Please present your INSURANCE CARDS as well as your DRIVER'S LICENSE to be scanned into your chart.

This form must be filled out COMPLETELY.

**Patient Information**:

**First Name:**_____ **Middle Name**:_____ **Last Name**:_____ Alias: _____

**SS#:** _____ **Birth Date:** _____ /_____ /_____ **Sex:** Male Female

**Mailing Address:** _____City/State: _____ ZIP: _____

**Home Phone:** _____ **Cell Phone:** _____ **County:** _____

FAX: _____ E-mail:_____ **Contact Preference:** e-mail phone mail fax

Employer: _____ Work Phone: _____Your position/job title: _____

**Race:** African American Asian Hispanic White Other: _____

**Ethnicity:** Hispanic/Latino NOT Hispanic/Latino

**Patient's Marital Status:** Married Divorced Separated Widowed Single

**Primary Care Physician:** _____ **Referring Physician:**_____

**How did you hear about us:** ☐ **Internet Search** ☐**Facebook/Instagram** ☐**TV ad** ☐**Magazine Ad** ☐**Billboard** ☐**Referring Physician** ☐**Friend/Relative** ☐**Other:** _____

**Spouse/Parent Information**:

**First Name:**_____ **Middle Name**:_____ **Last Name**:_____ Alias: _____

**SS#:** _____ **Birth Date:** _____ /_____ /_____ **Sex:** Male Female

**Mailing Address:** _____City/State: _____ ZIP: _____

**Home Phone:** _____ **Cell Phone:** _____ **Other Phone:** _____

Employer: _____ Work Phone :_____

**Emergency Contact** *other than spouse:*

**First Name:**_____ **Middle Name**:_____ **Last Name**:_____ Alias: _____

**Mailing Address:** _____City/State: _____ ZIP: _____

**Home Phone:** _____ **Cell Phone:** _____ **Other Phone:** _____

**Insurance Information**

Primary Insurance: _____ Policy Number: _____Effective Date: _____
Subscriber Name: _____Group #_____Phone :_____Copay: _____

Secondary Insurance: _____ Policy Number: _____Effective Date: _____
Subscriber Name: _____Group #_____Phone :_____Copay: _____

Additional Insurance: _____ Policy Number: _____Effective Date: _____
Subscriber Name: _____Group #_____Phone :_____Copay: _____

I hereby grant permission to Vascular Specialists of East Texas to employ such medical, surgical, and diagnostic procedures as my doctor may consider necessary in my diagnosis and treatment. I 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 agree to pay any charges incurred by me to Vascular Specialists of East Texas.

I authorize the release of medical information pertaining to my health to the following individuals: _____

_____

Signature: _____Date: _____

# ASSIGNMENT OF BENEFITS

Patient Name: _____ Account #: _____

**Financial Responsibility**

I understand that insurance billing is a service provided as a courtesy by Vascular Specialists of East Texas, and that I am at all times financially responsible to Vascular Specialists of East Texas and/or its affiliated entities for any charges not covered by health care benefits. It is my responsibility to notify Vascular Specialists of East Texas of any changes in my health care coverage. In some cases exact insurance benefits can not be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Vascular Specialists of East Texas and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

**Assignment of Benefits**

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Vascular Specialists of East Texas for all covered medical services and supplies provided to me during all courses of treatment and care provided by Vascular Specialists of East Texas and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will constitute a continuing authorization, maintained on file with Vascular Specialists of East Texas, which will authorize and allow for direct payment to Vascular Specialists of East Texas of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Vascular Specialists of East Texas.

**Authorization to Release Information**

I authorize the release of any medical or any other information to the billing department of Vascular Specialists of East Texas, my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by Vascular Specialists of East Texas. A copy of this authorization will be sent to the billing department of Vascular Specialists of East Texas, my insurance carrier(s), or other medical entity, if requested. The original authorization will be kept on file by Vascular Specialists of East Texas.

Signature of Insured: _____ Date: _____

Signature of Patient or Authorized Representative: _____

Witness: _____

# NOTICE 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 nurse who will answer most questions and consult the physician if required.

Your medication can only be managed by ONE physician. If another physician is prescribing pain medication for you, the on-call physician at Vascular Specialists of East Texas will NOT provide additional medication.

## POLICIES REGARDING CALLS FOR MEDICATION:

1. Telephone calls related to medications and/or refills must be called in to your pharmacy before 2:00pm Monday through Thursday and by 11:00am on Friday. Your pharmacy will then contact our office. Otherwise, the telephone call will not be handled until the next business day.

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

Please observe the above Policies to avoid problems and expensive ER visits for treatments.

In order to emphasize our position on the matter,

we request that you sign the following statement:

*As a patient of Vascular Specialists of East Texas, 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 Vascular Specialists of East Texas' 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.*

Patient's Signature: _____ Date: _____

(a copy of this statement will be provided for you. The original will be kept in your chart)

## ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of patient or personal representative Date

_____

Printed name of patient or personal representative

## I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (check all that apply):

**Home Telephone:**

_____ OK to leave message with detailed information

_____ Leave message with *call back number only*

**Written Communication:**

_____ OK to mail to my home address

_____ OK to mail to my work/office

**Work Telephone:**

_____ OK to leave message with detailed information

_____ Leave message with call back number only

## MY PERSONAL INFORMATION MAY BE RELEASED TO THE FOLLOWING INDIVIDUALS:

Name of Individual: _____ Relationship to Patient:_____

Name of Individual: _____ Relationship to Patient:_____

Name of Individual: _____ Relationship to Patient:_____

Name of Individual: _____ Relationship to Patient:_____

# Appointment Policy

Dear Patient,

Due to the number of patients that our practice sees each day it is necessary to implement a policy regarding the commitment of patients to attend their designated appointment times with our vascular technicians and practitioners. Our office staff contacts patients one week and 24 hours in advance of designated appointment times for confirmation. If you as a patient or patient representative confirm the appointment and the patient still fails to attend the appointment a $50.00 No-show fee will be applied to the patient's account.

Additionally, if our staff is unable to obtain a verbal confirmation of the appointment the slot may be filled with a patient on the wait list. If the patient is more than 20 minutes late for their designated appointment time (regardless of appointment confirmation) the appointment may be rebooked.

Please understand that this policy allows our practice to offer excellent service to all of our patients, it is one of our greatest desires to provide excellent and timely service which can only be achieved with attention to the tight schedule of ultrasound and physician appointments.

Thank you so much for your understanding in this matter, as a team we will continue to enjoy providing the best medical services in East Texas to our patients and Referring Physicians!

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Patient Name (printed) Patient Rep. Name (if necessary)

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Signature Date

VascularTyler, 1040 S. Fleishel Ave, Tyler, TX 75701
Phone: 903-533-8702 Visit us on the WEB!!!: www.VascularTyler.com

VASCULAR SPECIALISTS OF EAST TEXAS