SOUTH ATLANTA VASCULAR INSTITUTE

New Patient Registration Forms

Patient Information

Name (Last, First, Middle): _____ Date of Birth: _____

Social Security Number: _____ Driver's License #: _____ Issuing State: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Preferred Sex: □ Male □ Female □ Other _____

Race/Ethnicity: □ White/Caucasian □Black/African American □ Hispanic/Latino □Asian □Other _____

Marital Status: □ Single □ Married □ Divorced □ Widowed

Employer: _____ Work #: _____ Ext: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone #: _____

Insurance Information

Primary Insurance Company: _____ ID #: _____

Group: _____ Plan Type: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Relationship to the Patient: _____

Secondary Insurance Company: _____ ID #: _____

Group: _____ Plan Type: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Relationship to the Patient: _____

Pharmacy Information

Preferred Pharmacy: _____ Pharmacy Phone: _____

Pharmacy Address: _____

(PLEASE BRING YOUR INSURANCE CARD AND PHOTO ID TO ALL APPOINTMENTS)

How did you hear about us? _____

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Medical History Questionnaire

NAME: _____ **DOB:** _____

Reason for Visit: _____ **Who Referred You:** _____

Other Physicians providing care and phone number: **Reason for seeing physician:**

PCP: _____ _____

Specialist: _____ _____

Specialist: _____ _____

Past Medical History

Are you currently being treated or been treated in the past for any of the following medical conditions:

Medical Condition	✓	Medical Condition	✓
Aneurysm		High Cholesterol	
Arthritis		HIV/AIDS	
Asthma		Hepatitis	
Blood clots/ DVT/PE		Kidney Disease	
Cancer		Dialysis	
Carotid Stenosis		Peripheral Vascular disease	
COPD		Stroke	
Diabetes		Thyroid disease	
Heart Disease/MI		Varicose veins	
Heart failure		Wounds/Sores	
High blood pressure		Bleeding disorder	
Anemia		Seizures	
Sleep Apnea			

Please list any other disease or medical condition not listed above:

If you are receiving dialysis, who is your dialysis center: _____

What days do you receive dialysis? MWF or TTS ☐ ☐

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Medical History Questionnaire

NAME: _____ **DOB:** _____

Prior Surgeries or Hospitalizations

Please list any prior surgeries and/or procedures that you have had:

DATE	SURGERY OR PROCEDURE

Allergies

List any drug allergies:

Allergy	What is your reaction

Nickel allergy? Yes or No **Contrast dye?** Yes or No **Eggs?** Yes or No **Heparin?** Yes or No

Latex? Yes or No

Family History

Please mark an X to indicate if any immediate relatives (mother, father, grandfather, grandmother, sister, or brother) have had any of the following conditions:

Condition	Mother	Father	Grandmother	Grandfather	Sister	brother
Diabetes						
High blood pressure						
Heart disease/heart attack						
Aneurysm						
Blood clots						
Cancer						
Kidney disease						
Stroke						
Peripheral vascular disease						
Varicose veins						

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Medical History Questionnaire

NAME: _____ **DOB:** _____

Social History

Do you currently smoke? Yes or No Former Smoker? Yes or No If yes; how long? _____

How many packs per day? _____ Do you vape? Yes or No Chew Tobacco? Yes or no

Do you drink alcohol? Yes or No If yes how many drinks per week? _____

Any history of illicit drug use? Yes or No

Have you traveled outside the U.S. in the last 3 months? Yes or No If yes; where? _____

Do you have an Advance Care Directive? Yes or No

Medications

Please list your current Medications/Vitamins/Supplements:

Medication/Vitamin/Supplement	Dosage	Times per day

Patient/Guardian signature: _____

Date: _____ /_____/_____ **Relation to the patient:** _____

SOUTH ATLANTA
VASCULAR INSTITUTE

Release of Medical Records

Patient Name: _____ Date: _____

Social Security Number: _____ Date of Birth: _____

Address: _____

Phone Number: _____

Information Requested:

- Clinic Visits (3 most recent):_____
- Ultrasound reports: _____
- Operative reports: _____
- Entire Record:_____

Please submit via fax:
770-954-5168 or 470-781-5393

I hereby authorize South Atlanta Vascular Institute to receive the protected health information regarding the above-named patient from:

Name: _____

Organization: _____

Address / Fax Number: _____

Please detail the reason why information is being shared.

☐ Continuity of Care ☐ My request ☐ Other: _____

Signature: _____ Date: _____

Print your name: _____

Relationship to patient: _____

Re-disclosure: State and Federal regulations prohibit the disclosure of alcohol and drug testing, HIV, ARC and AIDS regulated diagnosis without specific written permission. Additionally, re-disclosure of the requested health information is specifically prohibited by the recipient. South Atlanta Vascular Institute cannot guarantee that the recipient will not re-disclose the requested health information to others.

7402 Davidson Circle West, Stockbridge, Georgia 30281
Office: 770.919.5238Fax: 770.954.5168 www.southatlantavascular.com

SOUTH ATLANTA
VASCULAR INSTITUTE

HIPAA CONSENT
CONSENT TO LEAVE MESSAGE

Patient name: _____ Date: _____
(Print)

I wish to be called at home☐; other ☐ (check all that apply) regarding my care, follow up, and financial information. The best telephone number(s) to reach me are:

_____ Home _____ Other

☐ I do give permission to leave relevant medical and/or financial information on my answering machine or voicemail.

☐ I do **NOT** give permission to leave relevant medical and/or financial information on my answering machine or voicemail.

The name(s) of the individual(s) with who you may leave pertinent information are:

_____

_____

_____ _____
Patient Signature Date

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PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing South Atlanta Vascular Institute, L.L.C. as your healthcare provider. The medical services you seek imply a financial responsibility on your part. This responsibility obliges you to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, we ask that you read and sign this form. Feel free to ask if you have any questions regarding your financial responsibilities. If someone else (parent, spouse, domestic partner, etc.) is financially responsible for your expenses or carries your insurance, please share this policy with them, as it explains our practices policy for insurance and patient billing. By signing below and/or by receiving medical services from South Atlanta Vascular Institute L.L.C., you agree:

1. **You are responsible for co-payments, deductibles, co-insurance amounts or any other patient responsibility indicated by your insurance carrier(s) at the time of check-in.**

2. **You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply:**
   (a) **Your health plan determines that services you receive at South Atlanta Vascular Institute L.L.C. are not medically necessary and/or not covered by your plan.**
   (b) **Your health plan coverage has lapsed or expired at the time you receive services at South Atlanta Vascular Institute, L.L.C.**
   (c) **You have not provided insurance coverage for services rendered and are deemed Self-Pay and as a Self-Pay patient, our fee is expected to be paid in full at the time of services.**

3. **Having secondary insurance does not mean your services are 100% covered. Secondary insurance policies typically pay according to coordination of benefits based on your plan provisions.**

4. **Co-payments, deductibles, or co-insurances cannot be waived. This is a violation of insurance rules.**

5. **Completing forms will be completed within two (2) business days, payment will be collected prior to completion: FMLA-$35.00, Disability Forms $0 UNLESS STIPULATED IN LETTER OF REQUEST, Complete Medical Records-$15.00.**

You will be mailed a billing statement that contains the total cost of your service(s) or procedure(s) received during your visit(s). You may generally expect this billing statement within twenty (20) days after your insurance carrier has responded to a submitted claim. You must notify us of any error or objections to the billing statement within (30) days or they will be deemed accurate, and the fees and expenses shall be deemed reasonable and necessary for the services incurred.

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Payment of any account balance is due within thirty (30) days of receipt of your billing statement. If any balance on your account is over one hundred and eighty (180) days past due, your account will be in default and subject to being referred to a collection agency. This can be resolved by contacting our billing department.

WE accept payment by check, cash, money order, debit card, credit card or Care Credit.
By signing below, this acknowledges that you have been provided a copy of South Atlanta Vascular Institute, L.L.C. PATIENT FINANCIAL RESPONSIBILITY STATEMENT, I have read, understand, and agree to the provisions and terms.

_____ _____

Patient/Responsible Party/Guardian **Date**

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