Patient Registration Form

Instructions: Please complete and provide a copy of your insurance card **and** photo ID upon arrival at your visit.

GENERAL INFORMATION

Patient Name: _____ Sex: M / F / N DOB: ____/____/____
Last First M.I.

Mailing Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____ Email: _____

Language: _____ Race: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other

Emergency Contact Name: _____
Last First

Relationship: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____
Carrier Policy Number

Secondary Insurance: _____
Carrier Policy Number

If Policy Holder / Subscriber is different than patient:

Name: _____ DOB: ____/____/____ Relationship: _____

PHYSICIAN AND PHARMACY INFORMATION

Primary Care Physician: _____

Other Providers (Please specify type, for example Cardiologist/Nephrologist/Podiatrist/Neurologist/Wound Center):

_____

_____

Preferred Pharmacy: _____

OTHER

Social History: ☐ Single ☐ Married or Domestic Partner ☐ Widowed ☐ Other

Would you like to be part of our patient portal? ☐ Yes ☐ No

Would you like to receive educational/promotional materials? ☐ Yes ☐ No

Medical History Form

Patient Name: _____ DOB: _____/_____/_____

GENERAL

Height:_____ft. _____in. Weight:_____lbs.

Do you have a Latex Allergy? ☐ Yes ☐ No

List allergies to any other medicines or substances:

_____

_____

_____

Have you or a family member had any problems with anesthesia? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

_____

_____

HABITS

Smoking:

☐ Never ☐ Quit *When:*_____

☐ Yes *How many packs per day:* _____

How many years: _____

Alcohol:

☐ None ☐ Rarely ☐ Social

☐ Daily ☐ Past Use

Other Drug Use:

☐ None ☐ Rarely ☐ Social

☐ Daily ☐ Past Use

FAMILY HISTORY

Please check if any family member has or had:

___ Aneurysm ___ High Blood Pressure

___ Heart Disease ___ Bleeding Problems

___ Stroke ___ Blood Clots

___ Vascular Disease ___ Cancer

___ Diabetes ___ High Cholesterol

___ Varicose Veins ___ Spider Veins

PAST MEDICAL HISTORY

___ Diabetes ___ High Blood Pressure

___ Heart Disease ___ Bleeding problems

___ Stroke ___ Cancer

___ High Cholesterol ___ Lung Disease

___ Kidney Disease ___ Thyroid Disease

___ Blood Clots ___ Liver Disease

___ Neuropathy ___ TB / Hepatitis / HIV

___ Other Infections

PREVIOUS SURGERY (if any)

___ Heart Surgery ___ Bone +/or Joint Surgery

___ Vascular Surgery ___ Surgery of Abdomen

___ Vein Surgery ___ Dialysis Access

___ Transplant ___ Gall Bladder

___ Lung Surgery ___ Caesarean Section(s)

Other Surgery: _____

_____

_____

_____

Medication List

Patient Name: _____ DOB: _____/ _____/ _____

Instructions: Please list your current medications or attach a current medication list.

Medication Name	Dose	Frequency

Please use reverse side for additional medications.

Financial Agreement with The Vascular Care Group and Assignment of Benefits

The Vascular Care Group is devoted to providing you with the best possible care. If you have health insurance, we are committed to helping you receive your maximum allowable benefits. We must emphasize that as health care providers, our relationship is with you, not your insurance company. The filing of insurance claims is a courtesy that we extend to our patients; all charges are your responsibility from the date the services were rendered.

By signing this agreement, I understand that I am financially responsible for any services not covered or allowed, but not paid due to the terms of my insurance coverage. I understand that it is my responsibility to comply with the guidelines set by my insurance company.

I understand that all co-payments, deductibles, and non-covered charges are due at the time of service.

I accept full responsibility for payment of services and/or for securing necessary primary care referrals or pre-approval for medical visits. If applicable, I understand that I have an obligation to obtain a referral for specialist services from my primary care physician (PCP) prior to having services rendered. I acknowledge that if the appropriate referral/authorizations are not on file at the time services are rendered, that I am financially responsible for any charges denied by my health insurance carrier as a result.

If uninsured, full payment for all services is due on the date of service. I understand that future appointments may be contingent upon having met my financial obligations within the office or having made appropriate arrangements with The Vascular Care Group.

If the visit is a work-related injury, I acknowledge that it is my responsibility to obtain an authorized claim number from my employer's worker's compensation insurance carrier and maintain approval for every visit. I am financially responsible for all non-authorized charges.

The office allows a 15-minute grace period for unexpected delays in arriving to an appointment. I understand that all missed appointments and appointments that are cancelled or rescheduled with less than a 24-hour notice are considered “no shows”. Multiple “no shows” may result in termination from The Vascular Care Group.

I hereby authorize payment directly to The Vascular Care Group[1] for services rendered otherwise payable to me. I authorize release of information required to complete insurance claims.

My signature below affirms that I understand this statement and have accepted responsibility for all fees incurred for my medical care.

Patient Signature: _____ Date: _____

Patient Name: _____ Patient DOB: _____/_____/_____

If applicable:

Legal Guardian Signature: _____ Date: _____

Guardian Name: _____ Patient DOB: _____/_____/_____

[1]This notice serves as a single notice for several health care providers that share common ownership or control: The Vascular Care Group, LLC; The Vascular Care Group Maine LLC; TVCG Newton-Wellesley, PLLC; TVCG UM, PLLC; TVCG Harrington, PLLC; Stephen J. Hoenig, MD, PLLC; Southeastern Vascular, PLLC; Vascular CT, PLLC (collectively referred to herein as The Vascular Care Group or “TVCG”).

Acknowledgement of Notice of Privacy Practices and Consent to Release PHI

I have read The Vascular Care Group's Notice of Privacy Practices, and I am aware of the following:

- I have the right to place certain restrictions on the way my protected health information is used or disclosed.
- I understand that The Vascular Care Group is not required to agree with my requested restrictions. I also understand that once The Vascular Care Group agrees to my restrictions, it must comply with those restrictions.
- I have the right to revoke my consent for the use and disclosure of my protected health information at any time. I understand that I must submit a written statement that I have signed in order to revoke my consent.
- I understand that The Vascular Care Group must immediately comply with my request to revoke consent, except to the extent that it has already taken some action that was based on my original consent. I understand that, if I revoke my consent, The Vascular Care Group may be unable to provide services to me.
- I understand that The Vascular Care Group has reserved the right to change from time to time the privacy practices that are described in the Notice of Privacy Practices. Whenever changes are made to these practices, I understand that I will be notified accordingly through publication.

You have my permission to discuss my condition and treatment with the following person(s):

Name: _____ Relationship: _____ Contact Information:_____

Name: _____ Relationship: _____ Contact Information:_____

While The Vascular Care Group will strive to limit the amount of information shared in voicemail, answering machine messages, email communication, or text messages regarding your care or appointment, these methods of communication can be inherently insecure. We will only communicate with you via email or text or leave messages with your consent.

I understand that voicemail or answering machine messages may be intercepted by others. You have my permission to leave me a message at the following number(s): _____

I understand that email communications may not be secure and may be intercepted or viewed by others, including my employer if I am using an email address provided by my employer. You have my permission to email me at the following address(es): _____

I understand that text messages may not be secure and may be intercepted or viewed by others. You have my permission to send me text messages at the following number(s): _____

By signing below, I acknowledge the above and consent to the release of protected health information that is required to carry out treatment, and payment of healthcare operations on my behalf.

Patient Signature: _____ Date: _____

Patient Name: _____

Notice of Privacy Practices for
The Vascular Care Group

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.

1. The Vascular Care Group[1] is permitted to use and disclosure your protected health Information for treatment, payment, and health care operations, including, but not limited to, in the ways described in the following examples:
    a) For treatment – Providing, coordinating, or managing your care and sharing information with other physicians and treating entities.
    b) For payment - Sending bills to insurance companies, determining eligibility or insurance coverage, reviewing services for medical necessity, and undertaking utilization review activities.
    c) For health care operations - Medical chart review, training and auditing activities, and other activities in support of our business activities. We also may share your protected health information with third-party "business associates" that perform various activities (for example, billing services) for us. The Vascular Care Group will have a written contract with these entities to protect the privacy or your protected health information.
2. The Vascular Care Group is permitted or required, under specific circumstances, to use or disclose protected health information without your written authorization, including as follows:
    a) If the use or disclosure is required by law.
    b) For public health activities to a public health authority.
    c) To a person who may have been exposed to a communicable disease or who may be at risk of contracting or spreading a communicable disease.
    d) To a health oversight agency.
    e) If we believe that you have been a victim of abuse, neglect or domestic violence.
    f) To report on the quality, safety, or effectiveness of a product regulated by the Food and Drug Administration.
    g) In the course of a judicial or administrative proceeding.
    h) For law enforcement purposes, including correctional institutions.
    i) To a coroner, medical examiner or funeral director.
    j) For organ, eye or tissue donation.
    k) To researchers in certain circumstances.
    l) To prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
    m) For certain military and national security purposes.
    n) For workers' compensation purposes.
    o) If permissible under other applicable law, to the parent or guardian of a minor patient.
    p) For health care operations.
3. Other uses and disclosures will be made only with your written authorization, including disclosures of your psychotherapy notes, or uses or disclosures that constitute a sale of protected health information, and you may revoke such authorization in writing at any time.
4. We are required to protect your medical information in accordance with the Federal HIPAA Privacy Rule for 50 years after your death. We may disclose medical information about you to a friend or family member who was involved in your medical care prior to your death, limited to information relevant to that person's involvement, unless doing so would be inconsistent with wishes you expressed to us during your life.
5. The Vascular Care Group may engage in one or more of the following activities:
    a) The Vascular Care Group may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
6. Unless you object, the Vascular Care Group may disclose to a member of your family, a close friend, or another person that you identify, your protected health information that directly relates to that person's involvement in your health care. We may use or disclose protected health information to notify a family member, personal representative, or any other person responsible for your care of your location, general condition or death. We may disclose your protected

[1] This notice serves as a single notice for several health care providers that share common ownership or control: The Vascular Care Group, LLC; The Vascular Care Group Maine LLC; TVCG Newton-Wellesley, PLLC; TVCG UM, PLLC; TVCG Harrington, PLLC; Stephen J. Hoenig, MD, PLLC; Southeastern Vascular, PLLC (collectively referred to herein as The Vascular Care Group or "TVCG").

health information to authorized individuals to assist in disaster relief efforts. If you are not present or able to agree or object, your caregiver may determine whether the disclosure is in your best interest.

7. The individual has the following rights regarding protected health information:
    a) The right to request restrictions on certain uses and disclosures of your protected health information. We are not required to agree to a restriction except if you request to restrict disclosure of information to a health plan and
        I. the disclosure is for payment or other health care operations purposes and not otherwise required by law, and
        II. the information pertains solely to a health care item or service for which you paid the Vascular Care Group in full.
    b) The right to receive confidential communications of your protected health information by alternative means or at an alternative location. We will accommodate reasonable requests.
    c) The right to inspect and copy your protected health information. We may charge you a reasonable fee for a copy of your records. If legally permitted, the Vascular Care Group may deny access to certain information, including psychotherapy notes and information compiled in anticipation of litigation. You may have the right to have this decision reviewed.
    d) The right to amend your protected health information. In certain cases, the Vascular Care Group may deny your request and you will have the right to file a statement of disagreement.
    e) The right to receive an accounting of certain disclosures of your protected health information. This right is subject to certain exceptions, restrictions, and limitations.
    f) The right to obtain a paper copy of this Notice from us upon request, even if you agreed to receive the Notice electronically.
8. You have the right to be notified of a breach of unsecured protected health information that affects you.
9. The Vascular Care Group is required by law to maintain the privacy of protected health information and to provide Individuals with notice of its legal duties and Privacy Practices with respect to protected health information.
10. The Vascular Care Group is required to abide by the terms of this Notice currently in effect.
11. The Vascular Care Group reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains.
12. The Vascular Care Group will provide you with a revised Notice by hand delivery at the time of your first visit following any such change. It is also posted in our offices and on our website.
13. If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer at 617-644-7615 or privacy@vascularcaregrp.com.
14. You may also contact the Office for Civil Rights, U.S. Department of Health and Human Services, without fear of retaliation by us, if you believe your privacy rights have been violated.

The address for the OCR is:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201
www.hhs.gov/privacy/hipaa/complaints

The effective date of this notice is July 1, 2023.

Public Notice of Nondiscrimination and Accessibility

TVCG complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. TVCG does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. TVCG:

1. Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign effectively interpreters
    - Written information in other formats, based on an individual's needs

2. Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact a staff member or supervisor.

If you believe that TVCG has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with the Office at:

Phone: 617-829-3004 Email: Compliance@mangrovemp.com

You can file a grievance in person or by mail or email. If you need help filing a grievance, the front desk is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf** or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Ave. SW
Room 509F, HHH Building
Washington, DC 20201

Phone: **800-368-1019**
TDD: **800-537-7697**

Complaint forms are available at:
www.hhs.gov/ocr/office/file/index.html

Vein History Form

Instructions: Please complete the sections below regarding your history of vein disorders (such as varicose veins, spider veins, deep vein thrombosis (DVT), iliac compression, and clotting/bleeding disorder).

Patient Name: _____ DOB: _____/_____/_____

PERSONAL HISTORY

Have you had any of the following (check all that apply):

- ☐ Vein stripping
- ☐ Vein ablation
- ☐ Phlebectomy
- ☐ Vein injections
- ☐ Other: _____

Have you had severe leg trauma (i.e., surgery to legs, car accident)? Please describe below.

_____

_____

Have you had a history of any of the following (check all that apply):

- ☐ Leg ulcers (calf or ankle) requiring medical treatment
- ☐ Pulmonary embolism, DVT, or blood clots in the leg
- ☐ Blood clotting disorders
- ☐ Ultrasound evaluation for venous disease or DVT
- ☐ Conservative treatments (check all that apply):
  - ☐ Use of compression stockings (If yes, duration: _____)
  - ☐ Weight loss/gain
  - ☐ Exercise
  - ☐ Leg elevation
  - ☐ Nonsteroidal or other pain medications

FAMILY HISTORY

Has anyone in your family had a history of the following:

- ☐ Varicose veins
- ☐ Pulmonary embolism or DVT
- ☐ Blood clotting disorders
- ☐ Other: _____

Medical Records Release Form

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient Name:_____**DOB:**_____ /_____ /_____**Phone:**_____

Release Details
I authorize The Vascular Care Group, LLC to disclose the following health information (check one):
☐ All of my health information ☐ My health information relating to the following treatment or condition: _____ _____
☐ My health information covering the period from _____ (date) to _____ (date) ☐ Other: _____ _____
This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. Separate consent must be given before this information can be released.
☐ I consent to have the above information released. ☐ I do not consent to have the above information released.
This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.
☐ I consent to have the above information released. ☐ I do not consent to have the above. information released.
Recipient
The Vascular Care Group, LLC may disclose this health information to the following recipient:
_____ Recipient Name _____ Phone _____ Street Address _____ Fax _____ City, State, Zip Code
Rights
I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Authorization Expiration

Unless otherwise noted below, this authorization shall remain valid for a period of **90 days** after receipt of signature.

Preferred Date of Expiration _____

Signature

Patient Signature: _____ **Date**: _____

If the patient is a minor or unable to sign, please complete the following:

☐ Patient is a minor (indicate age): _____ years of age

☐ Patient is unable to sign because: _____

Authorized Representative Name:_____

Authority of representative to sign on behalf of the patient:

☐ Parent ☐ Legal Guardian ☐ Court Order ☐ Other: _____

Authorized Representative Signature:_____ **Date**: _____