EndoVascular Consultants, LLC

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New Patient Registration Form

First Name: **Middle Name:** **Last Name:**			**Date of Birth:**
Address:		**City:**	**Zip:**
Home Phone #:	**Work Phone #:**	**Cell Phone #:**	**Email:**
Soc. Security	**Gender:** Male ☐ Female ☐	**Race:**	**Marital Status *(S-Single, M-Married, D-Divorced, W-Widowed*):**
Employer:	**Employer Phone #:**		**Occupation:**

Chief Complaint/Reason for Visit:
Any recent studies/imaging? **If yes, where?**

Name of Primary Care Physician: **Phone #:**

Who Referred You to Us? *(Check all that apply & specify)*

□ **Physician (Name)** □ **Internet/Website**

□ **Friend/Relative (Name)** □ **Advertising**

□ **Other**

Emergency Contact: Relation:
Phone #:

Primary Insurance: Policy ID #:
Policy Holder's Name:
Date of Birth:

Secondary Insurance: Policy ID #:
Policy Holder's Name:
Date of Birth:

Related to Workers Comp? NO ☐ **YES** ☐ **Date of Injury:**
Adjustor's name: **Phone #:**

Initial: **I agree to bring my insurance card and co-pay (if applicable) to *every* appointment. I am aware that if I do not, I may need to be cancelled/rescheduled. *We accept cash, checks and credit cards. (VISA, MasterCard, AMEX, Discover, Diners Club, JCB).***

Initial: I assign all medical and/or surgical benefits including Medicare, Medicaid, and/or any Insurance plans to which I am entitled, be made payable to: EndoVascular Consultants LLC on my behalf. This agreement will remain in effect until revoked by me in writing. I understand and agree I will be financially responsible for any charges, i.e. co-payments, deductibles, or non-covered services not paid for by my insurance carrier. I authorize any holder of medical information about me to release it to the Division of Family Services, the Health Care Financing Administration, listed insurer(s), and/or agents of these companies, and/or the listed responsible person(s), any information needed to determine these benefits or the benefits for other related services rendered.

PATIENT HEALTH HISTORY

Name: **DOB:** **Today's Date**:

Participating Pharmacy: **Phone #:**

Mail Order Pharmacy: **Phone #:**

List all medications (use back if you need extra space):

Current Medication(s)	Dose	Frequency

☐ Check if you have additional medications that are unable to be listed and please bring in a full medication list.

Allergies to medications and reactions:

Do you have a latex allergy? Yes ☐ No ☐

Please check if you have had any of the following medical problems:

☐ Mitral valve prolapses	☐ Cancer	☐ Emphysema
☐ Abnormal EKG	☐ High blood pressure	☐ Arthritis
☐ Angina	☐ Heart attack	☐ Lung disease
☐ Diabetes	☐ Heart failure	☐ Liver disease
☐ Bleeding problems	☐ HIV	☐ Kidney disease
☐ Peripheral Arterial Disease	☐ DVT/PE	Other:

Please check if you have had any of the following surgeries:

☐ Extremity Arterial Procedure	☐ Gallbladder removed	☐ Myomectomy
☐ Heart surgery	☐ Hysterectomy	☐ Varicose Vein
☐ Extremity Venous Procedure	☐ Kidney transplant	
☐ Others (please list)		

Surgeries/Hospitalizations	Year	Complications

If you are a dialysis patient, what days are you dialyzed?

Dialysis unit?

List any problems with anesthesia in past:

Any family history of:

☐ Cancer ☐ Diabetes ☐ High blood pressure ☐ Stroke ☐ Heart attack ☐ Bleeding disorder

Date of last menstrual period: **Pregnant**: Yes ☐ No ☐ Uncertain ☐

Patient Name: Date of Birth:

FAMILY HISTORY

Family Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (maternal)	☐	☐		
Grandmother (paternal)	☐	☐		
Grandfather (maternal)	☐	☐		
Grandfather (paternal)	☐	☐		
Mother	☐	☐		
Father	☐	☐		
Sister/Brother	☐	☐		
Sister/Brother	☐	☐		
Sister/Brother	☐	☐		

SOCIAL HISTORY

Occupation:

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Do you have children? ❑ Yes ❑ No How many?

Do you live alone? ❑ Yes ❑ No Who lives with you?

Do you drink alcohol? ❑ No, never (or rarely) ❑ No, but I used to
❑ Yes ❑ Daily ❑ 1 or more times a week ❑ 1 or more times a month

Do you smoke? ❑ Yes, I've smoked ____ packs of cigarettes per day for ____ years.

❑ Yes, I smoke cigars or a pipe.
❑ No, I have never smoked.
❑ No, I quit ___ years ago. At the time I was smoking ___ packs a day for ___ years.

❑ Electronic Cigarette/Vaping ❑ Yes How often _____ ❑ No

❑ Substance Abuse? ❑ Yes- Current ❑ Yes- Past ❑ Never
If Yes, Type
Are you at risk for HIV/AIDS (e.g. drug abuse, previous blood transfusion)?
❑ Yes ❑ No

Patient Name: **DOB:**

Review of systems: Please check any symptoms that are currently present.

General: Fever, Chills, Sweats, Decreased Appetite, Fatigue, Weightgain or loss

HEENT: Glasses, Sinus problems, Glaucoma, Cataracts, Infections, Hearing aids, Hearing loss, Ear pain/Infections, Nasal Congestion

Skin: Rash or Ulcer, Skin Disease, Skin Cancer, Breastpain, Nipple discharge

Cardiovascular: High Cholesterol, Heart Murmur, Chest pain, Hypertension, Irregular Pulse, Swelling and Pain in legs

Respiratory: Asthma, Cough, Emphysema, Shortness of breath, Bronchitis, Pneumonia, Lung Cancer, Bloody Sputum

Gastrointestinal: Nausea, Vomiting, Abdominal pain or swelling, change in bowel habits, Diarrhea or rectal bleeding, Jaundice

Genitourinary: Difficulty starting or stopping stream, Painful urination, Urinary Tract Infection, Incontinence, Kidney stones, Cancer, Hematuria

Musculoskeletal: Back pain, Pain or swelling of the extremities, Muscle cramping or weakness, Decreased range of motion, Arthritis

Neurologic: Headaches, Dizziness, Spinning sensation, Visual changes or weakness, Problems with memory, Disorientation, Difficulty with speech, Double or blurred vision, Facial weakness

Psychiatric: Depression, Anxiety, Change in sleep pattern

Endocrine: Cold intolerance, Hair changes, Sexual dysfunction, Diabetes, Thyroid disease, Increased appetite, Excessive Thirst, Hormone Problems

Hematology: Bleeding tendencies, Anemia, Hemophilia, Nosebleeds or prolonged bleeding, Swollen lymph nodes, Blood Transfusion

Allergy: Food allergies, Inhalant allergies, Immunology disorders

The above information is accurate to the best of my knowledge.

_____ _____

Patient Signature Date

EndoVascular Consultants, LLC

PATIENT CONSENT FORM

The Notice of Privacy Practices for EndoVascular Consultants, LLC provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Portability and Accountability Act of 1996.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations, including appointment reminders by postcard or messages on an answering machine.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the use of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent.

This Consent allows the Practice to disclose my information to the following people:

Name: _____ Relationship:_____
Name: _____ Relationship:_____
Name: _____ Relationship:_____
Name: _____ Relationship:_____

Signature of patient: _____ **Date: _____**

Printed name: _____

EndoVascular Consultants, LLC

Waiver of Responsibility and Release of Medical Information

I understand that if I am unable to obtain the proper referral/authorization from my primary care physician for my insurance, and/or in the event my workman's compensation/automobile or personal liability insurance defaults, I will be financially responsible for the services performed by EndoVascular Consultants, LLC, in full. Our financial policy is as follows:

We collect (payments & co-payments) at time of services are rendered. **PLEASE BRING ALL INSURANCE CARDS** at the time of your visit. If it is a workmen's compensation, motor vehicle accident or personal injury claim, please have the correct insurance information, including name, address, and claim/file numbers. Please be advised that if your workman's compensation company is from a State other than Delaware, you may be billed the balance not paid in full by another State. It is our policy that we do not bill lawyers for office visits and/or procedures. We require having your personal health insurance information on file, and if needed, a referral/authorization from your primary care physician for the visit.

I authorize release of all health information to EndoVascular Consultants, LLC and from all my previous and present treating physicians/hospitals concerning my care and treatment for the purpose of evaluating and administering my care. I also authorize EndoVascular Consultants, LLC the ability to release my health information to requesting physicians/hospitals for the purpose of evaluating and administering my care. Also, administering claims for insurance benefits otherwise payable to me directly to EndoVascular Consultants, LLC

Signature of patient: _____ **Date: _____**

Signature of parent/guardian: _____ **Date: _____**

ENDOVASCULAR CONSULTANTS, LLC
NOTICE OF PRIVACY PRACTICES SUMMARY

We know that medical information about you and your health is private. We do our best to protect medical information about you. The purpose of this Notice is to explain to you how we protect your information and what rights you have regarding your information. You have the right to receive a Notice of Privacy that tells you in detail how everyone here at EndoVascular Consultants, LLC protects your rights. By everyone, we mean doctors, nurses, x-ray technicians, receptionists, bookkeepers, physical therapists, physician assistants, secretaries and anyone else who might see your information or put information into your record(s). The actual Notice of Privacy is longer than this summary and has been offered to you in paper form and we hope you will take time to read it.

HOW ENDOVASCULAR CONSULTANTS, LLC CAN USE YOUR INFORMATION.

We at EndoVascular Consultants, LLC can use and give your information to anyone who is part of taking care of you. This includes different doctors, nurses and therapists. We can also give information to Medicare, Medicaid, or any insurance company or individuals who may be responsible for paying for your care.

We use medical information about you to provide you services. We may use your information to find ways to improve how we can take care of you. Some State or Federal laws require us to report certain diseases, abuse and crimes. We may also share information to find programs or services that might help you get better and/or stay better.

YOU HAVE THE FOLLOWING RIGHTS:

- **To read your records and have copies made. Requests to review and receive copies should be made in writing to director/manager of EndoVascular Consultants, LLC. If it is a billing record, please contact our billing department. We will get the records to you in 30 to 60 days, depending on where they are stored.**
- **To ask us to correct information that we have created. This request also must be made in writing and sent to our Privacy Officer along with the reason(s) to support your request.**
- **To know who has seen your information and if we have shared it for reasons other than to take care of you and to get paid. This request can also be made by contacting the Privacy Officer.**
- **To complain to EndoVascular Consultants, LLC the Manager or the Department of Health and Human Services if you believe we have not followed the law and the Notice of Privacy Practices.**

PAYMENT POLICY

If you are responsible for co-pays or deductibles please be prepared to pay by cash, check or credit card at the time of your visit. Thank you for your cooperation.

NOTICE OF PRIVACY PRACTICE

I have had the opportunity to receive and review Vascular & Interventional Associates of Delaware, LLC. Notice of Privacy Practices.

Signature: _____

Date: _____

EndoVascular Consultants, LLC
701 N. Clayton Street, MSB Ste 601
Wilmington, DE 19805
Phone (302) 760-9002 FAX (302) 482-1333

ENDOVASCULAR CONSULTANTS, LLC CANCELLATION POLICY

We understand that situations arise in which you must cancel an appointment. It is requested that you provide our office more than 24 hours' notice. This allows us to schedule appointments to other patients in need of immediate care. **New** patients who cancel less than 24 hours' notice are subject to a cancellation fee of $100.00 and will not be rescheduled until this payment is made. Established patients who cancel with less than 24 hours' notice are subject to a cancellation fee of $75.00 for physician appointments. All patients are subject to a cancellation fee of $100.00 for procedures unless cancelled more than 24 hours before the procedure.

Patients with Medicaid are excluded; however, the "Cancellation" will be documented with their insurance company. Patients who cancel two or more times will receive a letter emphasizing the importance of keeping scheduled appointments. Patients who continue to cancel after receiving the letter are subject to be discharged from the practice and may be denied any future appointments.

The Cancellation fees are the patient's responsibility and must be paid in full before the next appointment. We also understand that unavoidable circumstances may cause you to cancel less than 24 hours prior to your appointment; therefore, fees in these instances may be waived at managements discretion.

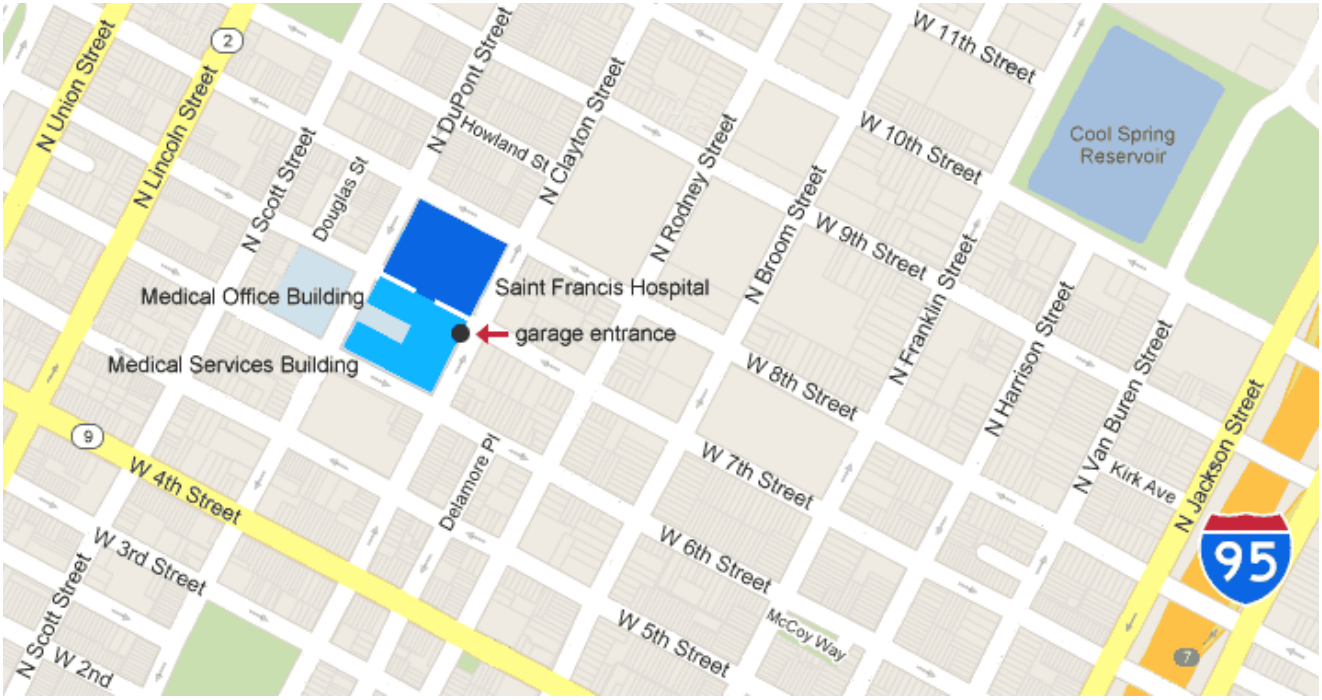
Our practice believes that good physician / patient relationships are based on understanding and clear communications.

Please sign below to acknowledge that you have read, understand and agree to this policy.

_____ _____
Patient Name (Please Print) Date of Birth

_____ _____
Patient Signature Date

DIRECTIONS & PARKING



Saint Francis Hospital
701 North Clayton Street
Wilmington, Delaware 19805

Phone 302.421.4100
Fax 302.421.4167

DUE TO ON GOING CONSTRUCTION ON 95 AND SURROUNDING AREAS, PLEASE CHECK FOR UPDATED DETOURS.

From the Philadelphia area

1. Head South on I-95 to Exit 7B Delaware Avenue.
2. Turn right at the first traffic light onto Pennsylvania Avenue.
3. Continue down Pennsylvania Avenue to DuPont Street.
4. Turn left onto DuPont Street.
5. Continue down DuPont Street to 6th Street.
6. Turn left onto Clayton Street.
7. Turn left into the Clayton Street Parking Garage.

From the Baltimore/Washington, D.C. areas

1. Head North on I-95 to Exit 7 Delaware Avenue/Route 52.
2. Turn left onto 10th Street.
3. Continue down 10th Street to DuPont Street.
4. Continue down DuPont Street to 6th Street.
5. The Hospital is on the left, and the employee parking garage is on the right.
6. Turn left onto 6th Street.
7. Turn left onto Clayton Street.
8. Turn left into the Clayton Street Parking Garage.

From the New Jersey Turnpike and Delaware Memorial Bridge

1. Take the New Jersey Turnpike to the Delaware Memorial Bridge.
2. Follow downtown Wilmington signs to I-95 North.
3. Head North on I-95 to Exit 7 Delaware Avenue/Route 52.
4. Turn left onto 10th Street.
5. Continue down 10th Street to DuPont Street.
6. Turn left onto DuPont Street.
7. Continue down DuPont Street to 6th Street.
8. The Hospital is on the left, and the employee parking garage is on the right.
9. Turn left onto 6th Street.
10. Turn left onto Clayton Street.
11. Turn left into the Clayton Street Parking Garage.

DR. GARCIA AND DR. MENDOZA ARE LOCATED IN ST. FRANCIS HOSPITAL, MSB SUITE 601.

ENTER PARKING GARAGE ON YOUR LEFT ON CLAYTON STREET AND PARK ON THE 6TH FLOOR.

FOLLOW RAMP WITH BLUE AWNING AND PRESS THE DOORBELL FOR OUR OFFICE.