

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:

- | | | |
|--|--|---|
| <input type="checkbox"/> High Cholesterol | | |
| <input type="checkbox"/> Aortic Aneurysm | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Stroke | <input type="checkbox"/> Clotting Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Congestive Heart Failure |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Support Hose |

Family History of Vascular Disease:

- | | | |
|--|---|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> 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

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: _____

Omar A. Araim, M.D.

Matthew P. Campbell, M.D.

Abdulrahman Hamdi, M.D

Siddhartha Agrawal, MD.

Alexander Nguyen, M.D

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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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:** _____



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 Area 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.



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- 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:

<p>South Valley Vascular Associates, INC. 820 S. Akers St Suite 100 Visalia, CA 93277 ATTN: Medical Director</p>	<p>Accreditation Association for Ambulatory Health Care 5250 Old Orchard Road, Suite 200 Skokie, IL 60077 Email: infor@aaahc.org</p>
<p>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</p>	<p>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</p>
<p>Board of Registered Nursing P.O. Box 944210 Sacramento, CA 94244-2100 ATTN: Complaint Intake (916) 322-3350</p>	

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. This document will remain as part of your records.

Signature: _____ **Date:** _____

Print Name: _____ **Relationship to Patient:** _____