DESERT VASCULAR SPECIALISTS

OFFICE POLICIES

Welcome to Desert Vascular Specialists. We are glad that you have chosen us to participate in your care. Please take a few minutes and review our office policies.

Telephone Contacts & Address: Our phones are answered from 8:00am-5:00pm Monday- Friday. We have provided for your convenience, our office address and a list of phone numbers and prompts below.

Address:	1940 N. Alma School Rd Chandler, AZ 85224
Main Telephone Number:	(480)890-0280
Main Fax Number:	(480)890-2047
Appointments:	(480)890-0280 Prompt: 1
Surgery Scheduling:	(480)890-0280 Prompt: 3
Office Manager:	(480)890-0280 Prompt: 5
Insurance/Billing:	(480)890-0280 Prompt: 6

Most test results are not given over the phone. Please allow a week to ten days after the testing is complete for our physician to receive and review your tests. A visit with your physician is the best way to discuss the results of the test(s) and your plan of care.

Finance/Insurance: Each patient is responsible for payment of his/her medical bills. Co-pays, co-insurance and/or deductibles are due at the time of service. As a courtesy, we file insurance claims on your behalf. We cannot, however, mediate disputes or resolve differences between you and your insurance company. Please remember that it is your responsibility to advise our office immediately of any changes in your insurance or contact information. Payments may be made in the form of cash, check and most major credit cards (Visa, MasterCard and Discover).

Completion of Additional Paperwork: There is a $30 charge for our office staff to complete additional paperwork you request on behalf of your employer or insurance company such as: FMLA (Family Medical Leave Act) or extended leave paperwork. Please allow two weeks for completion of paperwork. Our physicians **do not** perform disability determination assessments.

Appointment Cancellation: If you find you are unable to keep a schedule appointment, please notify our office at least **24 hours** prior to the scheduled appointment time. A late fee of $40 may be assessed for a no show/late cancellation appointment.

DESERT VASCULAR SPECIALISTS

Arizona Vascular Surgery Consultants, PC** dba **Desert Vascular Specialists

Patient Insured Agreement

Benefits for medical, diagnostic, and surgical services vary from plan to plan. Health Care Benefits are subject to deductibles and co-insurances that can range greatly in cost for a variety of medical services. We urge every patient to review their insurance agreements to better understand their benefits as a whole. While we will advocate for our patients, we recommend using the resources that the insurance companies provide like; online portal access and telephone access.

In an effort to provide better communication to our patient's please take time to review the following financial policies:

- **Insured Patients**: An insurance agreement is an agreement between the patient and their insurance company. As a courtesy to our patients, we will file insurance claims on their behalf. Any remaining balances from medical services rendered will be due upon receipt of a statement.

  We ask that our patient's notify us of any changes in their insurance benefits and/or policies as soon as they receive them. In the event we do not receive the proper communication and/or information, the patient may be held responsible for any additional fees or uncovered service charges due to non-communication of any insurance changes.

- **In-Office Procedures**: Certain in-office procedures may have a co-insurance or deductible. We require any payment due be paid in full prior to the services being rendered.

- **Self-Pay/ Private Pay Patients**: Patients have the right to pay for medical services completely out of pocket (independently from their insurance company). We ask that any payment due is paid prior to any services being rendered.

We make every effort to collect any deductibles, co-insurances and co-pays at the time of service so that we are not in violation of our insurance company contracts. We will accept In-Network benefits for those plans that we have an active contract with.

Our staff will call to verify coverage and benefits for medical, diagnostic and surgical services provided by our office. The information that we receive back is based on the information that the insurance company has provided and is not always a guarantee of payment.

In all cases, the insured/patient will be responsible for any non-covered services, deductibles, co-pays, and co-insurance amounts deemed as patient responsibility by the insurance company.

This agreement supersedes all other verbal agreements

I have read and agree to be financially responsible for all service both ***covered*** and ***non-covered*** by my insurance company.

Signature of Patient or Guarantor: X______________________________Date__________________________

Privacy Notices

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), you, as a patient of *Desert Vascular Specialists*, are entitled to the rights of privacy regarding your health related information as set forth under applicable law. *Desert Vascular Specialists* will strive to ensure that your information is used for purposes authorized by you and otherwise required by law. Upon request, we can provide you with a complete copy of our Privacy Policies. Please do not hesitate to contact our HIPAA Officer, Amber Long, at (480)890-0280 ext. 309 in the event you have any additional questions or if you feel that your privacy has been breached.

_______ Acknowledgement of HIPAA Notice of Privacy Practices

I acknowledge that I have received and I have read through the HIPAA Notice of Privacy Practices. I understand that the providers and staff at *Desert Vascular Specialists* will not discuss my health information with others unless I provide approval to do so.

Contact Information:

Desert Vascular Specialists may need to contact you regarding information such as; appointments, clinical information, and/or business related issues.

May we:

Leave a message on your voicemail? : Yes / No

Leave a message at home with a person? : Yes / No

_______ I ***GIVE*** the following people permission to speak to the office regarding appointments, clinical information, and/or business related issues on my behalf:

________________________ ________________________

________________________ ________________________

________________________ ________________________

_______ I ***DO NOT*** give the office permission to speak with anyone, other than myself, regarding appointments, clinical information, and or business related issues.

Medicare Patients:

I request that payment of authorized Medicare benefits be made to me or on my behalf to *Arizona Vascular Surgery Consultants, PC dba Desert Vascular Specialists* for any services furnished by *Desert Vascular Specialists*. I authorize any medical information about me to be released to Health Care Financing Administration and its agents as needed to determine these benefits or the benefits payable for related services.

Signature of Patient or Guarantor: X________________________ Date: ________________

Office Policies:

_______ I acknowledge that I have received a copy of *Desert Vascular Specialists* office policies.

Financial Polices:

_______ I acknowledge that I have received a copy of *Desert Vascular Specialists* financial policies

Signature of Patient or Guarantor: X________________________ Date: ________________

PATIENT INFORMATION SHEET

Please present most up-to-date insurance cards at check-in

Date: _____/_____/_____

Patient Name: ____

Last First MI

Date of Birth: ____/____/____ Gender: M / F / T SSN: _____-_____-_____

Circle One

Marital Status: Married / Single / Widowed/ Divorced / Separated

Circle One

Employer/Profession/ Retired: ____

Race: Hispanic/ Asian/ Caucasian/ African American/ Native American, Alaskan Native/ Other Pacific Islander/ Other Race/ Unreported or Refused to Report

Circle One

Ethnicity: Hispanic or Latino / Non-Hispanic or Latino / Refused to Report

Circle One

Local Address: ____

Street address City State/Zip

Alternate Address: ____

Street address City State/Zip

Home Phone: (______) _______-_______ Mobile Phone: (______) _______-_________

Email Address: ____

Emergency Contact: ____

Last First

Phone: (______) _______-_______ Relationship to Patient: ____________________________

Primary/Family Provider Name: ____

Referring Provider Name: ______________________________Specialty: ____________________

Other Provider Name: _________________________________Specialty: ____________________

Other Provider Name: _________________________________Specialty: ____________________

DESERT VASCULAR SPECIALISTS

PATIENT INTAKE FORMS

Please present a current medication/allergy list at check-in

Primary Reason for Visit today:

____

Medical History: ***Do YOU have any of the following conditions?***

Aneurysm	Yes / No
Type:________________	
Arthritis	Yes / No
Bleeding Disorder	Yes / No
Type:________________	
Cancer	Yes / No
Type:________________	
Coronary Artery Disease (CAD)	Yes / No
Myocardial Infarction (MI)	Yes / No
Hypercholesterolemia	Yes / No
Hyperlipidemia	Yes / No
Hypertension	Yes / No
Diabetes	Yes / No
Type:________________	
Congestive Heart Failure (CHF)	Yes / No
Pacemaker	Yes / No
Defibrillator	Yes / No
COPD	Yes / No
Emphysema	Yes / No
Pulmonary Embolism (PE)	Yes / No
Kidney Disease	Yes / No
Dialysis Access	Yes / No
Erectile Dysfunction	Yes / No
Leg Trauma	Yes / No
Deep Vein Thrombosis (DVT)	Yes / No
Stroke/CVA	Yes / No
Varicose Veins	Yes / No
Hepatitis	Yes / No
Type:________________	
HIV	Yes / No
Tuberculosis (TB)	Yes / No

Social History:

Do you smoke cigarettes? Yes / No

Year Start: ___________ Quit: ___________

Packs per Day________

Do you Drink Alcohol? Yes / No

Family History: ***Has your immediate family been diagnosed with any of the following conditions?***

Aneurysm	Yes / No
Type:________________	
Arthritis	Yes / No
Asthma	Yes / No
Bleeding Disorder	Yes / No
Cancer	Yes / No
Coronary Artery Disease	Yes / No
Myocardial Infarction (MI)	Yes / No
Coronary Artery Bypass Graft	Yes / No
Hypertension	Yes / No
Hyperlipidemia	Yes / No
CVA/Stroke	Yes / No
Diabetes	Yes / No
Kidney Surgery	Yes / No
Renal Disease	Yes / No
Deep Vein Thrombosis (DVT)	Yes / No
Varicose Veins	Yes / No

Past Surgical History: *Please list any major surgeries below*

___________________________Date______________

___________________________Date______________

___________________________Date______________

___________________________Date______________

___________________________Date______________

___________________________Date______________

___________________________Date______________

DESERT VASCULAR SPECIALISTS

Allergies: ***Do you have an allergy to any of the following:***	**Medication List-:** **Are you currently taking any of the following:**
Iodine or Contrast Agents Yes / No Reaction:____________________ Latex Yes / No Reaction:____________________ **Medication Allergies:** Please list allergies below or attach list if necessary: ____________________ Reaction:____________ ____________________ Reaction:____________ ____________________ Reaction:____________ ____________________ Reaction:____________	Asprin Yes / No Dose:____________ Plavix (Clopidogrel) Yes / No Dose:____________ Pletal (Cilostazol) Yes / No Dose:____________ Coumadin(Warfarin) Yes / No Dose:____________ Effient (Prasugrel) Yes / No Dose:____________ Pradaxa (Dabigatran) Yes / No Dose:____________ Xarelto (Rivaroxaban) Yes / No Dose:____________ Aggrenox Yes / No Dose:____________
Medication List: ***Attach separate list if necessary*** ____________________ Dose:____________ ____________________ Dose:____________ ____________________ Dose:____________ ____________________ Dose:____________	**Medication List:** ***Continued*** ____________________ Dose:____________ ____________________ Dose:____________ ____________________ Dose:____________ ____________________ Dose:____________

Please initial one of the following:

______ I ***WILL ALLOW*** Desert Vascular Specialists access and may use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

______ I ***WILL NOT ALLOW*** Desert Vascular Specialists access to my prescription medication history.