ProActive
HEART & VEIN CENTER

Patient Information

Name: (Last, First, Middle)	Date of Birth:	SSN:	Sex:	Race:
Address:	Phone:	Other Phone:		
Email:	Primary Care Dr.:	PCP Phone:	Referrring Physician and Phone #	
Language:	Marital Status:			
Emergency Contact:	Emergency contact phone:	Relationship to Patient?		
Employer:	Work Phone:	Work Address:		

Responsible Party Information (If different than above)

Name: (Last, First, Middle)	Sex:	Date of Birth:	SSN:	Patient Relationship:
Address:	Phone:	Other Phone:		

Primary Insurance

Name of Insurance Company:		Policy #:	Group/Acct #:
Date effective:	Copay:	Deductible:	
Name of Policy Holder:		Policy Holder's Date of Birth:	Policy Holder's SSN:
Address of Insurance Company:		Ins. Co. Phone #:	Plan Type:

Secondary Insurance

Name of Insurance Company:		Policy #:	Group/Acct #:
Date effective:	Copay:	Deductible:	
Name of Policy Holder:		Policy Holder's Date of Birth:	Policy Holder's SSN:
Address of Insurance Company:		Ins. Co. Phone #:	Plan Type:

Appointment Reminder Preferences- What is the best way to remind you of your appointments?

_____ Cell Phone TEXT — What is your cell phone number? _____

_____ Cell Phone VOICE CALL — What is your cell phone number? _____

_____ Home Phone Voice Call — What is your home phone number? _____

_____ Email — What is your email? _____

HOW DID YOU HEAR ABOUT US? We would like to know who to thank for bringing you to our office today.

_____

ProActive
HEART & VEIN CENTER

Patient Name: _____ **Date:** _____

We need to know all the medications you are taking so that we do NOT prescribe medication(s) that will interfere with others you are taking, that may have been prescribed by other physicians. It is very important that you list ALL the medications you take currently, including "over the counter" medications.

Medication Name	Dosage	How many times/day

If more space is needed use back of page.

I am allergic to the following medications:

LIVING WILL

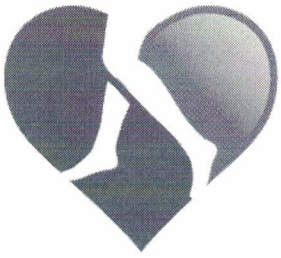
I have an Advance Health Care Directive or LIVING WILL (instructions about your own health care, or have named someone else to make health care decisions for you).

□ YES □ NO (Check one) ♦ *If yes, please provide a copy for us to put in your file.*

Please fill out this brief questionnaire to assist us in providing you with the best care possible.

Check all that apply:

□ Do you have pain, cramping, aching, numbness, tiredness, weakness or burning in your buttock, thigh, calf or foot?
□ Do you have restless legs?
□ Do you have numbness is your legs or feet?
□ Does your skin appear pale and feel cool to the touch?
□ Do you have foot or toe pain or tingling that does not go away with rest?
□ Do you have a feeling that the hip or leg is "giving out" while walking?
□ Do you have skin wounds, sores, infections or ulcers on your legs or feet that heals slowly or does not heal at all?
□ Do you have swelling of ankles or lower legs?
□ Do you have heavy, tight or achy legs?
□ Do you have varicose veins or spider veins?
□ Do you have skin that becomes discolored, feels leathery, flaky and/or itchy?
□ Do you have chest pain?
□ Do you have shortness of breath?



ProActive
HEART & VEIN CENTER

Michael A. Nelson, MD
7751 Wolf River Blvd
Germantown TN 38138
Phone (901) 297-4000
Fax (901) 531-8344

Medical Records Release

Date: _____

Patient's Name: _____ Date of Birth: _____

I, _____, hereby authorize the release of my medical records to:

Proactive Heart & Vein Center

7751 Wolf River Blvd

Germantown, TN 38138

Any information including diagnosis, records of treatment, prescribed medications, examination and test results rendered to me.

_____ A. Complete Medical Records

_____ B. Services during the time period of _____ to _____. Description of records to be released: _____.

_____ C. Medication History from all prescribers.

_____ _____

Signature of Patient or Legal Guardian Date

ProActive
HEART & VEIN CENTER

Michael A. Nelson, MD
7751 Wolf River Blvd
Germantown TN 38138
Phone (901) 297-4000
Fax (901) 531-8344

Medical Records and Forms Fee Policy

Forms: A $25.00 fee will be charged to complete to complete any forms. This includes all medical leave forms. We ask that this fee be paid at the time of request to ensure the availability to fax or mail the requested forms upon completion. FMLA forms that are faxed to us will not be completed until after the fee is paid. To better serve you these fees can be paid over the phone (901-297-4000 option 1) with a credit card.

Medical Records: A fee of $25 will be charged for a copy of your medical record for the first 25 pages. Any additional pages will be charged $.25/page. If medical records are mailed an additional fee to cover the cost of shipping will apply.

Federal Aviation Administration (FAA) patients: All patients associated with the FAA will be charged $100 for copies of all requested studies and additional required paperwork.

In order to comply with your requests in a professional and efficient manner, we ask that you allow 7-10 working days for the forms/medical records request to be completed. If you are going to pick up the forms/records from our office please call ahead to ensure forms/medical records are ready.

I acknowledge that I have been notified of these fees and understand this policy.

_____ _____ _____

Patient Signature Patient Printed Name Date

Test and Lab Results Permissions

_____ I give Proactive Heart & Vein Center permission to leave results of tests and labs as well as instructions and appointment time on my

_____ Answering Machine/Voice Mail

_____ With the following people listed below:

_____ Relationship_____

_____ Relationship_____

_____ I do not give Proactive Heart & Vein Center permission to leave results with any person other than myself nor on an answering machine or voice mail.

Patient Signature_____

ProActive
HEART & VEIN CENTER

FINANCIAL POLICY

Thank you for choosing Proactive Heart & Vein Center as your Cardiac and Vascular healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we provide as pertinent information prior to any treatment.

Appointments

It is very important that you make every effort to keep your appointment. We try our best to allocate the proper amount of time for each patient. If you are unable to keep your scheduled appointment, please call 24 hours in advance to cancel so that we may open that slot for another heart patient. **Please be aware that there is a $35 no-show fee for missing any scheduled physician appointments.** We truly appreciate your effort to call the practice in advance if you cannot keep your scheduled appointment.

Cancellation/rescheduling of nuclear stress tests, exercise stress tests, ultrasounds and echocardiograms: Proactive Heart & Vein Center requires three (3) business days' notice for cancellation or rescheduling for any stress tests or ultrasounds. A cancellation fee of $125 will be applied for cancellations of less than three (3) business days. A cancellation fee of $175 will be applied for cancellations of less than three (3) business days for nuclear stress tests.

Cancellation/rescheduling of peripheral, peripheral arterial disease (PAD) or EVLT vein procedures: Proactive Heart & Vein Center requires ten (10) business days' notice for cancellation or rescheduling of peripheral or vein procedures. A cancellation/rescheduling fee of $500 will be applied for cancellations of less than ten (10) business days of your scheduled peripheral or vein procedure. **An additional $500 will be charged for any cancellations of less than five (5) business days.** A cancellation or missed appointment of a sclerotherapy session within 24 hours of the scheduled procedure will result in a $50 charge.

Insurance

We have made arrangements with many insurance carriers and other health plans to accept assignment of benefits, because of this it is crucial to provide us with the correct insurance information. Proactive Heart & Vein Center will bill those plans with whom we have an agreement. Co-payments and deductibles are due at the time services are rendered.

We gladly file your primary and secondary insurance as a courtesy to you. We extend this courtesy for a period of 45 days. If no payment has been received from them by that time, we ask that you contact your carrier regarding any 45 day outstanding claims. We will continue to assist you in acquiring reimbursement to the extent we are able, but ultimately payment for services rendered is the patient's responsibility. Please be aware that some or all of the services we provide may not be covered by your carrier and may not be considered reasonable and necessary under the Medicare program and/or other medical insurances; thus, reimbursement is fully your responsibility.

Medicare Patients

If you have Medicare, please be aware that we are required by Medicare to collect deductibles and co-pays from you when you do not have secondary insurance coverage or if your secondary coverage does not cover the entire 20% patient responsibility per Medicare allowable. Please furnish your Medicare card and secondary insurance card to our

Receptionist.

ProActive
HEART & VEIN CENTER

FINANCIAL POLICY

Private Pay Patients: As a rule, we do not accept private pay patients – exceptions may be made on a case by case basis at the discretion of Proactive Heart & Vein Center.

Delinquent Accounts

Proactive Heart & Vein Center reserves the right to charge 12% interest on any charges not paid by third party payers which are more than 60 days' delinquent and to turn over to our collection agency any accounts delinquent after 180 days. Should an unpaid balance be transferred to the collection agency, or legal action commenced, a 35% surcharge will be added to the balance owed.

Regarding Referrals

In the event your insurance company requires a referral from your primary care physician (PCP) and you arrive for your appointment without an authorized referral, or an incorrect referral, you will be responsible for the completion charge or you may reschedule your appointment.

Dependent Patients

For all services rendered to a minor or dependent patient, Proactive Heart & Vein Center will request the parent and/or guardian to be responsible for all payments.

Medical Records Requests

A fee of $25 will be collected prior to researching and copying patient medical records for the first 25 pages. Any additional pages will be assessed a charge of $0.25/page. If medical records are mailed, an additional shipping fee may apply. Please see Medical Records and Forms Fee Policy for additional details.

Billing Inquiries

Any questions regarding charges or insurance balances should be directed to our billing department at

888-608-7999.

Thank you for taking the time to read our Financial Policy. Please let us know if you have any questions or concerns as we want you to fully understand our policy.

_____ _____

Please PRINT name of Patient or Responsible Party (Parent/Guardian) **Relationship to Patient**

_____

Signature of Patient or Responsible Party

ProActive
HEART & VEIN CENTER

Assignment of Benefit Form

I, _____, hereby assign my healthcare benefit payments, to which I am entitled through _____ (name of insurance company) to Proactive Heart & Vein Center, PLLC ("assignee").

This assignment is pursuant to the Employee Retirement Income Security Act (ERISA) as defined in 29 CFR 2560-503-1, and applicable by State law, and will remain in effect until revoked by me in writing.

I understand that I am financially responsible for all charges not paid by my insurance. I hereby authorize said assignee to release all information necessary to secure payment of said benefits.

Proactive Heart & Vein Center, PLLC is hereby authorized to initiate on my behalf any complaints regarding my healthcare benefit payments or adverse benefit determinations as defined in 29 CFR 2560-503-1, with the State Insurance Commissioner for a possible violation of State Insurance Laws or Employee Benefits Security Administration and the Secretary of Labor as it pertains to ERISA, specifically 29 USC 18§§1003(a) and 1144(a).

Proactive Heart & Vein Center, is allowed full disclosure of any and all information, documentation, policies, procedures and resources used by _____ (name of insurance company) to perform an adverse benefit determination, as defined by 29 CFR 2560-503-1 of my covered benefits.

Proactive Heart & Vein Center, PLLC is authorized to represent me in any and all Federal lawsuits against my insurance company, _____ pursuant to the ERISA. A copy of this document is as valid as the original.

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (PRINT) Patient or Legal Guardian SIGNATURE

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____