Patient Information

Northwest Endovascular Surgery
Dr. Saravanan Kasthuri

Date: _____

Patient Name: _____ Date of Birth:_____

Government regulations require us to ask the following demographical questions.

Please circle: Ethnicity: Non-Hispanic Hispanic **Preferred Language**: _____

Race: African/African American Asian/ Asian American Caucasian/European American

Native American/Alaskan Native Hawaiian/Other Pacific Islander Other

What would be the preferred method of communication?

Please circle: Phone Home phone Cell Mail

Home Phone: _____Cell:_____Work_____

Address: _____City:_____State:_____Zip_____---_____

Email: _____ Social Security No: _____-_____-_____

Emergency Contact: _____ Phone: _____ Relationship:_____

Referring Physician:_____PCP:_____

Other physicians you see (and phone numbers): _____

_____

Primary Insurance: _____Group #:_____Member ID#:_____

Insured's Full Name (if different from self):_____Date of Birth: _____

Insured's Social Security:_____-_____-_____ Relationship to Insured:_____

Secondary Insurance: _____Group #:_____Member ID#:_____

Insured's Full Name (if different from self):_____Date of Birth: _____

Insured Social Security: _____-_____-_____ Relationship to Insured:_____

If you are here to have a port or catheter removed, please answer the following questions.

When was the catheter/port placed?_____

Why was the catheter/port placed?_____

Why do you want to remove the catheter/port? Please circle below.

Treatment is complete I have another dialysis access Port is not working well

Infection

Signature: _____Date:_____

(Patient, Parent or Legal Guardian)

_____

If signed by patient representative, state relationship

NORTHWEST EndoVascular SURGERY

Patient Portal Access

The patient portal through our electronic health record, Patient Fusion, provides you with secure, online access to portions of your medical record, as well as an easy way to communicate with our team. Once logged in, the information you view pulls directly from your medical record here at NWES.

Patient Fusion gives you 24/7 access to your medications, diagnoses, allergies, lab results, vital signs, plan of care, and appointments.

Benefits of using Patient Fusion:

- Allows you to have a more active role in your healthcare.
- Provides a secure and efficient means of communication, eliminating sources of frustration such as "playing phone tag."
- Provides access to print or download parts of your chart at your discretion to take to other appointments with you, in turn reducing the amount of paperwork you may need to complete.

Patient Requirements:

- Access to the internet.
- An email address.

Your email address will be kept as part of your medical record and used only for patient care activities.

My current email address is _____.

☐ I do not have email/I do not wish to provide an email address for Patient Fusion. (If your email address is already on file, you will continue to receive appointment reminders from our office. If you wish to remove your email address from your record, please notify the staff.)

I have read and understand the opportunity Patient Fusion provides for my healthcare.

_____ _____

Signature Date

_____

Patient Name

MP/F

Acknowledgement of Receipt of Privacy Practices

- I give this practice my consent to use or disclose my protected health information (PHI) to carry out my treatment, to obtain payment from insurance companies and for health care operations (TPO).
- I have been informed that I may review the practice's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent. I understand this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.
- I understand that I have the right to request a restriction of how my PHI is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restrictions.
- I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used and disclosed. This authorization is valid until revoked.

Signature: _____Date:_____

(Patient, Parent or Legal Guardian)

_____

If signed by patient representative, state relationship

Northwest Endovascular Surgery, has my consent to:

Y N Leave Medical information on my home and/or cell phone answering machine.

Y N Send text message (SMS) or automated voicemail appointment reminders. (Standard rates may apply via your SMS provider.) Cell:_____

Y N Contact me at my place of employment.

Y N Leave medical information on voice mail at my place of employment.

Release of Information Consent

I authorize Northwest Endovascular Surgery, to discuss ANY information regarding my care with the below named persons: (Only list names of persons you are authorizing us to discuss ANY information with)

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Additional space on back of form if needed to include more family or friends if necessary.

Signature: _____Date:_____

(Patient, Parent or Legal Guardian)

_____

If signed by patient representative, state relationship

Northwest Endovascular Surgery Financial Policy

Thank you for choosing Northwest Endovascular Surgery. We are committed to successfully serving your health care needs and to ensuring that the charges associated with your care are handled efficiently and in accordance with the law.

Office visits and Procedures:

Payments in full for your portion of the visit are expected on the day of your appointment.

- Copays, co-insurance and any previous balance due (for prior services) will be collected before you are seen by the physician. If you are not able to pay in full, we have payment plans to help you to pay your bill. Please call 509-588-7613 and ask for the billing specialist.
- We accept cash, credit card (Visa and MasterCard) and personal checks.
- ***Self-Pay****:* If you do not have insurance, you will be required to pay for your care prior to seeing the physician. We offer a 20% discount off our charges.

Past Due accounts*: Just as we make every effort to accommodate you when you are in need of medical care, we expect that you will make every effort to pay your bill promptly.*

- If your insurance company has not processed your claims within 90 days, you will be expected to pay the outstanding balances. Any balance remaining after your insurance has paid in full is due within 30 days from receipt of your statement.
- If your account has had no payment for 60 days and becomes delinquent, and you have not established or met payment options with our office, your account will be turned over to a collection agency. You will responsible for all collection costs which may incur on your account.

Referrals and Authorization:

- Our physician is a specialist. Your insurance may require a referral to our office from a primary care physician or another specialist to be seen.
- Your insurance plan may require a prior authorization before receiving any specialty care. It is your responsibility to confirm any referral or prior authorization needed for that appointment.

Missed appointments:

- A fee of $25 will be charged for any appointment has been cancelled within 24 hours notice and must be paid before another appointment is scheduled.

Returned checks:

- There is $25 fee for any check returned by the bank. Any additional fees associated with a returned check will be your responsibility.

Health Insurance:

We will bill your health insurance company as a courtesy to you. It is your responsibility to ensure that your plan covers the services we provide. While we contract with all major insurance companies, your specific plan may have additional restrictions for network of

providers or covered services. We will be happy to provide the specific code and information you need to do so.

We require that you bring proof of insurance coverage to the appointment. Please remember that your insurance contract is between you and your insurance company and you agree to pay any portions of the charges not covered by your benefit plan.

Assignment of benefits:

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private
insurance and any other health/medical plan, to issue payment check(s) directly to Columbia Interventional Radiology Consulting Inc., dba Northwest Endovascular Surgery for medical services rendered to myself and/or my dependents.

A copy of this agreement is available when requested.

I attest to having provided accurate and current information regarding my insurance coverage.

Patient signature: _____ Date:_____

Patient name (printed): _____

Patient Rights and Responsibilities

As a patient, you or your representative have the right to:

- Receive impartial access to treatment regardless of race, color, sex, national origin, religion, or sources of payment for care.
- Have access to complete and current information, to the degree known, regarding your health status in terms you can understand.
- Receive considerate, respectful care at all times and under all circumstances with recognition of your personal dignity.
- Report any comments or concerns regarding the quality of services provided to you by Northwest Endovascular Surgery without fear of retribution or denial of care, to be involved in resolving problems with care decisions, and to receive fair and timely follow-up on your comments, and resolution within 10 business days.
- Have personal privacy respected and be treated in a secure environment.
- Be protected from abuse and neglect and have access to protective services.
- Know the identity, credentials, and professional status of your healthcare providers and expect them to provide the highest quality of services.
- Be informed of the scope of services available at this facility and related fees for services rendered.
- Receive instructions for after hours and emergency care after discharge from the facility should it become necessary.
- Be involved in all aspects of your care.
- Receive information regarding treatment options to make informed decisions about your medical care, including the right to agree to or refuse medical or surgical treatment and the right to leave the facility even against the advice of your physician. Upon leaving against medical advice, a release of liability form is to be signed by the patient and witnessed by a staff member of the facility.
- Confidentiality of records, patient disclosures, and communications. Except as required by law, you have the right to approve or refuse their release.
- Have access to your medical records.
- Be informed of any experimental, research, or educational projects affecting treatment and have the option to refuse participation without hindering access to care.
- Receive Advance Directive and Durable Power of Attorney information and be informed of the facility's policy regarding advance directives.
- Family input in care decisions, in compliance with existing legal directives of the patient that have been provided to the facility or existing court-issued legal orders.
- Be informed before any transfer to another facility or organization and ensure the receiving facility has accepted the transfer.
- Expect the facility to comply with Federal Civil Rights Laws that assure it will provide interpretation for individuals who are not proficient in English.
- Access spiritual care and cultural practices that do not harm or interfere with the planned course of medical therapy for the patient.
- Receive a second opinion and to choose or change your healthcare provider.
- Be informed of unanticipated outcomes.
- Have communication, and to have any communication restrictions necessary for patient care and safety explained to you and your representative.

As a patient, you are responsible for:

- Providing, to the best of your knowledge, accurate and complete information about your present health status and past medical history and for reporting any unexpected changes to the appropriate healthcare provider.
- Following the treatment plan recommended by the practitioner involved in your care, including the instructions of nurses and other health professionals as they carry out the physician's orders.
- Respecting the property of others and the facility, as well as being considerate of other patients and personnel, assisting in the control of noise and other distractions.
- Indicating whether you clearly understand a contemplated course of action and what is expected of you.
- Providing an adult to transport you home after the procedure and an adult to be responsible for you at home for the first 24 hours after the procedure.
- Your actions if you refuse treatment, leave the facility against the advice of the practitioner, and/or do not follow the practitioner's instructions relating to your case.
- Assuring that the financial obligations of your health care are fulfilled as promptly as possible by providing accurate insurance and/or credit information.
- Providing information about and/or copies of any living will, durable power of attorney, or other advance directive that you desire us to know about and follow.
- Following the facility's policies and procedures regarding conduct.
- Identifying any patient safety concerns and bringing them to the attention of the staff.

To report comments or concerns, or to file a grievance, please contact:

Vasavi Rajagopal, Administrative Team Leader

1341 Spaulding Avenue

Richland, WA 99352

(509) 588-7613

vasavi@circcare.com

AND/OR

Washington State Department of Health

HSQA Complaint Intake

PO Box 47857

Olympia, WA 98504-7857

Phone: 360-236-4700

Toll Free: 800-633-6828

Fax: 360-236-2626

Email: HSQAComplaintIntake@doh.wa.gov

Office of the Medicare Beneficiary Ombudsman

http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

Medicare Help and Support: 1-800-MEDICARE

I have read and understand the patient rights and responsibilities of Northwest Endovascular Surgery. I understand that a paper copy will be provided to me at my request.

_____ _____

Signature Date