MEMPHIS VASCULAR CENTER

PATIENT REGISTRATION

CHART #: ______________ DATE: ____________________

PATIENT INFORMATION

Pt Home Ph #:________________ Pt Cell #:________________ Pharmacy #:________________ DOB:____________

Patient's Last Name:________________________ First Name:________________________ MI:__________

Address:________________________ City:________________________ ST______ ZIP:__________

Email address:________________________ SSN:________________ Sex: M F Marital Status: S M D W Separated

Referred By: Physician [ ] Friend/Relative [ ] Emergency Room [ ] Yellow Pages [ ] Other: ________________

Referring Physician:________________________ Physician Phone:________________

Physician Address:________________________ City:________________ ST:______ ZIP:__________

Employer:________________________ Employer Phone:________________

Employer Address:________________________ City:________________ ST:______ ZIP:__________

Emergency Contact:________________________ Contact Phone:________________

Emg Contact Address:________________________ City:________________ ST:______ ZIP:__________

RESPONSIBLE PARTY

Last Name:________________________ First Name:________________________ MI:__________

Address:________________________ City________________ ST:______ ZIP:__________

Phone No (Home):________________ DOB:________________ SSN:________________

Employer Name:________________________ Employer Phone:________________

Employer Address:________________________ City:________________ ST:______ ZIP:__________

INSURANCE INFORMATION

Primary Insurance Company:________________________ Ins Co Phone:________________

Policy Holder:________________________ DOB:________________ SSN:________________

Policy Holder Address:________________________ City:________________ ST:______ ZIP:__________

Policy No:________________ Group No:________________ Ref No:________________

Other Ins Co:________________________ Ins Co Phone:________________

Policy Holder:________________________ DOB:________________ SSN:________________

Policy Holder Address:________________________ City:________________ ST:______ ZIP:__________

Policy No:________________ Group No:________________ Ref No:________________

ASSIGNMENT OF BENEFITS:
I hereby authorize the verification of my medical benefits and payments directly to the treating physician. I understand that I am responsible for any portion of my bill not covered by my insurance company.

RELEASE OF INFORMATION:
I hereby authorize the treating physician to release any information required in the course of my treatment to my insurance.

GUARANTEE OF PAYMENT:
I understand that pre-authorization is not a guarantee of payment from the insurance company. Memphis Vascular Center (Memphis Radiological, P.C.) will bill for the services rendered, but I understand that any agreement is between my insurance company and me. If any amount due for the service rendered becomes delinquent and the debt is assigned to a third party for collections, it is understood that court costs, attorney's fees and other reasonable costs of collection may be added to the amount of the account.

SIGNATURE (Responsible Party): ____ DATE: ______________

SIGNATURE (Witness): ____ DATE: ______________

PATIENT MEDICAL HISTORY

Past Medical History-please check any of the boxes that apply:

- ☐ Anemia
- ☐ Clotting Disorder
- ☐ Arthritis
- ☐ Ascites/ Abdomen Distention
- ☐ Asthma
- ☐ CAD (coronary artery disease)
- ☐ Cancer: type: ____________
- ☐ Cerebral Aneurysm
- ☐ Cirrhosis
- ☐ CVA (Stroke)
- ☐ Defibrillator
- ☐ Depression
- ☐ Diabetes: type I / II
- ☐ Emphysema
- ☐ Encephalopathy/ Confusion
- ☐ Endometriosis
- ☐ GERD (reflux disease)
- ☐ Glaucoma
- ☐ Hepatitis: type: A / B / C / Unknown
- ☐ HIV
- ☐ High Cholestoral
- ☐ High Blood Pressure
- ☐ IBS: Crohn's / Ulcerative Colitis / other:
- ☐ Heart Attack
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ PVD (peripheral vascular disease)
- ☐ Seizure Disorder
- ☐ Tuberculosis
- ☐ Thyroid Problems
- ☐ Stroke-like symptoms (TIA)
- ☐ Uterine Fibroids
- ☐ Other: ____________________

Family History-please check any of the boxes that apply and list the family or family members that condition applies to:

☐ Unknown Family History

☐ Adopted: Family Member: ______________________________

☐ Aneurysm: Family Member: ______________________________

☐ Cancer: Type: ______: Family Member: ____________________

☐ CVA: Family Member: __________________________________

☐ Diabetes: Family Member: ______________________________

☐ High Cholesterol: Family Member: _________________________

☐ High Blood Pressure: Family Member: _____________________

☐ Heart Attack: Family Member: ___________________________

☐ Osteoporosis: Family Member: ___________________________

☐ Peripheral Vascular Disease: Family Member: ______________

☐ Seizure Disorder: Family Member: _________________________

☐ Sudden Cardiac Death: Family Member: ____________________

☐ Other: ____

Family Member: ______________________________________

Allergies-please list any allergies to any medications you may have:

____

____

____

Please indicate the Pharmacy Name & Number you prefer to use- ____________________________

Social History-please check any of the boxes that apply:

Tobacco Use: ☐Non smoker ☐Smoker

☐Dip

☐Chewing tobacco

How many packs a day:

How many years:

Quit date:

Alcohol Use: ☐Non Drinker ☐Socially ☐Daily

Drug Use: ☐Analgesics ☐Cocaine ☐Crack Cocaine ☐Heroin

☐Marijuana ☐Narcotics ☐Methamphetamine ☐Other:____________

Martial Status: ☐Single ☐Married ☐Significant Other

☐Divorced ☐Widowed ☐Other:__________

Living Arrangements: ☐Alone ☐With Family ☐With Roommates

☐Assisted Living ☐Nursing Home ☐Other:____________

Employment: ☐Full Time ☐Part Time ☐Self Employed ☐Retired

☐Unemployed ☐Disabled ☐Other:_________

Occupation: ☐Please List: ____________________________________

Medication History -please list any medications you are currently taking:

____

____

____

____

____

Height: __________

Weight: __________

PATIENT SIGNATURE:____ **DATE** ____________________

Surgical History-please check any of the boxes that apply and list dates if they are known:

- ☐ Appendix Removed
- ☐ Bladder Suspension
- ☐ Heart Bypass: # of bypasses: _____
- ☐ Carotid Endarterectomy: Left / Right
- ☐ Carpel Tunnel Syndrome: Left / Right/ Both
- ☐ Cataract Right / Left
- ☐ Cesarean Section
- ☐ Gall bladder removed
- ☐ Colon Resection
- ☐ Colonoscopy
- ☐ D and C
- ☐ Endometrial Biopsy
- ☐ Essure
- ☐ Exploratory Lap
- ☐ Femoral Bypass
- ☐ Hernia Repair
- ☐ Hysterectomy: Total / Partial
  Abdominal / Vaginal/ Oophorectomy
- ☐ IUD
- ☐ Kidney Removal: Left / Right / Both
- ☐ Knee replacement: Left/Right/ Both
- ☐ LEEP
- ☐ Liver Resection
- ☐ Mastectomy: Left / Right / Both
- ☐ Myomectomy
- ☐ Organ Transplant: What organ: ___________
- ☐ Orthopedic Surgery: ____________________
- ☐ Stents: Please list:____________________
- ☐ Thyroidectomy: Total / Partial
- ☐ TIPS
- ☐ Tonsillectomy
- ☐ Tubial Ligation:
- ☐ Vasectomy
- ☐ Other: ______________________________
  ____

Memphis Vascular Center
7695 Poplar Pike
Germantown, TN 38138
901-683-1890

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Memphis Vascular Center is required to maintain privacy of your health information, called protected health information or PHI. and to provide you with this notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We abide by the terms of this notice and will not use or disclose your health information without your authorization, except as described in this Notice.. We reserve the right to change our practices and will provide you with a copy of the revised notice if we choose to do so.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following sections explain how we may use or disclose your PHI. Some of the uses and disclosures described may be limited or restricted by state laws or other legal requirements not listed.

For Treatment. Memphis Vascular Center will use your medical information for treatment purposes. An example is the information obtained by a nurse or a physician that will be recorded in your medical record. This information will be used by members of the healthcare team or may be shared with another physician who treats you to determine treatment and response for medical intervention.

For Payment. We may use or disclose your PHI in order to bill or collect payment for the services we provide to you. This may include disclosing appropriate medical billing information to a collection agency should efforts to collect from your insurance company or yourself become unproductive. We file insurance as a courtesy for patients, but the responsibility for payment is with the patient or the responsible party--as they are the policyholder.

For Health Care Operations. We may use and disclose your PHI in order to operate our practice. For example, we may use your PHI to manage your treatment and the services provided to you.

Individuals Involved in Your Care. Unless you notify us that you object, we may use or disclose health information to *notify or assist in notifying a family member, personal representative, or another person responsible for your care of your location or general condition.*

As Required by Law. We may use or disclose PHI about you when required to do so by federal, state or local law. We may also disclose PHI about you as required to comply with court orders, discovery requests or other legal process in the course of a judicial or administrative proceeding.

Law Enforcement. We may disclose PHI about you to law enforcement officials, when permitted or required by law.

For Public Health Activities. We may disclose PHI about you to government officials in charge of collecting information about reportable diseases or for other public health activities.

For Health Oversight Activities. We may disclose your PHI for oversight activities such as governmental oversight, licensure, auditing or other similar purposes

For Research Purposes. In certain circumstances, we may use or disclose PHI in order to conduct medical research. We will almost always ask for your specific permission if the researcher has access to your name, address or other information that reveals who you are.

For Public Safety. If necessary, we may disclose your PHI to prevent or lessen a serious threat to the health or safety of a person or the public.

Government Functions. If you are a member of the armed forces, we may disclose PHI about you as required by military command authorities. We may disclose PHI about you to authorized federal officials for intelligence, counterintelligence, protection of the President, other persons or foreign heads of state and other national security activities authorized by law.

Workers' Compensation. We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Organ and Tissue Donation. If you are an organ donor or potential recipient, we may disclose PHI about you to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Medical Examiners and Funeral Directors. We may disclose PHI about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death.

Inmates. We may disclose PHI of an inmate or other person when required by a correction institution or law enforcement official for health, safety and security purposes.

Business Associates. We contract with vendors and service providers, called business associates, to perform on our behalf or assist us in the performance of functions or activities involving the use or disclosure of PHI. By law and under the terms of our contracts, our business associates are required to safeguard and protect your PHI.

AUTHORIZATION

Other uses and disclosures of your PHI not described in this Notice will be made only with your written authorization. Uses and disclosures that require your authorization include any sale of your PHI and use

or disclosure of your PHI for paid marketing purposes. If you authorize us to use or disclose your PHI for a purpose not described in this Notice, you may revoke the authorization in writing at any time, except to the extent your PHI has already been disclosed under the authorization.

YOUR HEALTH INFORMATION RIGHTS

The Right to Inspect and Copy. You have the right to inspect and obtain a copy of your PHI that we use to make decisions about your care or payment for your care, including in some cases an electronic copy, by requesting access in writing. We will charge $.25 per page for paper copies. We may also charge reasonable fees for the labor and supplies to create an electronic copy, if requested.

Right to Request Corrections. You may request in writing that we amend your PHI if you feel that information we have is incorrect or incomplete. We are not required to make your requested amendment in all cases, but you may ask that we include your request to amend when we disclose your information in the future.

Right an Accounting of Disclosures. You may request in writing that we provide a list accounting for how we have shared your PHI in the six (6) years prior to the date of your request. This accounting will not include disclosures we have made for treatment, payment, our health care operations, certain disclosures required by law or as specifically authorized by you.

Right to Request Restrictions on Disclosure. You may request in writing that we not use or disclose your information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also may request that your health information not be disclosed to family members or friends who may be involved in your care. You must state the specific restriction requested and to whom you want the restriction to apply. This office is not required by law to agree to a restriction that you may request, except that we must agree to restrict disclosures of your PHI to your health insurer about a service or services for which you have paid us out of pocket in full.

Right to Request Confidential Communications. You may also request that we communicate with you about your health care using a certain means or at a certain location, such as a specific mailing address. Your request must be made in writing.

Right to Notification of a Breach. We are required to notify you of any breach of your unsecured protected health information that we discover.

Right to a Paper Copy of this Notice. You have the right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this Notice electronically. This Notice may be changed at any time.

TELEPHONE CONTACT, MESSAGES AND EMAIL

From time to time, Memphis Vascular Center may need to contact you regarding the treatment we provide to you. If contacting you by telephone, we may leave a voicemail or message if you have given us permission to do so on the form you sign acknowledging receipt of this Notice. We may also use email to contact you if you have given permission on the acknowledgement form.

FOR MORE INFORMATION

If you have questions or would like additional information, please contact our Privacy Officer at (901) 683-1890. If you believe your privacy rights have been violated, you can file a complaint with our office. Complaints may be addressed to:

Kim Asher, Privacy Officer
7695 Poplar Pike
Germantown, TN 38138
901-683-1890
asherk@medrad.net

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services using the contact information provided below. There will be no retaliation against you for filing a complaint.

EFFECTIVE DATE

This Revised Notice is effective September 23, 2013

MEMPHIS
VASCULAR
CENTER

7695 POPLAR PIKE
GERMANTOWN, TN 38138
901/683-1890
FAX: 901/334-5760

Notice of Privacy Practices

I, ______________________________, (please print your full legal name) have been provided the Memphis Vascular Center Notice of Privacy Practices, and have been offered a copy of such policy to keep for my records.

I hereby give permission for this office to mail me a summary of my office visit ___yes ___no

I hereby give permission for this office to leave messages on my voicemail/email at

____ My home	(please initial) ________		____ My Cell	(please initial) ________	
____ My office	(please initial) ________		____ Email/Text	(please initial) ________	

I hereby give the following people permission to receive information from this office on my behalf:

____
Name of Person   Relationship to me (e.g., Parent, friend, spouse)

____
Name of Person   Relationship to me

____
Name of Person   Relationship to me

(Signature) ________________________________   (Date)____________

NOTICE TO PATIENTS

Memphis Vascular Center has a fee of $25.00 per request for completion of papers that include, but will not be limited to FMLA, Disability, and Third Party Insurance Companies making payment to patients. This fee may be paid either by **check, credit card, or cash.** Please make checks payable to **MRPC.** Forms will be completed upon receipt of payment.

PLEASE ALLOW 5-7 BUSINESS DAYS FOR COMPLETION OF THIS PAPERWORK