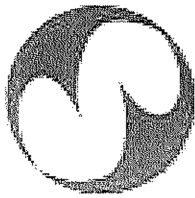


ADVANCED
VASCULAR THERAPY

PATIENT REGISTRATION FORM

Last name: ____________________ First: ____________________ Middle Initial: ____ Preferred: ________________

Mailing Address: ____City____________________Zip________________

Physical Address (if different): ____

Sex (circle one): M F Social Security #: ____________________________ DOB: _____/_____/_________

Marital Status: _______________ Name of Employer (or retired/unemployed): _______________________________

Primary Phone (Home/Work/Cell): ___________________ Secondary (Home/Work/Cell): _______________________

Email: _______________@ ________ Primary Care Physician: ____________________ Referred by: _______________

Pharmacy: ___________________________________ Location: ____

Insurance: ___________________________________ Group#: ________________ ID# ___________________________

Race: ____________________ Primary Language: ______________________ Ethnicity: _________________________

Do you have an **ADVANCED DIRECTIVE** on file? ☐ NO ☐ YES WHERE? __________________________________

Do you want our office to have a copy in your chart? ☐ NO ☐ YES ☐ Not applicable *A copy of how we use the advanced directive is available if you would like, please ask the front desk

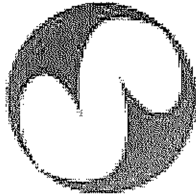
A **notice of privacy practices** is provided to all patients on their first visit. This identifies how medical information about you may be used or disclosed. It explains your rights to access your medical information; to request an accounting of disclosures of your medical information and to request additional restrictions on our uses and discoursers of that information. It explains your rights to complain if you believe your privacy rights have been violated, and our responsibilities for maintaining the privacy of your medical information, and letting you know if that privacy is breached. Please ask the front desk staff for a copy if you would like to have one for your records.

I consent to treatment necessary for the care of the above-named patient or myself. I authorize the release of all medical records/information to the referring, referred and/or family physician. I authorize the health care providers of Advanced Vascular Therapy, LLC (AVT) to release my medical information that is needed to determine insurance benefits or benefits payable to the Health Care Finance Administration and its agents. I hereby assign AVT, all monies to be paid by said insurance company for services provided by AVT, but not to exceed my indebtedness to said clinic. ***I understand and agree that the health insurance policies are an arrangement between the insurance carrier and me. I acknowledge that I am financially responsible for the deductible and co-pay. I also understand that any unpaid balances are my responsibility and any overdue balances may result in a finance charge and/or being assigned to a collection agency.***

**Don't forget to bring all 4 forms, completed, with you to your first appointment.

______________________________ ______________________________ ________________

Print Patient's Name Responsible Party Signature Date



ADVANCED
VASCULAR THERAPY

RELEASE OF INFORMATION

PERMISSION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION TO FAMILY MEMBERS, FRIENDS, OR LEGAL REPRESENTATIVES

IMPORTANT NOTICE: The law prohibits release of confidential medical information to any entity without the written, voluntary consent of the undersigned patient.

Patient Name: ____ Date of Birth: ______________

I authorize Advanced Vascular Therapy to release my information to: (Please mark all that apply).

Name: ____________________________ Relationship: ______________________ Phone: ___________

☐ **ALL** ☐ Discuss information regarding my appointment ☐ Discuss my medical condition

☐ Leave phone messages ☐ Emergency contact ONLY

Name: ____________________________ Relationship: ______________________ Phone: ___________

☐ **ALL** ☐ Discuss information regarding my appointment ☐ Discuss my medical condition

☐ Leave phone messages ☐ Emergency contact ONLY

Name: ____________________________ Relationship: ______________________ Phone: ___________

☐ **ALL** ☐ Discuss information regarding my appointment ☐ Discuss my medical condition

☐ Leave phone messages ☐ Emergency contact ONLY

Name: ____________________________ Relationship: ______________________ Phone: ___________

☐ **ALL** ☐ Discuss information regarding my appointment ☐ Discuss my medical condition

☐ Leave phone messages ☐ Emergency contact ONLY

☐ **I do not want information given to anyone other than myself.**

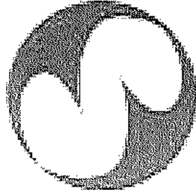
I understand this authorization form gives the person(s) listed above permission to verbally access the information specified.

I understand that by marking "I do not want information given to anyone other than myself", no friend, family member or legal representative will have access to my medical information, including questions regarding my upcoming appointments, financial account and medical condition.

I understand that I may revoke or change this authorization at any time. You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to Advanced Vascular Therapy. Please understand that revocation of this consent will *not* affect any action we took in reliance on this consent before we received your revocation.

Signature of Patient: ____ Date: ___________________

This authorization does not pertain to written records



Appointment Cancellation Policy

Advanced Vascular Therapy, LLC strives to provide excellent medical care to all of our patients. Your appointment times have been specifically scheduled to care for your medical needs. When these appointments are not canceled with enough notice we are unable to allocate these times to other patients and it delays the delivery of needed health care to others.

Starting October 1st, 2015 we request that you give our office at least 24-hour notice in the event that you need to cancel or reschedule your appointment. If you do not give 24 hour notice or no show for your appointment a fee will be assessed to your account and billed.

We understand situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case by case basis.

A charge of $20.00 will be assessed for each no show or late cancellation of office visits.

A charge of $100.00 will be assessed for each no show or late cancellation of each ultrasound.

A charge of $120.00 will be assessed for each no show or late cancellation if you were scheduled for both a vascular study and office visit the same day.

If an interpreter has been ordered for your appointment you will be charged for their services as well.

- The cancellation fee will need to be paid ***before*** the patient can be rescheduled for an office and/or vascular study.
- Please understand the insurance companies consider this charge to be entirely the patient's responsibility.
- Please sign and date below that you have read and understand the policy.

________________________ ________________

Patient signature Date

Notice of Your Right to Decline Participation in Future Anonymous or Coded Genetic Research

OAR 333-025-0165 Notification

The State of Oregon has laws to protect the genetic privacy of individuals, these laws give you the right to decline to have your health information or biological samples used for research. A biological sample may include a blood sample, urine sample, or other materials collected from your body. You can decide whether to allow your health information or biological samples to be available for genetic research. Your decision will not affect the care you receive from your health care provider or your health insurance coverage.

Research is important because it gives us valuable information on how to improve health, such as ways to prevent or improve treatment for heart disease, diabetes, and cancer. Under Oregon law, a special team reviews all genetic research before it begins. This team makes sure that the benefits of the research are greater than any risks to participants.

In anonymous research, personal information that could be used to identify you, like your name or medical record number, cannot be linked to your health information or biological sample. In coded research, personal information that could be used to identify you is kept separate from your health information or biological sample so it would be very difficult for someone to link your personal information to your health information or biological sample. Your identity is protected in both types of research.

If you have any questions or concerns about this notice, please contact Tom at 503.371.1756.

No matter what you decide now, you can always change your mind later. If you change your mind, tell your health care provider your decision in writing by sending a letter, including your mailing address to:

Advanced Vascular Therapy, LLC
2480 Liberty Rd NE #110
Salem OR 97301

If you want to allow your health information and biological sample to be available for anonymous or coded genetic research, **you do not have to do anything.** If you make this choice, your health information or biological sample may be used for anonymous or coded genetic research without further notice to you.

If you want to decline to have your health information and biological sample available for anonymous or coded genetic research, **you must tell your healthcare provider by signing the bottom of this form.**

☐ I **decline** to have my health information and biological sample available for anonymous or coded genetic research.

PATIENT NAME	PATIENT SIGNATURE	DATE