



Vascular Care

OF TEXAS, PLLC

Edic Stephanian M.D. James Hayhurst M.D. Shonda Banegas D.O.
Kamran Jafree M.D. Ranan Mendelsberg, M.D.

Patient Information Please Print

Legal Name: Last _____ First: _____ M.I. _____

Address: _____ City: _____ State: _____ Zip Code: _____

Age: _____ Date of Birth: _____ Sex: M F Social Security #: _____

Driver's License #: _____ Marital Status: Single __ Married __ Divorced __ Widow(er) __

Ethnicity: Hispanic/Latino __ Not Hispanic/Latino __ Preferred Language: _____

Race: American Indian or Alaskan __ Asian __ Black or African American __ White __
Native Hawaiian or Other Pacific Islander __ Other Race __

Dialysis Center: _____ Phone: _____

Referring Doctor: First Name: _____ Last Name: _____ Phone: _____

Primary Care Doctor: First Name: _____ Last Name: _____ Phone: _____

Pharmacy Name: _____ Address: _____ Phone: _____

(In addition to reviewing the medication list you provide, VCoT will request your medication history from your pharmacy.)

Insurance Information

Is your condition related to an on-the-job injury? Workers Compensation claims? Yes __ No __

Primary Insurance

Policy Holders Name: _____

Policy Holder's Date of Birth: _____

Insurance Co: _____

Your relationship to the policyholder: __ Self __ Spouse __ Child __ other

Secondary Insurance

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Insurance Co: _____

Your relationship to the policyholder: __ Self __ Spouse __ Child __ other

Responsible Party Statement and Payments of Benefits

As the responsible party, I understand that my health insurance policy is an arrangement between my insurance carrier and myself. This office will prepare any necessary reports and forms to assist me and making collection from the insurance company, however, I clearly understand and agree that all services rendered to me are charged directly to me and I am responsible for all charges for services rendered. All charges not paid by my insurance company will be my responsibility. Fees for services are due at time the services are rendered.

Notice of Physician Ownership

One or more of the physicians at Vascular Care of Texas, PLLC have an ownership interest in the following facilities: North Park Heart & Vascular Outpatient Surgery Center and Wellness Ambulatory Surgery Center. I understand that my physician may refer me to one of the Facilities for services. I also understand that I may speak with the physician about his financial relationship with the Facility and I may ask my physician to provide my treatment or surgery at a facility where he has no ownership interest.

Signature: _____

Today's Date: _____



I agree to allow Vascular Care of Texas to contact me in the following methods regarding my private health information, evaluation and treatment. I authorize Vascular Care of Texas to leave message for me when I am unavailable.

Method	Number/Address	Messages
<input type="checkbox"/> Home Phone	_____	<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Cell Phone	_____	<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Work Phone	_____	<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Alternate Phone	_____	<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Text Message	_____	
<input type="checkbox"/> Email – NEEDED FOR PATIENT PORTAL		<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Patient Portal	<input type="checkbox"/> opt in?	<input type="checkbox"/> yes <input type="checkbox"/> no

I authorize Vascular Care of Texas and medical staff to discuss my healthcare information (which may include history, diagnosis, labs, test results, treatment and other health information) with the contacts listed below. I understand that by leaving space blank I am indicating my choice to be “No Information” and I do not want any information released to anyone else. Please list all physicians that you would like medical information sent to, along with their contact information.

NAME	RELATIONSHIP TO PATIENT/PHYSICIAN	CONTACT INFO
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMERGENCY CONTACT ONLY

NAME: _____ PHONE: _____

By signing below I acknowledge that I have read and understood the information provided on the consent form. I understand the risk associated with the different methods of communication, especially e-mailed and texting, and consent to the conditions, restrictions and patient responsibilities as well as any other instructions that Vascular Care of Texas may impose.

Print Patient Name _____ Date _____

Patient/Authorized Signature _____ Relationship to patient _____

Vascular Care of Texas Patient Financial Policy

Thank you for choosing our office to provide you with medical care. We are committed to serving you with skill and high quality care. The medical services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. **All co-payments, co-insurance, or deductible amounts must be paid AT THE TIME OF SERVICE.** This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your portion of insurance benefits at each visit. As a courtesy, our office does verify benefits with your insurance carrier; however, the insurance agreement is a contract between you and your insurance carrier. It is recommended that you verify your benefits with your carrier as well.

MEDICARE: We are a participating Medicare provider. We accept Medicare benefit amounts. Medicare as well as your secondary insurance (if any) will be billed for you. However; that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not yet been met. You are also responsible for any copayments, which are usually 20% of the allowed amount for an item or service.

SECONDARY INSURANCE: Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for full payment of these services at the time of service.

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan which mandates us that when you visit a specialist such as ours, you must have a referral from your primary care physician prior to seeking specialty care. Therefore, you are financially responsible for the services received, unless your referral is presented at the time of this visit. If you do not have a referral from your primary care physician at the time of a visit, you will be financially responsible for all services received due in full upon completion of the visit. Full credit will be given if a referral is presented to our office within 48 hours of this visit. You will also be given the option to reschedule your appointment.

CLAIM SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

COPY FEE: We will provide copies of patient records at the patient's request. Copies of records may be subject to a copying fee of \$25 for the first 20 pages, and 50 cents for each page thereafter. You will bear complete financial responsibility for any fee(s) incurred.

COLLECTIONS FEE: You will be sent up to three notices for your financial responsibility (co-insurance, deductible) after payment and/or explanation of benefits (EOB) is received from your insurance company/companies. After the third and last notice, your account will be forwarded to our collection agency. If your account is sent to a collections agency, a **50% fee** will be added to your account. You bear complete financial responsibility for any fee(s) incurred.

FMLA/ DISABILITY FORMS: There will be a \$25 fee for each form completed on behalf of the patient for FMLA and short or long term disability. There is no charge for completion of forms required to file medical

claims to your insurance company for services rendered by our physicians or ancillary staff.

NO SHOW/LATE CANCELLATION FEE: There will be a \$25 fee for appointments which are cancelled within 24 hours of the appointment time and for failure to show for a scheduled appointment. This fee is due prior to rescheduling further appointments. Repeat offenders will be required to pay a deposit to “hold” future appointment timeslots.

Payment arrangements can be made on a case by case basis. We accept the following payment methods: Cash, Check or VISA/MasterCard/Discover/AMEX. An additional \$25.00 will be added to your statement if the check is returned from your bank. We do not accept starter checks. In the event that your insurance company sends payment to you, the patient, it should be forwarded to our office to be applied to your balance.

I have read the above policy regarding my *financial responsibility* to Vascular Care of Texas, PLLC. for medical services provided. I agree to pay Vascular Care of Texas, PLLC any balance unpaid by my insurance carrier for myself or the below named person.

PRIVACY STATEMENT: Any information disclosed in your records will remain confidential and will not be used for any other reason except in providing quality care and treatment as well as to submit your claim to your insurance company and contact you as needed.

PATIENT ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICES: By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have (or had the opportunity to read if I so chose) and understand the Notice and agree to its terms.

Assignment of Benefits

I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to **Vascular Care of Texas, PLLC.** all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, co-insurance, non-covered services and other fees **AT THE TIME OF SERVICE.** I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize Release of Medical Information to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

I understand that it is my responsibility to inform the doctor’s office if there is a change in my health insurance information:

PRINT Patient Name: _____

Signature: _____

Date: _____



Vascular Care

OF TEXAS, PLLC

Patient Name: _____

Today's Date: _____

	NO	YES		NO	YES
CONSTITUTIONAL			Nausea		
Recent Change in appetite?			Rectal bleeding		
Fatigue			Stomach problems		
Fever			Vomiting		
Night Sweats			GENITOURINARY		
Weight gain			Kidney failure		
Weight loss			Kidney problems		
OPHTHALMOLOGIC			MUSCULOSKELETAL		
Wear corrective lenses			Joint stiffness		
Trouble with vision			Muscle aches		
RESPIRATORY			PERIPHERAL VASCULAR		
Cough			Blood clots in legs		
Hemoptysis			Cold extremities		
Shortness of breath			Decreased sensation in extremities		
Wheezing			Pain/cramping in legs after exertion		
Bronchitis once a month			Painful extremities		
CARDIOVASCULAR			Ulceration of feet		
Recent stress test			SKIN		
Chest pain			Ulcers		
Shortness of breath on exertion			Blistering of skin		
Palpitations			Discoloration		
GASTROINTESTINAL			Masses		
Abdominal pain			Skin oozing		
Blood in stool			NEUROLOGIC		
Constipation			Head injury		
Diarrhea			Headache		
Difficulty swallowing			Tingling/numbness		
Heartburn			Paralysis		



Vascular Care

OF TEXAS, PLLC

MEDICAL HISTORY

Today's Date _____

NAME: _____

OCCUPATION: _____

What is your approximate height? _____

Weight? _____

Reason for seeing the doctor today? _____

List all major illnesses or medical problems:

List all surgeries (give dates & type)

List all medications you are allergic to and the reaction you have

PERSONAL HISTORY

Have you had any of these conditions and when:

	No	Yes	Date
Pulmonary Embolism	_____	_____	_____
Blood Clots/DVT	_____	_____	_____
Rheumatic Fever	_____	_____	_____
Thyroid Disease	_____	_____	_____
High Blood Pressure	_____	_____	_____
Circulatory Problems	_____	_____	_____
Heart Disease	_____	_____	_____
Heart Murmur	_____	_____	_____
Hepatitis	_____	_____	_____
Chemotherapy	_____	_____	_____
Excess Bleeding	_____	_____	_____
Diverticulosis	_____	_____	_____
Pancreatitis	_____	_____	_____
Tuberculosis	_____	_____	_____
Emphysema	_____	_____	_____
Jaundice	_____	_____	_____
Arthritis	_____	_____	_____
Cirrhosis	_____	_____	_____
Cancer	_____	_____	_____
Colitis	_____	_____	_____
Diabetes	_____	_____	_____
Ulcer	_____	_____	_____
Epilepsy	_____	_____	_____
Anemia	_____	_____	_____
Stroke	_____	_____	_____
Asthma	_____	_____	_____
Hernia	_____	_____	_____
Glaucoma	_____	_____	_____

FAMILY HISTORY

Has someone in your paternal or maternal family had any of these medical conditions?

	No	Yes	Relation
Pulmonary Embolism	_____	_____	_____
Blood Clots/DVT	_____	_____	_____
Diabetes	_____	_____	_____
Tuberculosis	_____	_____	_____
Lung Disease	_____	_____	_____
Heart Disease	_____	_____	_____
Stroke	_____	_____	_____
Kidney Disease	_____	_____	_____
High Blood Pressure	_____	_____	_____
Cancer	_____	_____	_____
Bleeding Tendency	_____	_____	_____
Do you use alcohol?	_____	_____	_____
If yes, how often? _____	_____	_____	How long? _____
Do you use tobacco?	_____	_____	_____
If yes, amount? _____	_____	_____	How long? _____

MEDICATION INFO

Medication Name:	Strength	Dosage
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____
11. _____	_____	_____
12. _____	_____	_____



NEW PATIENT CHECKLIST

Thank you for choosing our providers. We pride ourselves in providing our patients with the best medical care.

Your new patient visit will consist of a consultation and any testing which the physician made need to order to evaluate your condition. This visit could take anywhere from one to two hours, occasionally longer. Please allow time.

Bring the following to your appointment:

1. Completed paperwork –
2. List of medications or bring all medications with you
3. Please plan to arrive 15 minutes prior to your scheduled appointment
4. Bring any records pertaining to your visit, including CDs of testing (if your referring doctor has already sent your paper records, you do not need to bring those.)
5. Driver's License or other government issued ID
6. Insurance card(s)
7. Payment is due at time of service, if your insurance has any patient portion due.