South Valley Vascular
BASS MEDICAL GROUP

Vascular Consult

Name: _____ **Date:** _____

Date of Birth: _____ **Age:** _____

How did you hear about us? ☐ Referral ☐ PCP ☐ TV ☐ Friend/Family ☐ Other: _____

What physician referred you? _____ **Primary Physician:** _____

Who is your Podiatrist? _____ **Who is your Cardiologist?** _____

Who is your Nephrologist? _____ **Dialysis Facility:** _____

Dialysis Days: **M T W TH F S** **Time:** am/pm

Risk Factors: Do you have and/or have you ever had any of the following:

☐ High Cholesterol

☐ Aortic Aneurysm	☐ High Blood Pressure	☐ Heart Disease
☐ Irregular Heartbeat	☐ Stroke	☐ Clotting Disease
☐ Diabetes	☐ Pacemaker	☐ Congestive Heart Failure
☐ Kidney Disease	☐ Lung Disease	☐ Support Hose

Family History of Vascular Disease:

☐ Heart Disease	☐ Varicose Veins	☐ Aortic Aneurysms

Other medical problems: _____

How far can you walk comfortably? _____

Please List All Past Surgeries:

_____

_____

_____

Allergies to food/shellfish: _____ **Allergies to medicine:** _____

Allergies to tape: **Yes** **No** **(adhesive or paper)** **Allergies to latex:** **Yes** **No**

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Please list all medications you are currently taking

_____ _____

_____ _____

_____ _____

_____ _____

Non-prescription Drugs: _____ _____ _____

Pharmacy: _____

Social History

Occupation: _____

With whom do you live: _____

Frequency of alcohol consumption: ☐ Heavy ☐ Occasional ☐ None

Smoking consumption: ☐ Heavy ☐ Occasional ☐ None

Are You Currently Experiencing Any of The Following: (Please check all that apply)

GENERAL	CARDIOVASCULAR	Indigestion
Fever	Chest Pain	Hepatitis
Chills	Palpitations	Jaundice
Weight Loss	Shortness Of Breath	Anemia
Glasses	Leg Swelling	Bruising
Blurred Vision	Heart Murmur	Rash
Eye Pain	Irregular Heartbeat	NEURO
Loss Of Hearing	RESPIRATORY	Seizures
Ringing In Ears	Cough	Memory Loss
Nose Bleeds	Wheezing	Headache
Sinusitis	OTHER	Dizziness
Dentures	Nausea	Fainting
Difficult To Swallow	Vomiting	Numbness
Bleeding Gums	Diarrhea/Constipation	Weakness
	Thyroid Problems	
	Kidney Stones	
	Urinary Problems	
	Blood In the Urine	

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Patient Demographics

Full Name of Patient: _____
First Middle Last

Home Address: _____
City Zip Code

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email address: _____

Date of Birth: _____ Age: ____ Male or Female Marital Status: Married____ Single____ Other_____

Race: _____Language: _____Ethnicity: _____

Social Security Number: _____ Driver's License Number: _____

How did you hear about us? ☐ Family ☐ Friend ☐ Website ☐ Commercial ☐ Theatre ☐ Other

Primary Care Physician: _____ Referred by Dr. _____

INSURED RESPONSIBLE PARTY INFORMATION

Responsible Party Name: _____ Relation to Patient: _____

Address: _____ Phone Number: _____

Employer: _____ Responsible Party SS #: _____

Driver's License Number: _____ Date of Birth: _____

PRIMARY INSURANCE

Insurance Name: _____ID #_____

SECONDARY INSURANCE

Insurance Name: _____ID #_____

EMERGENCY CONTACT

Name of Nearest/Relative (Not living with you)

Name: _____ Phone: _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by insurance.

ASSIGNMENT OF BENEFITS – FINANCIAL AGREEMENT

I directly assign all medical/surgical benefits to South Valley Vascular Associates and understand that I am financially responsible to all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I further agree that a photocopy to this agreement shall be valid as the original.

PATIENT SIGNATURE: _____ DATE: _____

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Omar A. Araim, M.D. | *Matthew P. Campbell, M.D.* | *Abdulrahman Hamdi, M.D*
Siddhartha Agrawal, MD. | *Alexander Nguyen, M.D* | *Frederick Gilliam PA-C*
Flavio Gonzalez, FNP | *Cathy Eckert Juarez, FNP-C* | *Diana Caudillo, FNP*

Visalia
820 S. Akers Ste. 120
Visalia, CA 93277
Fax: 559-625-6004

Porterville
384 Pearson Dr.
Porterville, CA 93257
Fax: 559-793-4288

Hanford
125 Mall Dr. Ste. 211B
Hanford, CA 93230
Fax: 559-530-3536

Fresno
7045 N. Maple Ave. Ste. 108
Fresno, CA 93720
Fax: 559-558-8183

Medicare Acknowledgement (Consent)

Patient Name: _____ **Medicare Number:** _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf, directly to **South Valley Vascular/BASS Medical Group,** for all services rendered to me by this physician or facility. I authorize any holder of my Protected Health Information to release to the Health Care Financing Administration (HCFA) and its agents, any information needed to determine these benefits or the benefits payable for and to the related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to process/pay the claim. If item 12, 13, and 27 of the HCFA 1500 claim form is completed, my signature authorizes releasing the information to the insurer or agency shown (I.e. secondary insurance information). In Medicare assigned cases, the determination of the Medicare carrier is the full charge and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary Signature Date

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Visalia	Porterville	Hanford	Fresno
820 S. Akers Ste. 120	384 Pearson Dr.	125 Mall Dr. Ste. 211B	7045 N. Maple AveSte.108
Visalia, CA 93277	Porterville, CA 93257	Hanford, CA 93230	Fresno, CA 93720
Fax: 559-625-6004	Fax: 559-793-4288	Fax: 559-530-3536	Fax: 559-558-8183

Medical Records Release Form

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

AIDS, **HIV/AIDS:** I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to or infection with any other causative agent of AIDS with the rest of my medical records.

Initial: _____ **Date:** _____

The information you may release subject to this signed release form is as follows:

❑Complete Records ❑History & Physical ❑Progress Notes ❑Care Plan

❑Lab Reports ❑Radiology Reports ❑ Pathology Reports ❑Treatment Record

❑Operative Reports ❑Hospital Reports ❑ Medication Record ❑Other (please specify):

I authorize South Valley Vascular/BASS Medical Group to obtain my Protected Health Information from the following physician/person/facility/entity:

NAME: _____

ADDRESS: _____

CITY: _____STATE: _____ZIP CODE: _____

PHONE: _____ FAX: _____

Purpose of requested disclosure: ❑Medical Care ❑ Personal ❑ Other (Specify):

_____

I, the Patient, may inspect or obtain a copy of the medical records that I am being asked to disclose or allow to be used. And I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization. I may revoke this authorization at any time but must do so in writing and submit it to **South Valley Vascular Associates**. Revocation will take place upon receipt but will be effective to the extent that the Requestor or others may have already acted in reliance upon this Authorization. I have a right to review and receive a copy of this Authorization. ***Note to patient:*** California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.

PRINT PATIENT NAME

SIGNATURE OF PATIENT/ GUARDIAN/ PERSONAL REPRESENTATIVE

_____

DATE

_____

RELATIONSHIP TO PATIENT

_____

I AUTHORIZE THE RELEASE OF ALL INFORMATION AND I AM AWARE THAT THE RECORDS RELEASED MAY CONTAIN CONFIDENTIAL INFORMATION RELATING TO PSYCHIATRIC OR PSYCHOLOGICAL TESTING OR DRUG/ ALCOHOL ABUSE

☐☐CHECK HERE TO EXCLUDE CONFIDENTIAL INFORMATION

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Financial Policy

Welcome to South Valley Vascular/BASS Medical Group. We would like to take this opportunity to acquaint you with the financial policies of our group. Our goal is to provide you with the highest quality of medical care possible. In order to accomplish this, we have highly trained, professional staff available to answer any questions you may have regarding your treatment, insurance or billing issues. Please do not hesitate to ask any one of our Customer Service Representatives for assistance.

South Valley Vascular/BASS Medical Group is contracted with most Preferred Provider Organizations (PPOs) as well as many Health Maintenance Organizations (HMOs). It is the patient's responsibility to verify that South Valley Vascular/BASS Medical Group is contracted with your specific health plan. If your health care expenses are covered by any one of these plans, you will be required to pay all deductibles, co-pays and co-insurance amounts at the time of service. We will submit a bill to your insurance plan for the remaining balance. If our practice is not contracted with your specific insurance plan, we will require payment in full at the time of service. Please remember that medical services are rendered directly to each patient at their request; therefore, each patient is responsible for payment in full for all services rendered.

A copy of your current insurance card or cards are required at each visit. It is your responsibility to notify South Valley Vascular/BASS Medical Group of any changes in your coverage status. This information will be maintained in your medical file.

You will receive a monthly billing statement whenever a balance is due on your account. Charges billed to your insurance plan will be noted on your statement until payment and/or an Explanation of Benefits (EOB) is received from the insurance company. We will bill your plan directly as a courtesy to you; however, this should not be considered a substitution of your primary responsibility for payment. All unpaid charges by the insurance plan are the patient's responsibility and all patient due balances must be paid within thirty (30) days of receipt of the statement. **There will be a $25.00 service charge on all returned checks**.

Patient's Name (Please Print): _____

Patient's Signature: _____ Date: _____

South Valley Vascular
BASS MEDICAL GROUP

Patient Rights & Responsibilities Notice

All patient rights will be exercised without regard to sex, ethnicity, religion, national origin, age, disability, medical condition, marital status, sexual orientation, gender identification, educational background, economic status or source of payment for care.

Patient Rights:

1. Receive the care necessary to help regain or maintain his/her maximum state of health.
2. Expect personnel who care for the patient to be friendly, considerate, respectful and qualified through education and experience. To perform the services for which they are responsible, with the highest quality of care. When the need arises, reasonable attempts are made for healthcare professionals and other staff to communicate in the language or manner primarily used by the patient.
3. Expect full recognition of individuality, including privacy in treatment and care. IN addition, all communications and records will be kept confidential.
4. Complete information to the extent known by the physician regarding diagnosis, treatment, prognosis, as well as alternative treatments or procedures including possible risks and side effects associated with treatment.
5. Be fully informed of the scope of the services available at the facility including but not limited to; provisions for after hours and emergency care, payment policies, fees for services rendered, the credentials of health care professionals, information regarding the absence of malpractice insurance coverage or their right to change their provider if other providers are available.
6. Be participant in decisions regarding the intensity and scope of treatment. If the patient is unable to participate in those decisions, the patient's rights shall be exercised by the patient's designated representative or other legally authorized representative.
7. Refuse treatment to the extent permitted by law and be informed of the medical consequences of such refusal. The patient accepts responsibility for his/her rights without being subjected to discrimination or reprisal.
8. Approve or refuse the release of medical records to any individual outside the facility, except in the case of transfer to another healthcare facility or as required by law or third-party payment contract. Personal records are accessible.
9. Be informed of human experimentation or other research/educational projects affecting his/her care or treatment. Patients can refuse participation if such experimentation or research without compromise to the patient's usual care.
10. Change primary or specialty physicians. To be informed if a physician does not have malpractice coverage. Bay Are Surgical Specialists require that all physicians possess malpractice insurance. The patient has a right to request his/her surgeons' credentials.
11. The patient has the right to have an advance directive, such as a living will or healthcare proxy. Any patient who has an advance directive must provide a copy to the facility and his/her physician so that his/her wishes may be known and honored upon transfer to a higher level of care from the facility. However, the patient also has the right to know that such directive will not be followed during their surgical event/appointment.
12. Be fully informed before any transfer to another facility or organization.

13. Express those spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of medical therapy for the patient.
14. Not to be subjected to misleading marketing or advertising regarding the competence and capabilities of Bay Area Surgical Specialists.
15. Be free from any form of abuse or harassment.
16. Express grievances/complaints and suggestions at any time. TO file a complaint or grievance please notify:

Bay Area Surgical Specialists 460 N. Wiget Ln. Suite B Walnut Creek, CA 94598 ATTN: Medical Director	**Accreditation Association for Ambulatory Health Care** 5250 Old Orchard Road, Suite 200 Skokie, IL 60077 Email: infor@aaahc.org
California Department of Public Health Center for Health Certification Division P.O. Box 997377, MS 3000 Sacramento, CA 95899 ATTN: Deputy Director Complaints: (800) 236-9747 General Information: (916) 558-1784	**The Office of Medicare Beneficiary Ombudsman** http://www.cms.gov/center/ombudsman.asp **For Medicare Beneficiaries-Medicare Ombudsman** http://www.cms.hhs.gov/center/ombudsman.asp
Board of Registered Nursing P.O. Box 944210 Sacramento, CA 94244-2100 ATTN: Complaint Intake (916) 322-3350	

During the course of your treatment, you may be referred to our procedure room. It is our duty to inform you that one or more of our physicians may have a financial interest in the procedure room for the service associated with your surgical care. You have the option to choose to have these services performed at any facility you wish, and we would be happy to discuss your options with you and answer any questions you might have. Potential sources of information concerning alternatives can either be obtained from the yellow pages or Tulare County Medical Society which can be reached at (559) 627-2262.

Acknowledgment

This acknowledges that you have received and read a copy of the Patients' Rights notice. This Document is not a contract, authorization, release, or consent form. Thia document will remain as part of your records.

Signature: _____ Date: _____

Print Name: _____ Relationship to Patient: _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY!

We are required by law to keep your protected health information confidential. Authorization for the disclosure of your protected health information to someone who is not legally required to keep it private may cause the information to no longer be protected by state and federal confidentiality laws. In accordance with state and federal patient privacy laws, including HIPPA (the Health Insurance Portability and Accountability Act of 1996), this Notice describes how your protected health information may be used or disclosed and how you, the patient, can get this information. Please review this Notice carefully.

DEFINITION OF "PROTECTED HEALTH INFORMATION": Your "protected health information" is health information about you, which someone may use to identify you, and which we keep or transmit in electronic, oral, or written form. It includes information about your name; contact information; past, present, or future physical or mental health or medical conditions; payment for health care products or services, and/or prescriptions.

PERMITTED USES & DISCLOSURES: The law permits us to use or disclose your protected health information to the following. Note: This is a non-exhaustive list.

- Another specialist or physician who is involved in your care.
- Coroners, medical examiners, or funeral directors when an individual dies.
- Your insurance company, for the purpose of obtaining payment for our services.
- Our staff, for the purpose of entering your information into our computerized system.
- To run our practice, improve your care, and contact you when necessary (e.g., to manage the services and treatment you receive or to monitor the quality of our health care services).
- To outside persons or entities that perform services on our behalf, such as auditing, legal, or transcription ("business associates"). The law requires our business associates and their subcontractors to protect your protected health information in the same way we do. We also contractually require these parties to use and disclose your protected health information only as permitted and to appropriately safeguard your protected health information.
- Other entities during the course of your treatment, in order to obtain authorizations, referral visits, scheduling of tests, etc. Much of this information is sent via fax which is a permitted use allowed by law. We have on file with these sources, verification for the confidentiality of the fax used and its limited access by authorized personnel.
- If this practice is sold, your protected health information will become the property of the new owner.
- We may release some or all of your protected health information when required by law (e.g., responding to a court or administrative order or subpoena, discovery request, etc.). Except as described above, this practice will not use or disclose your protected health information without your prior written authorization.
- We may use and disclose your protected health information to address and respond to workers' compensation or other government requests.
- We may share your protected health information to report injuries, births, and deaths; prevent disease; report adverse reactions to medications or medical device product defects; report suspected child neglect or abuse, or domestic violence; and/or avert a serious threat to public health or safety.
- For organ and tissue donation requests.
- We may share your protected health information for some types of health research.

Federal and state law allows us to use and disclose our patients' protected health information in order to provide health care services to them, to bill and collect payments for those services, and in connection with our health care operations. We also use a shared Electronic Medical Record that allows both our physicians and staff access to our patients' protected health information. The purpose for this access is to expedite the referral of patients within the BASS Medical Group, other providers, and to assist in providing and managing their care in a coordinated way.

Information in the Electronic Medical Record can be released outside the BASS Medical Group only with the patient's express authorization or as otherwise specifically permitted or required by law.

PATIENT RIGHTS: The law also establishes patient rights and our responsibility to inform you of those rights. These include:

- You have the right to request in writing any uses or disclosures we make with your protected health information beyond the normal uses referenced above.
- You have the right to limit the use or restrict the use disclosure of your protected health information. Our office will follow any restrictions notated by you on page 2 of this Form.
- You have the right to request in writing to inspect and/or receive a copy of your protected health information.* Our office may charge a reasonable fee to cover copying and mailing of these records to you. Some releases of your protected health information may require the completion and submission of a separate request or form from this one, as our Privacy Officer may determine.
- You have the right to request an alternate means or location to receive communications regarding your protected health information.* Otherwise, such communications will be mailed to the home address in your medical or billing record and/or sent to the alternative address and/or by the alternative means of communication(s) you designate below (E.g., via telephone text or email).
- You have the right to request in writing an amendment or change to your protected health information. Our office may agree or disagree with your written request, but we will be happy to include your statement as part of your records. If an agreement to amend or change is acceptable, please be advised that previous documentation is considered a legal document and cannot be deleted or removed. Our office will simply notate the amendment and the reason for it and add it to your records.

  * Conditions and limitations may apply; obtain additional information from our Privacy Officer.
- We may use your information to contact you. For example, we may use the U.S. Mail, the telephone, a Text message, or email to remind you of an appointment or call you with information regarding your care. If you are not at home, this information may be left on your answering machine, voicemail, sent via Text, via email, or with the person who answered the phone. In an emergency, we may disclose your protected health information to a family member or another person designated responsible for your care.
- **MINORS**: We take patient privacy laws very seriously. **The State of California** limits what type of health information we can share with the parents or legal guardians of **minor** teenage children between the ages of 12 and 17. Accordingly, we will maintain an exclusive phone number and/or email address for **minors** in this age range, as they may designate.

  IF PATIENT IS A MINOR, PLEASE STATE AGE: _____ AND DATE OF BIRTH: _____
- **WHOM I DESIGNATE: Please designate who our offices CAN disclose your protected health information to, including, but not limited to correspondence, test results, prescriptions, medical records, or billing information, who are 18 years or older, by checking the boxes below and signing below:**

  This authorization to Release Protected Health Information is voluntary.

  ☐ OK to Spouse: Please list name, alternative address, phone number, and email addresses of Family Member(s), as applicable:

_____

_____

☐ **OK to Other (e.g. Attorney, Accountant, Financial Advisor, Power of Attorney, Legal Guardian, Conservator, or other legally authorized agent or representative). Please list name(s), alternative address, phone number, and email addresses of authorized personnel or entities:**

_____

_____

☐ **OK to leave protected health information on answering machine, voicemail, telephone, text, or email.**

☐ **DO NOT RELEASE AND SEND ANY INFORMATION to anyone other than myself (the Patient). Please send my information to my home address or the alternative address, phone number, and email address I list here:**

Address: _____ **Phone:** _____

Email address: _____

IF PATIENT IS A MINOR, PLEASE STATE AGE: _____ **AND DATE OF BIRTH:** _____

☐ **DO NOT RELEASE TO:** _____
(Please list names, as applicable)

PATIENT CHOICES: For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, please contact our Privacy Officer at (925) 627-3424 who will make reasonable efforts to follow your instructions.

In these cases, you have both the right and choice to tell us whether to:

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation.

If you are unable to tell us your preferences, we may share your information if we believe it is in your best interest according to our best judgment. We may also share your information when needed to lessen a serious and imminent threat to health and safety.

In these cases, we will not share your information unless you give us written permission:

- Marketing purposes.
- Other uses and disclosures not described in this Notice.

You may revoke your authorization at any time, but it will not affect information that we already used and disclosed.

We will promptly notify you if a data breach occurs that may have compromised the privacy or safety of your protected health information. We reserve the right to change our privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and our office will notify you of the changes in writing. You have the right to file a complaint with the Department of Health and Human Services, 200 Independent Avenue, S.W., Room 509F, Washington, DC 20201. Our office will not retaliate against you for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your protected health information privacy, please contact our Privacy Officer at (925) 627-3424.

ACKNOWLEDGEMENT, AUTHORIZATION, & CONSENT

This acknowledges that you have received arid read a copy of our HIPAA Privacy Practices Notice and Consent to the use and disclosure of your protected health information to the person(s) or entities you have designated above. This document will remain as part of your medical and billing record.

Signature: _____ Date: _____

Patient's Name: _____ Date of Birth: _____

If person signing is not patient, please provide name and identify the relationship to the patient and in what capacity you/they are signing (E.g., parent, guardian, conservator):

Name: _____

Capacity and/or Relationship to patient: _____

This authorization/consent may be revoked at any time prior to the release of the requested information. The revocation must be in a writing, signed by the patient or their authorized representative, and delivered to BASS at their address referenced below.

Patient's authorized representative is entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION/CONSENT: Unless otherwise revoked, rescinded, revised, updated, or changed by you in a writing signed by you, this Authorization & Consent shall not expire and will last indefinitely.