Financial Agreement and Release of Information

Mountain Spring Vascular LLC DBA National Vascular Associates ("NVA")

The entire team of National Vascular Associates welcomes you! We want to thank you for choosing National Vascular Associates for your vascular health needs. We are committed to providing you with the best possible care, and an important part of that commitment is effective communication with our patients, their families, and/or caregivers.

The following is our Financial Agreement and Release of information, which we ask you to read prior to the beginning of your evaluation and treatment, initial it, sign it and date it.

Authorization for Treatment: I hereby authorize treatment by NVA and/ or affiliated medical staff member(s) on behalf of myself and legal responsibilities, including the patient whom I have medical power of attorney over. The possibility exists (during treatment) for health care workers to become directly exposed to my blood or bodily fluids. In the event of such exposure, State Law requires a sample of my blood to be tested for the presence of infectious diseases. **Initials** ________

Release of Information: I hereby authorize the release of all medical and/or charge information as is necessary for reimbursement from any third party or governmental agency involved in the payment of my treatment including but not limited to Insurance Payers, HMOs, Workers Compensation carriers, Medicare, Tricare and Medicaid. I also authorize the taking and use of photographs. I understand these photos will become a part of my medical record. **Initials** ________

Release of Medication History: I hereby authorize the release of all medication history information as is necessary and pertinent for my medical care at NVA. **Initials** ________

Financial Responsibility: I am financially responsible for the services provided to me. I am financially responsible for all co-payments, co-insurances, deductibles and other out of pocket expenses assigned as patient responsibility by my insurance company for the services provided by NVA. **Initials** ________

Past Due Balances and Collections process: All outstanding patient balances are my financial responsibility. I will make all efforts to make payments to NVA for professional services provided. I understand that if I fail to meet my financial obligation to NVA all past due balances may be transferred by NVA to a third-party Collections Agency. **Initials** ________

For Patients with Medical Insurance Benefits: NVA participates in most major health plans. It is my responsibility to provide accurate and up to date insurance primary, secondary and tertiary information, if applicable, to NVA. I understand that it is my financial responsibility to pay for all outstanding claims if my insurance is not active at the time of service, if there is an issue with coordination of benefits, and/or if any additional information is needed from me directly to resolve outstanding claims, etc. **Initials** ________

Referrals: If my insurance company requires a referral from my primary care physician, it is my responsibility to obtain it. Failure to obtain the referral may result in lower or no payment from the insurance company, which will make me financially responsible for the visit. **Initials** ________

For Patients with NO Medical Insurance Benefits: The cost for professional services will be communicated to me prior to the visit by NVA Staff. I am financially responsible for full payment at the time of service. **Initials** ________

Non-covered and out of network services: Medical services that determined by my insurance company as noncovered, out of network, or not medically necessary will be my responsibility for full payment. If my insurance company pays me directly for the services provided by one of NVA providers, it is my responsibility to forward the payment to NVA at the time of receipt. **Initials** ________

Insurance Authorizations: NVA will contact my insurance company for a pre-authorization for all medical or surgical procedures prior to treatment. The authorization process might take 2-3 weeks. A pre-certification, prior authorization or predetermination of benefits is not a guarantee of payment. It is an acknowledgement from insurance company that the recommended treatment plan is medically necessary and is subject to coverage at the time of service. It is my responsibility to understand my insurance benefits. If services are not covered by my insurance plan it is my financial responsibility to pay for the service provided. **Initials** ________

No Show and Cancellation Policy: NVA requires a 48-hour notice, in advance, to cancel or reschedule any appointment or procedure. All appointments that are missed without a call-in advance are deemed a “No show/ No call” and may incur a $50 fee for a regular visit, $100 fee for an Ultrasound and $200 for a procedure. This charge is not covered by insurance. I am financially responsible for this cost. **Initials** ________

I have read and understood the Financial Agreement and Release of Information above.

Patient/ Guardian Name: ____

Patient/Guardian Signature: ____

Today’s Date: ____

Mountain Spring Vascular DBA National Vascular Associates

General Medical Records Release And Authorization For Use Or Disclosure Of Protected Health Information

I, the undersigned, authorize____
____to release my health information as noted below.

Patient Name:_________________________________**DOB:**_________________________________
Address:____
Phone:____________________________________**Email:**____________________________________

I authorize the disclosure/release of the following information:

________ Office Notes ______ X-Ray/radiology records _______ Lab/Path records _______Op Notes

_______________________________Other (describe) Specify date range:________________________

Please send the above records listed above to (circle one):

NVA- VB Office
5589 Greenwich Road, Ste 100
Virginia Beach, VA 23462
Phone# 757-437-2882
Fax# 1-833-448-3261

NVA- Warrenton Office
550 Broadview Avenue, Ste 102
Warrenton, VA 20186
Phone# 540- 680-3433
Fax# 1-833-673-0375

NVA- Manassas Office
9161 Liberia Avenue, Ste 400
Manassas, VA 20110
Phone# 540-680-3433
Fax#1-833-673-0375

The information may be used/disclosed for each of the following purposes:
At my request (patient)_______ For continuity of care _________Other__________________________

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law.
By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Signature of patient or legal guardian____

Printed name of patient or guardian____

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending a written request to one of the National Vascular Associates addresses listed above.

Mountain Spring Vascular DBA National Vascular Associates

NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

This is notice that National Vascular Associates participates with the Privacy Practice HIPAA regulations. It is our intent to protect our patient's confidentiality within all reasonable means. The HIPAA regulations are meant to protect your personal health information. However, frequently the practice encounters patients who appoint others to call the office to arrange appointments and take care of the financial aspects of their care.

Please indicate below if there are any persons whom you may provide the practice authorization to release information regarding your appointments, financial and/or medical information.

Please check all that apply.

Name:____Relationship_____________________

□Appointments □Financial □Medical □All

Name: ____Relationship_____________________

□Appointments □Financial □Medical □All

Please indicate if you would like a copy of our HIPAA policy: □Yes □No

Our practice not only respects your privacy, but your time as well. While it is our intent to always see patients at their scheduled appointment, there are unpredicted events that occur throughout the course of a busy day.

Printed Patient Name ____

Signature of Patient or Legal Guardian____________________________________ Date_____________

Mountain Spring Vascular DBA National Vascular Associates

Patient Registration Form

Name:________________________________ Date of Birth:____________ SSN:____________________

Address:____

Phone Number: (H)_______________ (C)_______________ Email:_______________________________

Emergency Contact Name:__________________ Number:_______________ Relationship:_____________

Marital Status: □Single □Married □Divorced □Widowed

Language: □English □Non-English speaking

Race: □African American □Asian □Caucasian □Hispanic □Native American

Ethnicity: □Hispanic or Latino □Non-Hispanic or Latino

Sex: □Male □Female

Code Status: □Full Code □DNR □DNI □DNR/DNI

Primary Care Doctor:

Name:___________________________________Address:_____________________________________

____Phone number: ________________________________

Referring Provider:

Name: ___________________________________ Address:____________________________________

____ Phone Number:_______________________________

Other Care Team: (where we will send correspondence about your care to)

Name: ___________________________________ Address: ____________________________________

____ Phone Number: ______________________________

Name: ___________________________________ Address: ____________________________________

____ Phone Number: ______________________________

Name: ___________________________________ Address: ____________________________________

____ Phone Number: ______________________________

Dialysis Patients:

Nephrologist: ______________________________ Dialysis Unit: _______________Days: _____________

Are you Diabetic: □No □Yes If yes, do you have a Podiatrist: □No □Yes

Name of Podiatrist: ____

BP: O2: HR: Temp: HT: WT:

Mountain Spring Vascular DBA National Vascular Associates - History & Physical Form		
Pt Name:	ID#(office use)	DOB:

Current Medications

	Medication Name	Dose	Frequency	Route
1				
2				
3				
4				
5				
6				

Allergies:

Vaccines

Pharmacy

Name	Location	Phone #

Surgical History

Surgery	Date

Family History

Mother: □Bleeding Disorder □Cancer □Stroke □Heart Attack □Diabetes □Hypertension □Blood clots
Age of onset:_______ Living: Yes or No Age Deceased:________

Father: □Bleeding Disorder □Cancer □Stroke □Heart Attack □Diabetes □Hypertension □Blood clots
Age of onset:_______ Living: Yes or No Age Deceased:________

Brother: □Bleeding Disorder □Cancer □Stroke □Heart Attack □Diabetes □Hypertension □Blood clots
Age of onset:_______ Living: Yes or No Age Deceased:________

Sister: □Bleeding Disorder □Cancer □Stroke □Heart Attack □Diabetes □Hypertension □Blood clots
Age of onset:_______ Living: Yes or No Age Deceased:________

Social History

Does anyone in your house smoke cigarettes? □Yes □No

Do you smoke cigarettes? □Never Former: # years quit ______ Current: # of years___

Do you use any other forms of nicotine? If yes, what__________Packs/week______ Packs/day_____

Alcohol Use: □None □Occasionally □Moderate □Heavy #Years___

Illicit Drugs: □No □Yes Type:________________

Caffeine: □No □Yes Cups/day:____________

Exercise: □None □Occasionally □Moderate □Heavy

Diet: □Regular □Vegetarian □Gluten Free □Cardiac □Diabetic

Are you able to take care of yourself? □No □Yes

Do you have difficulty with any of the following?

□Walking □Climbing Stairs □Dressing □Bathing □Running Errands

Past Medical History-please check all that apply

□Asthma □AAA □Bleeding Disorder □Back Pain □Cancer □Coronary Artery Bypass

□COPD □Deep Vein Thrombosis □Diabetes □Heart Disease □High Blood Pressure

□HIV □Hepatitis □High Cholesterol □Kidney Disease □Impotence □Osteoarthritis

□Migraines □Patent Foramen Ovale (hole in heart) □Peripheral Artery Disease

□Pulmonary Embolism □Stroke □Vision Problems □Hearing Problems □Uterine Fibroids

□Hemorrhoids □Varicose Veins □Pelvic Congestion Syndrome □Skin Ulcerations

□Lymphedema □Other____

Current Problems- please check all that apply

□Leg pain □Leg swelling □Knee pain □Ulcerations □Skin discoloration □Shoulder pain

□Deep vein thrombosis □Peripheral Artery disease □Dizziness □Weakness □Passing out

□Fatigue □Vision Disturbances □Shortness of breath □Weight loss/gain

□Appetite: increase/decrease □Digestive problems □Urinary problems □Bowel problems

□Varicose veins □Bleeding hemorrhoids □Uterine Fibroids □Other___________________

The information in this form is complete to the best of my knowledge and I understand that the information given in this form is documented within my medical record.

Patient: ____ Date:________________________

Guarantor: ____ Date:_________________________