning my care and treatment.
- Means of communication among the many health professionals who contribute to my care.
- Legal document describing the care I received.
- Means by which I or a third-party payer can verify that services billed were actually provided.
- A tool in educating health professionals.
- A source of data for medical research, a source of information for public health officials charged with improving the health of this state and the nation.
- A source of data for Advanced Vascular and Vein Center, LLC’s planning and marketing.
- A tool which Advanced Vascular and Vein Center, LLC, can assess and continually work to improve the care rendered and the outcomes achieved.

Authorized Release:

I understand that Advanced Vascular and Vein Center, LLC, is only allowed to release medical information to the individual patient with the exceptions of minors, Worker Compensation cases, and any individual designated by patient, in writing, to access his/her medical records. This includes picking up medication, prescriptions, DME products and x-rays. I give permission to the following individual/s to have access to this information. Proof of ID must be shown any time information is received.

(Name)

(Relationship)

(Name)

(Relationship)

(Name)

(Relationship)

I can change this information at any time by notifying Advanced Vascular and Vein Center, LLC, in writing of the changes.

(Patient/Responsible Party Signature)

(Date)