Precision
Vascular & Interventional
Part of Stride Healthcare

PATIENT REGISTRATION FORM

Name _____
First Middle Last

Cell _____ Home _____ Work _____

Email _____

Address _____
Street Apt# City State Zip

DOB _____ Age _____ Gender _____ Social Security # _____

Emergency Contact _____ Relationship _____ Phone _____

Employed ❑Yes ❑No ❑Full Time ❑Part Time ❑Self Employed ❑Retired ❑Student

Marital Status ❑Single ❑Married ❑Divorced ❑Widowed Occupation _____

Race ❑White ❑Black ❑Hispanic ❑Asian ❑Other _____

Language ❑English ❑Spanish ❑Mandarin ❑Other _____

Referring Physician Name | Specialty | Phone Number

Primary Care Physician Name | Specialty | Phone Number

INSURANCE INFORMATION

***You must present your cards at EVERY appointment**

PRIMARY Insurance Company Name | Policy Number | Group Number

PRIMARY Insured | Insured's DOB | Insured's SSN | Relationship to Patient

SECONDARY Insurance Company Name | Policy Number | Group Number

SECONDARY Insured | Insured's DOB | Insured's SSN | Relationship to Patient

PREFERRED PHARMACY INFORMATION

Pharmacy Name | Phone Number | Cross Streets

****** How did you hear about our practice (Circle all that apply) ******

Radio Google Facebook Yelp TV Instagram Google+ Friend Healthgrades Insurance Company Primary Doctor

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ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES
APPOINTMENT OF AUTHORIZED REPRESENTATIVE

_____Precision Vascular & Interventional and associated physicians are committed to securing the privacy of your health information. We are supplying you with a copy of our Notice of Privacy Practices. You are not required to read this notice. By initialing, you are acknowledging receipt of this notice.

_____I request that payment of authorized Medicare and other insurance benefits be made on my behalf to Precision Vascular & Interventional for any services furnished to me by any healthcare providers associated with that group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or insurance company for any information needed to determine these benefits of the benefits payable for related services.

_____I appoint Precision Vascular & Interventional to act as my authorized representative in requesting an approval from my insurance plan regarding its denial of services or denial of payment.

_____Unless I request to the contrary in writing, I will receive appointment reminders on my home or cell phone answering system and/or appointment reminder cards sent by mail, whichever is the policy of the practice.

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

In order to maintain our fees at the lowest possible level, it is important that we have a good understanding with our patients regarding financial responsibility. We hope that this summary will be helpful toward that end. We encourage you to discuss it with us and to ask questions.

We understand that your health coverage is provided through_____.
INSURANCE COMPANY

- If you have out-of-network benefits, we will happily file claims on your behalf.
- You must pay any co-payment and applicable deductible amounts at the time of service unless other arrangements have been made with our office.
- The remainder of your bill will be sent to your health plan for direct payment to our office.
- If your insurance carrier has not paid our claim within 45 days, we will expect payment from you.
- If, by mistake your health plan remits payment to you, please send it to us along with all paperwork sent to you at the time.
- You will remain responsible for amounts and any services that are not covered by your insurance plan.
- Your health plan may refuse payment of a claim for some of the following reasons:
    1) This is a pre-existing illness that is not covered by your plan.
    2) You have not met your full plan year deductible.
    3) The type of medical service required is not covered by your plan.
    4) The health plan was not in effect at the time of service.
    5) You have other insurance which must be filed first.

Please understand that the financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies this claim for any of these or other reasons, our office cannot be responsible for this bill. It is your responsibility as the patient to pay the denied amounts in full.

Our primary mission is to provide you with quality, cost effective, medical care. Together we are trying to adapt to the changing way that health care is financed and delivered. Again, we value you as a patient and our first priority is to provide you with the best possible care. With this housekeeping core complete, we are pleased to serve you.

Sincerely,

Precision Vascular & Interventional

I have completed this form with accurate information. I have read and understand my obligations and responsibilities. I acknowledge that I am fully responsible for supplying correct insurance information, billing information, and payment of any services not covered or approved by my insurance carrier.

_____ _____
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE

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AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Name of Patient: _____
FIRST MI LAST

DOB: ____/____/____ Social Security #: _____

I, the undersigned, authorize the release of or request access to the information specified below from:

_____
PHYSICIAN NAME

_____
PHYSICIAN ADDRESS

_____
PHYSICIAN PHONE NUMBER PHYSICIAN FAX NUMBER

of the above-named patient's medical record(s).

PATIENT INFORMATION IS NEEDED FOR:

o Continuing Medical Care	o Military	o Social Security/Disability
o Insurance	o Personal Use	o Legal Purposes
o School	o Other: _____	

INFORMATION TO BE RELASED OR ACCESSED:

o History & Physical	o Operative Reports	o X-Ray Reports/Images
o Progress Notes	o Lab/Pathology Reports	o Emergency Room Record
o Care Plan	o Consultation Report	o Face Sheet
o EKG Reports	o Discharge Summary	o Other: _____

The above information may be released to: **PRECISION VASCULAR AND INTERVENTIONAL**
12400 COIT ROAD, SUITE 505
DALLAS, TEXAS 75251
PHONE: (214) 382-3200 FAX: (214) 382-3201

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned to my signing this authorization, except in certain circumstances such as for participation in research programs or authorization of the release of testing results for pre- employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged retrieval/processing fee and for copies of my medical records according to Texas Hospital Licensing law.

This authorization will not expire unless I revoke the authorization in writing.

_____ _____
SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE DATE

_____ _____
PRINTED NAME OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE DATE

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PATIENT NAME DATE OF BIRTH

❑ PATIENT PORTAL ACTIVATION

Our office now has the ability to communicate with patients through an electronic Patient Portal. This portal will allow you to request appointments, view lab results, view current scheduled appointments, request medication refills, request referrals to specialists, complete medical questionnaires, view summaries of your recent visits and more. In order to activate this functionality for you personally, we MUST have an active e-mail address associated with your account.

Please list your e-mail address here:_____@_____
We will activate your account today and you will receive an e-mail within 24-48 hours with your login information.

❑ AUTHORIZATION TO OBTAIN PRESCRIPTION HISTORY

I authorize this office to have access to my prescription drug history. I understand the authorization allows this office to obtain my prescription history electronically from retail pharmacies.

❑ AUTHORIZATION TO COMMUNICATE THROUGH TEXT OR EMAIL

I authorize this office to communicate with me through email or text. I understand that these forms of communication may not be secure and may allow other people to see my personal health information.

❑ ACKNOWLEDGEMENT OF PRIVACY RIGHTS NOTIFICATION

I acknowledge receipt of this Notice of Privacy Rights, which I have reviewed and give my permission to **Precision Vascular & Interventional** to use and disclose my health information in accordance with it.

❑ AUTHORIZATION TO DISCLOSE MEDICAL/FINANCIAL INFORMATION

Federal privacy guidelines, HIPPAA, prevent this office from disclosing protected health information (PHI) to anyone other than the patient. By signing this form, you are allowing us to communicate with designated individuals regarding your medical and financial record with this facility.

I, the undersigned, hereby authorize Precision Vascular & Interventional to disclose PHI from my medical or financial record to the following person(s):

Name: _____

Relationship:_____ Type of Information (Circle One) Medical Financial Both

Name: _____

Relationship:_____ Type of Information (Circle One) Medical Financial Both

***ADDITIONAL PERSONS MAY BE LISTED ON THE OTHER SIDE IF NECESSARY. ***

This authorization is given freely with the understanding that:
I may revoke this authorization in writing at any time, but not retroactively. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the information I have authorized.

_____ Signature of Patient

_____ Signature of Patient's Representative

_____ Name of Patient (Print or Type)

_____ Relationship of Representative to Patient

_____ Date

_____ Date

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OFFICE GUIDELINES AND PROCEDURES

GENERAL:

- Office hours 8:00am - 5:00pm Monday through Friday.
- Calls after 4:00pm may not be addressed until the next business day.
- If you are over 15 minutes late for your appointment, we may have to reschedule the appointment. If we are able to work you in we will do so, but you may have to wait until the other patients who were here for their scheduled appointment time have been seen.
- You will be asked to verify and sign that your information has not changed every 30 days. You will also be asked to show your driver's license and insurance card(s) each time. This is to protect you as well as our physicians. If you have questions, please ask to speak with the Practice Manager.
- We ask everyone to update patient information biannually or when changes occur. We understand it is an inconvenience and time consuming, but it is necessary for us to be able to contact the patients for medical, billing, and legal (HIPAA) reasons. We also realize that some information may have not changed, but this has to be done.
- It is the patient's responsibility to know the insurance benefits. Co-Pays, deductibles, and coinsurance amounts are due at time of service as per our contract agreement with your insurance. We reserve the right to reschedule appointments if not paid at the time you will be seen by the physician.

MEDICATIONS:

- Medications will NOT be prescribed unless the patient sees the physician first.

FEES:

- All co-pays, coinsurance, deductibles, etc. are due on the date of service.
- Any previous balances owed are due on that day of service.
- Payment for services is the responsibility of the patient or the parent/guardian of the patient.
- The account will be turned over to a collection agency if it has not been paid after 150 days.
- There is a $40 charge for the doctor or the office staff to fill out any paperwork. Included in this FMLA forms and Short Term or Long Term disability forms. This is in addition to the office visit charge and needs to be paid before the forms are filled out. These papers take time to fill out in order for them to be correct. Please allow up to 10-14 business days for these to be done.
- Medical records are sent with a WRITTEN and SIGNED Release of Medical Records. This form is available in our office. The first 20 pages are $25 and then it is $0.50 for each page thereafter. Records will be copied after this fee has been paid. Please allow up to 15 business days for this to be completed.

_____ _____

Signature of patient or responsible party Date

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PAYMENT POLICY

Thank you for choosing us as one of your providers. We are committed to providing you with quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, payment is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. Copayments, deductibles, and co-insurance. All co-payments, deductibles, and co-insurance must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, deductibles, and co-insurance from patients can be considered fraud. Please help us in upholding the law by paying your portion due at each visit.
3. Non- covered services. Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of the visit.
4. Proof of Insurance. All patients must complete our patient information forms before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. Claims Submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. Coverage Changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer to your account to a collection agency and you will be notified by regular and certified mail that you have 30 days to find an alternate medical care. During that 30 day period, our physician will only be able to treat you on an emergency basis.
8. Missed Appointments. Our policy is to charge $25 for missed appointments not canceled within 24-hours of your scheduled appointment. These changes will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date