Vascular Surgical Associates, P.C.

Today's Date: _____ /_____ /_____

Office Use Only:

Chart No. **Employee Init.:**

Patient's Information

Last Name:_____ First Name:_____ MI: _____ Sex: M F

SSN#:_____-_____-_____ Are you a resident of a Skilled Nursing Facility? Yes / No If yes, list facility: _____

Birth Date:_____/_____/_____ Email Address:_____

Street Address: _____ Address Line 2 (i.e. Apt #): _____

City_____ State_____ Zip_____ Marital Status: M S W D

Please check box next to preferred primary telephone number:

☐ Home Ph. #: _____ ☐ Cell Ph. #: _____ ☐ Work Ph. #: _____

_____By initialing this, I consent to receive text and email appointment reminders and related messages from VSA . I understand that this will apply to all future appointment reminders unless I choose to opt out. I consent to allow VSA to communicate with me via text, email, or phone and I acknowledge that those messages may contain protected health information.

Usual Provider at VSA.	Referring Physician	Primary Care Physician
_____	_____	_____

Are you a Dialysis Patient? Yes _____ No _____ If so, please list your doctor:_____

Dialysis Center:_____ Phone Number:_____

Emergency Contact Name:_____ Relationship to Patient _____ Phone Number:_____

Patient's Insurance Plan(s) Do you have a Health Savings or Reimbursement Account? Yes / No

Primary Insurance:_____ Policy Number.:_____

Specialist Co-Pay: $_____ Require Referral from PCP: Yes or No Group Number.:_____

Policy Holder Name:_____ Policy Holder Date of Birth:____ / ____ / _____

Secondary Insurance:_____ Policy Number.:_____

Specialist Co-Pay: $_____ Require Referral from PCP? Yes or No Group Number.:_____

Policy Holder Name:_____ Policy Holder Date of Birth:____ / ____ / _____

*Language:*_____ *Race:*_____ *Ethnicity:*_____

Authorization, Release, and Financial Responsibility: I hereby authorize Vascular Surgical Associates P.C. or its representatives to release any information acquired in the course of my examination or treatment to any person or corporation which is or may be liable for all or any portion of the charges, including insurance companies, workers' compensation carriers, adjusters or attorneys. I understand that all charges or co-payments, if applicable are due at the time of services. All profession services rendered are charged to the patient. The patient is responsible for all fees regardless of insurance coverage, unless the services are covered under a contractual agreement between this medical practice and the patient's insurance carrier. I instruct and direct my insurance carrier(s) to pay Vascular Surgical Associates P.C. by check or electronic remittance for services billed to them on my behalf. I agree to pay any portion determined my responsibility by my insurance carrier including but not limited to co-payments, deductibles, and non-covered services. I assume full financial responsibility for services not covered by insurance. If transactions are posted on my account that leave a patient credit of less than $1.00, I understand that this will remain on my account for 6 months and be applied to any outstanding patient balance due. After that 6 month period, any credit of less than $1.00 will be adjusted from my account. I understand that Vascular Surgical Associates P.C. utilizes Physician's Assistants for levels of practice approved by the state medical board. I understand and agree to receive services provided by such providers when necessary and appropriate. A photocopy of this document shall be considered as valid as the original. The undersigned certifies that he/she understands and agrees to the terms outlined above.

Signature:_____ Date:_____ / _____ / _____