Vascular and Endovascular Institute of Michigan, P.C.

42855 Garfield Road, Suite 112
Clinton Township, MI 48038
Phone: 586.228.3180 | Fax: 586.228.3725
WWW.MYVEIM.NET

Welcome to Vascular and Endovascular Institute of Michigan, P.C.

Thank you for allowing us to serve your health care needs. Our mission is to provide you with quality healthcare in a professional, efficient and caring manner. Enclosed are the forms that **MUST** be completed prior to your appointment.

Please **COMPLETE ALL** the forms and bring them with you to your appointment.

Please arrive 20 minutes prior to your scheduled appointment to ensure that the necessary registration process can be completed in a timely manner.

FINANCIAL: If you have medical insurance, please bring **ALL** of your current **INSURANCE IDENTIFICATION CARDS** with you to the appointment. Please check to make sure that the cards are not expired. You will also need to bring a **VALID PHOTO IDENTIFICATION CARD**.

It is necessary for you to bring any co-payments you will owe, according to your insurance benefits, to your office visit and it will be collected at the time of check-in. For self pay patients, payment must be paid in full at the time of service is **REQUIRED**. We accept cash, checks, care credit, and all major credit cards.

We request that you give us at least 24-hour notice if you are unable to keep a scheduled appointment. This will give us time to schedule someone else who may have an urgent need for care. Patients that arrive more than 20 minutes late for an appointment will be asked to reschedule the appointment.

If you have any questions regarding your appointment, please feel free to contact the office.

Sincerely,

Vascular and Endovascular Institute of Michigan, P.C.

PATIENT DEMOGRAPHIC INFORMATION *(Please Print)*

Last Name:	First Name:	DOB:	**Gender**: ☐ Male ☐ Female
Social Security:		**Marital Status**: ☐ Single ☐ Married ☐ Divorced ☐ Widow	
Address:	City:	State:	Zip:
Home Phone:	Cellular Phone:	E-mail Address:	
Dominant Hand: ☐ Right Handed ☐ Left Handed		**Ethnicity**: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino	

Race: ☐ Alaska Native ☐ American Indian ☐ Asian ☐ Black/African American ☐ More than 1 Race ☐ White ☐ Unreported/Refused to Report

Preferred Language: ☐ Albanian ☐ Arabic ☐ English ☐ German ☐ Italian ☐ Japanese ☐ Spanish ☐ Polish ☐ Other:_____

IN CASE OF AN EMERGENCY, WHO CAN WE CONTACT?

Name:	Relationship:	Phone:

PHYSICIAN CONTACT INFORMATION

Referring Physician:	Referring Physician Phone:
Primary Care Physician:	Primary Care Physician Phone:
Cardiologist Physician:	Cardiologist Physician Phone:
Nephrologists Physician:	Nephrologists Physician Phone:
Name of Dialysis Center:	Dialysis Physician:
Dialysis Center Phone:	Days Dialyzed: ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

PHARMACY CONTACT INFORMATION

Pharmacy Name:	Pharmacy Phone:

INSURANCE INFORMATION

PRIMARY INSURANCE Company Name:	Subscriber Card Holder Name:
Member ID Number:	Group Number:
SECONDARY INSURANCE Company Name:	Subscriber Card Holder Name:
Member ID Number:	Group Number:

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that Payment of Authorized Medicare/ Other Insurance Company benefits be made to either me or on my behalf to Vascular and Endovascular Institute of MI, P.C. for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying in my treatment.

_____ _____

Patient/Guarantor Signature **Date**

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward. Notice of Privacy Practices, pursuant to the HIPAA regulations, I acknowledge that I have been offered the notice of privacy practices in effect at Vascular and Endovascular Institute of MI, P.C. and have been made aware that this same notice is posted in the lobby. Medicine is not an exact science, I have been made no promises or guarantees as to the outcome of my care.

_____

Patient Name (Print)

_____ _____

Patient/Guarantor (Signature) **Date**

DISCLOSURE OF PATIENT RECORDS

The HIPAA privacy act gives patients the right to request a restriction on the uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications or that the communication of PHI can be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The following is a list of choices for you to determine how your protected health information can be used or shared:

I wish to be contacted in the following manner:

HOME PHONE	CELL PHONE	WORK PHONE
☐ Leave a detailed message ☐ Leave a call back number only	☐ Leave a detailed message ☐ Leave a call back number only	☐ Leave a detailed message ☐ Leave a call back number only
Please note that marking "Leave a call back number only" could impact patient care by preventing us from leaving important messages in a timely manner.		

Written Communications will automatically be sent to your home address (i.e. Lab results, correspondence) unless otherwise indicated below:

☐ **I wish for my PHI to be mailed to a place other than my home:**

Street Address/PO Box/Apt. or Unit Number:		
City:	State:	Zip:

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made with the authorization requested by the individual.

I hereby give the office my permission to release any necessary information to the following individuals listed below should they call on my behalf:

Name:	Relationship:
Name:	Relationship:

This information may be revoked or changed at any time by filling out a new form.

_____

Patient Name (Print)

_____ _____

Patient/Guarantor (Signature) **Date**

PATIENT MEDICAL HISTORY

Patient Name: _____ **Date of Birth:** _____

Have you been treated for any of these MEDICAL PROBLEMS in the past? *(Please check all that apply)*		
☐AAA	☐Deep vein thrombosis	☐HIV/AIDS
☐Alcoholism	☐Depression	☐Hyperlipidemia
☐Anemia	☐Diabetes mellitus	☐Hypertension
☐Angina	☐Diverticulitis	☐Kidney Disease
☐Anxiety	☐Dizziness	☐Liver Disease
☐Arthritis	☐Dysphagia	☐Lupus
☐Asthma	☐Edema	☐Myocardial Infarction
☐Atrial Fibrillation	☐Emphysema	☐Neuropathy
☐Back Pain	☐Erectile Dysfunction	☐Pancreatitis
☐Cancer: _____	☐GERD	☐Peripheral Vascular Disease
☐Cardiomyopathy	☐Gout	☐Pulmonary Embolus
☐Carotid Stenosis	☐Guillain-Barre	☐Raynaud's Disease
☐CHF	☐Hearing loss	☐Schizoaffective disorder
☐Cirrhosis	☐Heart Attack	☐Seizures
☐Claudication	☐Heart Disease	☐Stroke / TIA
☐COPD	☐Heart Failure	☐Thyroid disease
☐Coronary Artery Disease	☐Hepatitis:_____	☐Varicosities / Phlebitis
☐**Other:** _____		

SURGICAL HISTORY *(Please check all that apply)*			
☐ AAA	☐ C-Section	☐ Hip Surgery	☐ Shoulder Surgery
☐ Abdominal Angioplasty	☐ Dialysis Access Surgery	☐ Knee Surgery	☐ Spine Surgery
☐ Amputation	☐ Ear Surgery	☐ Mastectomy	☐ Stent
☐ Ankle Surgery	☐ Elbow Surgery	☐ Mediport	☐ Skin Graft
☐ Appendectomy	☐ Eye Surgery	☐ Nose Surgery	☐ Throat Surgery
☐ Back Surgery	☐ Femoral Endarterectomy	☐ Neck Surgery	☐ Tonsillectomy
☐ Biopsy:_____	☐ Fistula for Dialysis	☐ Pacemaker	☐ Triple Heart Bypass
☐ Breast Surgery	☐ Foot Surgery	☐ Penile Implant	☐ Tubal Ligation
☐ CABG X:_____	☐ Gallbladder	☐ Permacath	☐ TURP
☐ Carotid Artery	☐ Hand Surgery	☐ Pseudoaneurysm	☐ Urologic Surgery
☐ Cataracts	☐ Heart Surgery	☐ Rhinoplasty	☐ Vein Stripping
☐ Colonoscopy	☐ Hernia	☐ Rotator Cuff	☐ Wrist Surgery
☐**Other:** _____			

FAMILY MEDICAL HISTORY *(Please check all that apply)*	
Father	☐Unknown Medical History ☐Anemia ☐Aneurysm ☐Cancer ☐Diabetes ☐Heart Disease ☐Hyperlipidermia ☐Hypertension ☐Seizures ☐Stroke
Mother	☐Unknown Medical History ☐Anemia ☐Aneurysm ☐Cancer ☐Diabetes ☐Heart Disease ☐Hyperlipidermia ☐Hypertension ☐Seizures ☐Stroke
Brother	☐Unknown Medical History ☐Anemia ☐Aneurysm ☐Cancer ☐Diabetes ☐Heart Disease ☐Hyperlipidermia ☐Hypertension ☐Seizures ☐Stroke
Sister	☐Unknown Medical History ☐Anemia ☐Aneurysm ☐Cancer ☐Diabetes ☐Heart Disease ☐Hyperlipidermia ☐Hypertension ☐Seizures ☐Stroke

SOCIAL HISTORY *(Please check all that apply)*		
TOBACCO USE	**ALCOHOL USE**	**ILLEGAL DRUG USE**
☐Current Every Day Smoker	☐Currently Drinks	☐Currently uses illegal Drugs:(type of drug)_____
☐Current Some Day Smoker	☐Occasionally Drinks	☐Former illegal Drug User
☐Former Smoker	☐Former Drinker	☐Never used illegal Drugs
☐Never Smoker	☐Never Drank Alcohol	

MEDICATION LIST

Patient Name: _____ **Date of Birth: _____**

Help us care for you better by telling us what prescriptions and over-the-counter medications you take.

PRESCRIPTIONS			
Name of medication	**Dose (total mg)**	**How many times per day taken?**	**Why do you take this medication?**

ALLERGIES TO MEDICATION	