VALLEY VASCULAR CONSULTANTS, P.C.

201 Sivley Road, Suite 530 Phone: (256) 265-7480
Huntsville, AL 35801 Fax: (256) 265-7481

RON C. JOHNSON, M.D., F.A.C.S. • FRED S. STUCKY, III, M.D., F.A.C.S. • ANDREW W. KNOTT, M.D.
MELL BURRESS WELBORN, III, M.D., F.A.C.S. • MARCO CIOPPI, M.D., F.A.C.S.

CHART NO.
DATE

CO-PAY $ ____________

PATIENT'S NAME IN FULL (NO NICKNAMES)	MARITAL: S / M / W / D / SEP	DATE OF BIRTH	AGE	SEX	SOCIAL SECURITY NO.

ADDRESS	CITY & STATE	ZIP CODE	HOME TELEPHONE NO. ( )

OCCUPATION (INDICATE IF STUDENT)	EMPLOYER	HOW LONG EMPLOYED?	CELL PHONE NO. ( )

EMPLOYERS ADDRESS	CITY & STATE	ZIP CODE	BUSINESS PHONE NO. ( )

HUSBAND, WIFE, PARENT OR GUARDIAN NAME	DATE OF BIRTH	SSN

EMPLOYER OF ABOVE NAME	CITY & STATE	ZIP CODE	BUSINESS PHONE NO. ( )

PERSON TO NOTIFY IN CASE OF AN EMERGENCY	I ALSO GIVE PERMISSION TO RELEASE MEDICAL INFORMATION TO EMERGENCY CONTACT ☐ YES ☐ NO

ADDRESS	CITY AND STATE	ZIP CODE

HOME PHONE ( )	BUSINESS PHONE NO. ( )

OTHER DATA: This information is being obtained to comply with Federal Regulations for Electronic Medical Records (may choose more than 1)

RACE: ________ American Indian / Alaskan Native ________ Native Hawaiian ________ Asian ________ Other Pacific Islander
________ Black / African American ________ Hispanic ________ White ________ Other Race ____ Unreported

ETHNICITY: (this is not same as Race) ________ Hispanic or Latin American ________ Not Hispanic or Latin American ________ Unreported

LANGUAGE: ____ English ____ Other ____ Indian (includes Hindi & Tamil) ____ Spanish ____ Russion ____ Unreported

INSURANCE

PRIMARY INSURANCE CO.	
NAME OF POLICY HOLDER	DATE OF BIRTH
GROUP NO.	ID NO.
SECONDARY INSURANCE CO.	
NAME OF POLICY HOLDER	DATE OF BIRTH
GROUP NO.	ID NO.
AUTOMOBILE ACCIDENT	OTHER ACCIDENT? SPECIFY:

WORKMAN'S COMPENSATION INFORMATION

WERE YOU INJURED ON THE JOB? ☐ YES ☐ NO	DATE OF ACCIDENT
WORKMAN'S COMPENSATION CARRIER	CLAIM NO.
ADDRESS	ATTENTION TO:
CITY & STATE	ZIP CODE
PHONE NO.	VERIFIED BY:
EMPLOYER AT TIME OF ACCIDENT	
DATE OF ACCIDENT	NAME OF ATTORNEY

ARE YOU IN A NURSING HOME OR SKILLED REAHB AT THE PRESENT TIME? ☐ YES ☐ NO

THE ABOVE INFORMATION, AS PROVIDED BY ME, IS CORRECT TO THE BEST OF MY KNOWLEDGE.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the above named professional association or hospital to release to my insurers full information, including copies of records and operative notes relative to this illness.

AUTHORIZATION TO RECEIVE: I hereby authorize the above name professional association or hospital to obtain information from other healthcare providers for continuation of care.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to the above mentioned for the benefits payable under the terms of my policy for this period of illness. I understand that I am financially responsible for the charges not covered by this authorization.

DATE________________________ ________________________________
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

* **AFTER HOUR Phone Calls:** Valley Vascular Consultants, P.C. encourages patients to call during normal business hours. There will be a $15 fee assessed for phone calls that occur when the office is closed.

* **PAPERWORK FEE:** There will be a $10 fee for paperwork and letters to be written or filled out by us.

SERVICES CAN BE CHARGED TO YOU THROUGH MASTERCARD OR VISA

Name: ____________________

Date of Birth: ______________

Valley Vascular Consultants, P.C.

Medical History Questionnaire

Today's Date: ______________

REASON FOR VISIT ____

____

Referring Physiaicn: ______________________ Family Physician: ______________________

PREVIOUS SURGERIES

TYPE OF SURGERY / DATE

____

____

____

____

REVIEW OF SYSTEMS (Check all that apply) Height ______________ Weight ______________

CARDIOVASCULAR ❑ N/A

❑ Chest Pain
  ❑ With Exercise
  ❑ At Rest

❑ High Blood Pressure (uncontrolled)

❑ Ankle Swelling

❑ Fainting

EYES, EARS, NOSE & THROAT ❑ N/A

❑ Blurry Vision

❑ Nosebleeds

❑ Shade going over Eye

❑ Change in Vision

❑ Lack of Vision in Visual Field

NEUROLOGICAL (Dominant Side ❑ Right ❑ Left) ❑ N/A

❑ Difficulty Moving a Side or Limb If yes, specify: ❑ Right ❑ Left ❑ Both Acute vs. Chronic

❑ Numbness of a Side or Limb If yes, specify: ❑ Right ❑ Left ❑ Both Acute vs. Chronic

❑ Dizziness

❑ Loss of Consciousness

❑ Paralysis

❑ Slurred Speech

RESPIRATORY ❑ N/A

❑ Shortness of Breath If yes, specify: ❑ At Rest ❑ With Exertion

GASTROINTESTINAL ❑ N/A

❑ Abdominal Pain
  Rate on a scale of 0 to 10 (0= no pain, 10 = extreme pain) ______________

❑ Abdominal Bloating

❑ Weight Gain/Loss Unintentional

❑ Changes in Appetite

❑ Difficulty Swallowing

MUSCULOSKELETAL/SKIN ❑ N/A

❑ Back Pain

❑ Joint/Pain Stiffness

❑ Numbness and/or Tingling

❑ Leg Pain at Rest (❑ Right ❑ Left ❑ Both)

❑ Upper Extremity Discomfort with Activities and Edema

❑ Lower Extremity Discomfort with Activities

❑ Cramping with Exercise

❑ Leg Fatigue w/Prolonged Standing

❑ Skin Color Changes

❑ Heaviness/Achiness in Legs
  ❑ Right ❑ Left

❑ Neck Pain

❑ Sores on Legs and.or Feet
  ❑ Right ❑ Left

How far can you walk? __________ feet, __________ yards, ___________ blocks

Location of your leg pain? ❑ Buttock ❑ Thigh ❑ Calf ❑ Foot

Name: ____________________

ARE YOU CURRENTLY ON DIALYSIS? ❑ Yes ❑ No (If yes, please complete information below)
Name of Dialysis Center: ____________________ Dialysis Physician: __________
Address: ____________________
City: ____________________ State: __________ Zip: __________
Office Phone: (______) __________ Office Fax: (______) __________
Days: ❑ M W F ❑ T Th Sa

PREVIOUS STRESS TEST? ❑ Yes ❑ No (If yes, in the past year? ❑ Yes ❑ No) ❑ **N/A**
Name of Cardiologist: ____________________
Address: ____________________
City: ____________________ State: __________ Zip: __________
Office Phone: (______) __________ Office Fax: (______) __________

MEDICAL HISTORY (Check/fill in all that apply) ❑ **N/A**

- ❑ Aneurysm
- ❑ Thoracic (chest)
- ❑ Carotid (neck)
- ❑ Popliteal (knee)
- ❑ Abdominal (stomach)
- ❑ Renal (kidney)
- ❑ Other
- ❑ Traumatic Brain Injury
  Year: __________
  Mechanism of Injusy: ______
- ❑ Headaches (severe)
- ❑ Migraines
- ❑ Stroke
  yr ______ deficits ______
- ❑ Transient Ischemic Attack (TIA)
  yr ______ deficits ______
- ❑ Dizziness
- ❑ Seizure / Epilepsy
- ❑ Alzheimer's / Dementia
- ❑ Parkinson's Disease / Tremors
- ❑ Lupus
- ❑ Multiple Sclerosis (MS)
- ❑ Rheumatoid Arthritis
- ❑ Carotid Stenosis (narrowing)
- ❑ Coronary Artery Disease
- ❑ Heart Attack yr ______
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Heart Valve Disorder
- ❑ Mitral
- ❑ Aortic
- ❑ Pacemaker / Defibrillator
  Type ______
  Year Placed ______

- ❑ Coronary Artery Bypass Grafting
- ❑ Coronary Artery Angioplasty
  yr ______
- ❑ Coronary Artery Stent (heart)
- ❑ Congestive Heart Failure (CHF)
- ❑ A-fib
- ❑ Abnormal Hearth Rhythm
- ❑ Asthma
- ❑ Pulmonary Embolism
- ❑ COPD
- ❑ Emphysema
- ❑ Sleep Apnea
- ❑ CPAP/BIPAP (home setting)
- ❑ Oxygen Dependent
  ______ liters
- ❑ Gastresophageal Reflux (GERD)
- ❑ Ulcers
- ❑ Irritable Bowel Syndrome (IBS)
- ❑ Gallstones
- ❑ Kidney Problems
- ❑ Kidney Stones
- ❑ End Stage Renal Disease (ESRD)
- ❑ Peritoneal Dialysis
- ❑ Hemodialysis
  M/W/F
  T/TH/Sat
- ❑ Arteriovenous Fistula (AVF) or Arteriovenous Graft (AVG)
  Year placed ______
- ❑ BUN/Creatinine levels ______
- ❑ Benign Prostatic Hyperplasis (BPH)
- ❑ Peripheral Stent (non-heart)
- ❑ Peripheral Angioplasty (non-heart)
- ❑ Deep Vein Thrombus (DVT)
  Location ______

- ❑ Gout
- ❑ Raynaud's Disease
- ❑ Varicose Veins
- ❑ Spider Veins
- ❑ Diabetes Mellitus (DM)
- ❑ Type I
- ❑ Type II
- ❑ Oral Diabetic medicine
- ❑ Insulin
- ❑ Diet Controlled
- ❑ Hyperthyroidism (high)
- ❑ Hypothyroidism (low)
- ❑ Cancer
  Area: ______
  Chemo when: ______
  Radiation when: ______
- ❑ Blood Disorder
- ❑ Anemia
- ❑ Sickle Cell Anemia
- ❑ Factor S Deficiency
- ❑ Factor V Leiden
- ❑ Hepatitis Type ______
- ❑ HIV / AIDS
- ❑ Tuberculosis (TB)
- ❑ Glasses
- ❑ Contacts
- ❑ Blind
- ❑ Hard of Hearing
- ❑ Hearing Aids
- ❑ Left ❑ Right ❑ Bilateral
- ❑ Other: ______

Name: ______________________

SOCIAL HISTORY

Gender: ☐ Male ☐ Female
Married: ☐ Yes ☐ Divorced ☐ Widowed ☐ Other ______________
Children: ☐ No ☐ Yes How many: ______________
Occupation: ______________ ☐ Retired If yes, when? ______________

Do you have any of the following? ☐ **N/A**
☐ Advance Directive ☐ Living Will ☐ Durable Power of Attorney ______________

Smoking Status: ☐ Never ☐ Quit; when: __________ How long before quitting: __________
☐ Current; packs per day: __________ How many years: __________
If current or past, what type? ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chewing Tobacco

Do you use recreational or intravenous drugs? ☐ Yes ☐ No
If yes, what type? ______________ How many years? __________

Do you drink alcohol? ☐ No ☐ Yes If yes, what type? ☐ Wine ☐ Beer ☐ Liquor
If yes, how many? __________ drinks/day (1 = 5oz wine = 12oz beer = 1.5oz liquor)

FAMILY HISTORY:

Please check any condition below that any blood relative has experienced and note relationship (e.g. father, sister, etc.)

Condition						
☐ Aneurysm	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	☐ Aunt	☐ Uncle
☐ Blood Clots in Legs	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	☐ Aunt	☐ Uncle
☐ Blood Clots in Lungs	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	☐ Aunt	☐ Uncle
☐ Blood Clotting Problems	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	☐ Aunt	☐ Uncle
☐ Circulation Problems (leg/Arm)	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	☐ Aunt	☐ Uncle
☐ Diabetes	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	☐ Aunt	☐ Uncle
☐ Heart Attack	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	☐ Aunt	☐ Uncle
☐ Heart Disease	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	☐ Aunt	☐ Uncle
☐ High Blood Pressure	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	☐ Aunt	☐ Uncle
☐ Stroke	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	☐ Aunt	☐ Uncle
☐ Cancer	☐ Mother	☐ Father	☐ Sibling	☐ Grandparent	☐ Aunt	☐ Uncle

☐ Other : ______________________
☐ Unknown Family History

MEDICATIONS/ALLERGIES

Are you allergic or have you had a "bad reaction" to?

Latex: ☐ No ☐ Yes If yes, what type of reaction: ______________
Contrast (IV Dye): ☐ No ☐ Yes If yes, what type of reaction: ______________

Have you had a reaction to other medication or substances? ☐ No ☐ Yes If yes, specify below:

____

____

____

Name: ______________________

Pharmacy Name: ____________________________

Pharmacy Location: ____________________________

Pharmacy Phone Number: ______________________

What medications do you presently take?

Medication Name	Dosage (Amount)	Frequency (How Often)
Example: Lipitor	*10mg*	*2x per day*

Do you take any non-prescription medicines, herbal remedies, or tonics? (e.g. aspirin, vitamins, antacids, or cold remedies) ❑ No ❑ Yes If yes, specify below

Name of Medicine, Remedy, Tonic, etc.	Dosage (Amount)	Frequency (How Often)
Example: Multivitamin	*1 pill*	*1x per day*

VALLEY VASCULAR CONSULTANTS, P.C.

FINANCIAL PAYMENT POLICY

Ron C. Johnson, M.D. Fred S. Stucky, III, M.D. Andrew W. Knott, M.D. Burress Welborn, III, M.D. Marco Cioppi, M.D.

We are committed to providing you with the best possible care. We find that communication with our patients regarding our financial policy assists us in providing the best service to you. Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks and credit cards (Am Express, Discovery, MasterCard, VISA). We will be happy to process your insurance claim form for your reimbursement. In order to achieve these goals, we need your assistance and understanding of our payment policy. We have therefore taken the time to answer some of the most commonly asked questions.

1. **COPAYMENTS/DEDUCTIBLES**: Copayments and deductibles are expected at the time of service.

2. **Self Referred Self Pay Patients**: Required to pay $500.00 up front at time of service.

3. **REGARDING INSURANCE**: The doctor's service is provided directly to you, and not to an insurance company. Thus, you are expected to pay the doctor's bill should your insurance company reject/deny. We cannot render services on the assumption that charges will be paid for by the insurance company.

   Our office uses a standardized medical accounting system. As a courtesy to our patients, we will bill your insurance company for you. If the insurance company has failed to pay within 45 days, we will expect you to pay the balance of your bill in full. You must then collect from your insurance company.

   <u>NOTE</u>: Any and all patients who have enrolled through the Health Insurance Exchange are required to provide proof of premium payment with receipt PRIOR to any and all scheduled office visit, PV scan/study, or outpatient/inpatient procedure/surgery.

4. **SPECIAL NEEDS**: This office understands special needs. It may be necessary to set up a payment plan for your services and/or procedures. If this situation is necessary for you, please bring this to our attention as soon as possible.

5. **OUTSTANDING BALANCE/ADDED PENALTY FEE**: A penalty fee of 50% will be added to your outstanding debt prior to turning your account over to our collection agency.

6. **RETURNED CHECK FEE:** A returned check fee of $35.00 will be added to your outstanding debt for returned checks. You are expected to pay the $35.00 returned check fee, in addition to the amount of your returned check, by cash or money order.

7. **MEDICAL RECORD COPY FEE**:
   - $5.00 administrative search fee
   - $1.00 per page for the first 25 pages
   - $0.50 per page for each additional page thereafter
   - Postage under the current postage rate

We must emphasize that, as medical care providers, our relationship is with you and not your insurance company. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Thank you for taking the time to read this policy statement. If you have any questions about the above information or any uncertainty regarding your insurance coverage, please don't hesitate to ask us.

WE ARE HERE TO HELP!

I hereby understand the financial policy of this office:

Signature: ______________________________ **Date:** ____________________

Valley Vascular Consultants, P.C.
201 Sivley Road, Suite 530
Huntsville, AL 35801

Patient Consent for the Use and Disclosure of
Protected Health Information

Patient Name: ____ DOB: ________________

Email address; ____

This is my consent for **VALLEY VASCULAR CONSULTANTS, P.C.** to use and disclose my protected health information to carry out treatment, payment, and healthcare operations. This is my acknowledgement that I may view **VALLEY VASCULAR CONSULTANTS P.C.** Notice of Privacy Practices.

Due to the new privacy HIPAA guidelines, we are unable to speak with family members or caregivers without your written authorization. Please complete this form and return to us at your earliest convenience.

The staff of Valley Vascular Consultants, P.C. has my permission to discuss the following with the person(s) listed below:

______ Medical Records ______ Financial Information _____ Other: __________________________

Family Members:

______ Any ______ Spouse ______ Children

Name: ________________________________ Name: ________________________________

Name: ________________________________ Name: ________________________________

Non Family Members:

Name: ________________________________ Relationship: ____________________________

Name: ________________________________ Relationship: ____________________________

Name: ________________________________ Relationship: ____________________________

____
Patient Signature

Varicose / Spider Vein Questionnaire

Name:		Date:	

Date of Birth:		Sex:	Male or Female

VEIN HISTORY

Do you have varicose veins?	Yes	No
Do you have spider veins?	Yes	No
Have you ever had any type of procedure related to your veins?	Yes	No
If so, please explain:		
Have you seen any other doctors for treatment of your veins?	Yes	No
If so, please explain:		

Do you experience the following in your lower extremities?					
Aching/Pain	Yes	No	Swollen Ankle/Legs	Yes	No
Heaviness	Yes	No	Leg Cramps	Yes	No
Tiredness/Fatigue	Yes	No	Throbbing	Yes	No
Itching/Burning	Yes	No	Restless Legs	Yes	No

Have your varicosities ever ulcerated?	Yes	No
Do your varicosities ever bleed?	Yes	No
Have you ever had a blood clot?	Yes	No
If yes, please detail when and which leg:		

TREATMENT HISTORY

Do you or have you ever worn compression stockings?	Yes	No
Do/did they help?	Yes	No
If yes, what gradient?		
Does elevating your legs help your symptoms?	Yes	No
Does exercise help your symptoms?	Yes	No
Are your problems interfering with your lifestyle?	Yes	No
What length of time were these conservative therapies tried?		

Medicare Part B

Extended Patient Signature Authorization

TO BE COMPLETED BY PROVIDERS OF SERVICE - Please PRINT or TYPE

Provider's Name *(If you are a DME supplier, please complete certification at bottom of page)* VALLEY VASCULAR CONSULTANTS, P.C.	Provider's I.D. Code

Provider's Address *(Street, City, State,* ZIP Code)
201 SIVLEY ROAD, SUITE 530 HUNTSVILLE, AL 35801

Beneficiary's Name	Medicare HIC Number	Applicable MEDIGAP Group Number

TO BE COMPLETED BY BENEFICIARY OR AGENT - Directions For Payment Of Benefits And Release Of Medical Information

STATEMENT FOR PAYMENT OF MEDICARE BENEFITS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to

Dr. Valley Vascular Consultants, P.C. *or to* ______________________ *(the Supplier) for any services or items furnished to me by the physician or supplier. I authorize any holder of medical* Information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

....

STATEMENT FOR PAYMENT OF MEDIGAP BENEFITS

I request that payment of authorized MEDIGAP benefits be made either to me or on my behalf to

Valley Vascular Consultants, P.C. for any services furnished to me by the physician/supplier. I authorize any holder of medical information about me to release to (name of MEDIGAP insurer)

______________________ any information needed to determine these benefits or the benefits payable for related services.

X ______________________ ______________
Signature of Beneficiary or person signing for Beneficiary Date Signed

Address of Person Signing For Beneficiary *(Street, City, State, ZIP Code)*	Relationship Of Agent To Beneficiary

Reason Beneficiary Is Unable To Sign

IMPORTANT INFORMATION FOR PHYSICIANS

In submitting claims under this procedure, PHYSICIANS undertake:

1. To complete and submit promptly the appropriate Medicare billing form for all services covered by the request for payment - even those in which the physician has not accepted assignment.
2. To incorporate, by stamp or otherwise, information to the following effect on any bills they send to Medicare patients: "DO NOT USE THIS BILL FOR CLAIMING MEDICARE BENEFITS. A CLAIM HAS BEEN OR WILL BE SUBMITTED TO MEDICARE ON YOUR BEHALF." This requirement is necessary to prevent patients from submitting duplicate claims.
3. To cancel the authorization on request by the patient.
4. To make the patient signature files available for carrier inspection upon request.

IMPORTANT INFORMATION FOR SUPPLIERS

1. Only use this extended patient signature authorization for assigned claims
2. Renew the patient signature agreement if a new item is rented or purchase.
3. Place alongside the beneficiary's signature the following statement: "RESPONSIBILITY FOR OVERPAYMENT ON ASSIGNED CLAIMS ACCEPTED."

DURABLE MEDICAL EQUIPMENT SUPPLIERS AGREEMENT

NOTE: THE FOLLOWING STATEMENT MUST BE SIGNED BY THE DME SUPPLIER PRIOR TO AUTHORIZATION OF PAYMENT FOR RENTAL OF DURABLE MEDICAL EQUIPMENT IN ASSIGNMENT CASES.

This supplier assumes unconditional responsibility for refunding of all overpayments for assigned claims for rental of durable medical equipment that may result from the failure of the Carrier to receive prompt notice of the return of, or the end of need for the rental of equipment, or the death or institutionalization of the Beneficiary.

______________________ ______________
Signature of Durable Medical Equipment Supplier Date Signed