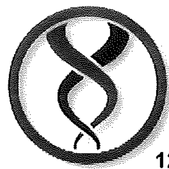

VEIN CENTER OF LOUISIANA | ACADIANA VASCULAR CLINIC

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# PATIENT INFORMATION REGISTRATION

**Name:** ______________________ **Sex**: Male or Female **Age:** ________

**Prefer to be called:** ______________________ **Date of Birth:** ______________

**Spouse's Name:** ______________________________________________

**Home Phone:** ____________________ **Work Phone:** ____________________

**Cell Phone:** __________________ **Email:** ____________________________

**Mailing Address:** ______________________________________________

**City:** ______________________ **State:** __________ **Zip:** ____________

**Social Security #:** ______________________________________________

**Employer Name**: ____________________ **Occupation**: ____________________

**Contact person in case of emergency**: ______________________________

**Relation:** ____________________ **Phone Number:** ____________________

**Referred by:** ______________________________________________

**Ownership Disclosure Statement:** In compliance with 42 CFR, I understand that members of Acadiana Vascular Center, LLC, have ownership in the Heart Hospital of Lafayette, or other outpatient facilities to which I may be referred. I understand that I have an opportunity to ask questions and to discuss treatment options at other facilities.

I have read, understood and agreed to the terms of this document. All my questions or concerns have been answered to my satisfaction prior to signing below.

**Patient/Guardian Signature:** ______________________________ **Date:** ______________

*In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial policies of this office.*

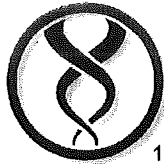
**PAYMENT IS REQUIRED FOR ALL SERVICES AT THE TIME THEY ARE RENDERED.**

We accept payment in the form of cash, check, MasterCard or Visa. In the event of hospitalization or major procedures, our office will file with the appropriate insurance. However, before such claims are filed, coverage will be preverified and you will be asked to pay any unmet deductible, non-covered services and co-payments. Please check the rules of your insurance coverage.

Additionally, I understand that if my account becomes **DELINQUENT** after 90 days, I will be **DISCHARGED** from the practice and will be responsible for all fees including Legal or other costs incurred in the collection of the account.

Your signature below signifies your understanding and willingness to comply with this policy. Further, your signature authorizes the doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the doctor when assigned claim is filed. I have received the notice of privacy practices.

**Patient/Guardian Signature:** ______________________________ **Date:** ______________



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**PRIMARY INSURANCE**

**Policy #**____________________ **Group #**____________________

**Insured's Name**____________________ **Relationship to the patient**____________

**Insurance Company Name**______________________________

**SECONDARY INSURANCE**

**Policy #**____________________ **Group #**____________________

**Insured's Name**____________________ **Relationship to the patient**____________

**Insurance Company Name**______________________________

## FOR MEDICARE PATIENTS ONLY

**PAYMENT POLICY:**
Medicare: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% co-payment. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balance billed.

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 carrier any information needed for this or a related Medicare 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. Regulations pertaining to Medicare assignment of benefits apply.

**Signature**____________________________ **Date**____________
***Signature as it appears on Medicare Card***

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file. I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

**Signature**____________________________ **Date**____________

VEIN CENTER OF LOUISIANA | ACADIANA VASCULAR CLINIC

**Authorization to Disclose Protected Health Information**
**The undersigned authorizes:**
**Acadiana Vascular Clinic**
**129 Rue Louis XIV Lafayette, LA 70508**
**(P) 337-289-9700 (F) 337-289-9702**
to release my health information as noted below:

## Patient Information

**Patient Full Name:** ______________________ **Other Names?** ______________

Patient Address: ______________________ Date of Birth: ______________

City: ____________ State: ______ Zip: ________Phone #: ______________

## Release Information To

**Email address for record delivery:** *Please ensure email address is legible!*

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

If email delivery is preferred, you must provide a valid email address of either your own or that of your designated recipient. Your records will be provided as an Adobe PDF file on BACTES Mail Express portal. If you do not retrieve your records within 30 days, they will be deleted. You will receive an email from Bactes.com containing instructions for accessing the records. There may be a fee for collecting your records.If so, an invoice will be provided to you through email or mail.

**Name/Facility:** ______________________ **Attention:** ______________

Address: ______________________ Phone: ______________

City: ____________ State: ______ Zip: ________ Fax #: ______________

**Purpose of Request:** ___ Personal ___ Treatment ___Legal ___Insurance ___Transfer ___Other:__________

## Information to be Released

***If you fail to specify, a 1 year abstract will be provided.***

___Please release a **1 year abstract** of my records (includes most recent notes, labs, procedures & testing)

___Please release a **2 year abstract** of my records (office notes, labs, procedures & testing, up to 2 years)

___**Date Range**: ______________________:

□ Progress Notes □ Radiology Reports □ Labs
□ Operative Reports □ Injections □ Physical Therapy
□ Other: ______________

___**Radiology Disc**

(**Please pick ONE delivery option**)

| [ ] Send by Email<br>[ ] Records on CD | [ ] Fax to Doctor | [ ] Records on Paper |
|---|---|---|

Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. If you want the entire medical record, the rate will increase proportionally based on the cost. At no time will the cost-based fees exceed Louisiana State law Statute: 40:1299.96

## Authorization to Release Protected Health Information

**I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.*** __________(*Please Initial*)

I understand that: I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition:**______________ *If I do not specify expiration this authorization will expire in 90 days.* If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations and may be disclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.

STOP **Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released, we may be unable to fulfill this request.**

**Signature*:**______________________________________**Date:** ______________

** For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy -of the legal documentation for patient's representative must be supplied with a copy of this form.*

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# AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS, POWER OF ATTORNEY, ETC.

I authorize Acadiana Vascular Clinic to release any and all information pertaining to my care, including but not limited to, future appointments, treatment plans, prognosis, etc., to the following individuals:

**o If permission given, list the name(s) of the individual(s) who will have the authority to receive any & all information pertaining to your care and then sign and date the form.**

**o IF YOU DO NOT WISH ANY INFORMATION TO BE RELEASED DRAW AN "X" OVER THE TWO SECTIONS LISTED BELOW and then sign and date the form.**

**Name:** ______________________________

**Telephone Number:** ______________________________

**Relationship to Patient:** ______________________________

**Name:** ______________________________

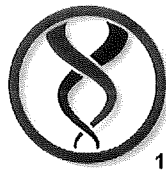
**Telephone Number:** ______________________________

**Relationship to Patient:** ______________________________

**Patient Signature:** ______________________________

**Printed Name of Patient:** ______________________________

**Date:** ______________________________



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# HIPAA

## PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION ACADIANA VASCULAR CENTER, LLC.

With my consent, Acadiana Vascular Center, LLC may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Acadiana Vascular Center, LLC Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Acadiana Vascular Center, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Acadiana Vascular Center, LLC Privacy Officer at 129 Rue Louis XIV, Lafayette, LA 70508.

With my consent, Acadiana Vascular Center, LLC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Acadiana Vascular Center, LLC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. However, the practice is not required to agree to my requested restrictions, if it does, it is bound by this agreement.

By signing this form, I am consenting to Acadiana Vascular Center, LLC use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Acadiana Vascular Center, LLC may decline to provide treatment to me.

______________________________

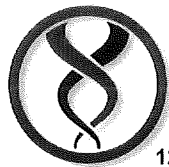
**Signature of Patient or Legal Guardian**

______________________________

**Print Patient's Name**

______________________________

**Date**



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# PATIENT PORTAL

We have exciting news! We are now offering our patients access to their electronic medical records. This new feature will allow patients to view portions of their chart, request medication refills, review test results, and send **NON-URGENT** messages to their medical providers. To join the patient portal you can provide us with your email address, the email address of your trusted family member, or follow the directions below to request an account.

Please fill out the below information if you would like to have access to your health information through the patient portal.

**Name:** ______________________________________________________________

**Email Address**: _______________________________________________________

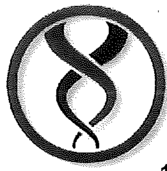
______ **I do not wish to participate**.

We will receive a notification that you have requested access and will soon link the request to your chart here at Acadiana Vascular Center LLC.

*Please sign below stating that you have received this invitation to our patient portal.*

_________________________________________ ___________________________

**Patient Signature** **Date**



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# HOW DID YOU HEAR ABOUT US?

**Please check all areas that apply:**

Referral from another Physician: _______

- If so, list who: ____________________________________________________________

Family Member: _____

Facebook: _____

Radio: _____

Event: _____

Word of mouth: _____

Television Ad: _____

Internet Search/ Website: _____

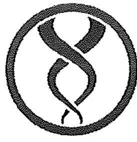
Billboard: _____

- If so, please list which event you saw us at: ______________________________________

**Other Source:** ____________________________________________________________

**(BELOW FOR OFFICE USE ONLY)**

**Patient Name:** ______________________________________ **ID #:** ____________________



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# Consent For Telemedicine Services

PATIENT NAME:______________________________DATE OF BIRTH:______________MEDICAL RECORD #:________________

## Introduction

Telemedicine is the delivery of healthcare services when the healthcare provider and patient are not in the same physical location with the use of technology. Providers may include primary care practitioners, specialists, and/or subspecialties. Electronically transmitted information may be used for diagnosis, therapy, follow-up and/or patient education, and may include any of the following:

- Patient medical records
- Medical Images
- Interactive audio, video, and/or data communications
- Output data from medical devices, sound, and video files

The interactive electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard that data to ensure its integrity against intentional or unintentional corruption.

## Potential Benefits:

1. Improved access to medical care by enabling a patient to remain in his/her physician's office (or at a remote site) while the physician obtains test results and consults with healthcare practitioners at distant/other sites.
2. Improved access to medical care by enabling a patient to remain in his/her home or other remote location while the physician performs a video office encounter with the patient

## Potential Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

1. Information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s).
2. The consulting physician (S) are not able to provide medical treatment to the patient through the use of telemedicine equipment nor provide for or arrange for any emergency care that I may require.
3. Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
4. Security protocols could fail, causing a breach of privacy of personal medical information.
5. A lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other medical judgement errors.

## By signing this form, I understand and agree to the following:

1. The laws that protect the privacy and confidentiality of medical information also apply to telemedicine. No information obtained during a telemedicine encounter which identifies me will be disclosed to researchers or other entities without my consent.

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2. I have the right to withhold or withdraw my consent to the use of telemedicine during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment, nor will it subject me to the risk of loss or withdrawal of any health benefits to which I am otherwise entitled.
3. I have the right to inspect all information obtained and recorded during the course of a telemedicine interaction and may receive copies of this information for a reasonable fee.
4. A variety of alternative methods of medical care may be available to me, and I may choose one or more of these at any time. My physician has explained the alternative care methods to my satisfaction.
5. Telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out-of-state.
6. I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured. My condition may not be cured or improved, and in some cases, may get worse.

## Patient Consent to the Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby consent to and authorize________________________________(name of provider) to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for patient):____________________________Date:______________

If authorized signer, relationship to patient: __________________________________________Date:______________

Witness:__________________________________________Date:______________

I have been offered a copy of this consent form (patient initials)_______________