KANSAS CITY VASCULAR INSTITUTE

INITIAL PATIENT QUESTIONNAIRE

Patient Information:

Patients Full Name: _____ SSN: _____

Date of Birth: _____ Gender: _____

Race: _____ Ethnicity _____

Marital Status: _____ Language _____

Is the person completing these forms the patient or another authorized party?

☐I am the patient ☐I am the patient's authorized representative, named: _____

How can we reach you?

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Mobile Phone: _____

Work Phone: _____

Email: _____

Pharmacy Name and Location: _____

Important Message

Communications between a doctor and a patient are integral to proper care. Kansas City Vascular Institute communicates to patients on a variety of issues: appointments, reminders, patient surveys, promotions, etc. We frequently use applications such as eClinicalWorks deliver messages efficiently and securely.

Messages:

I give my consent to Kansas City Vascular Institute to leave/send a message to discuss treatment, surgery, lab, radiology results, or other information regarding my healthcare as follows: (Please check all that apply)

☐ Ok to leave a message on home phone ☐ Ok to leave a message on cell phone ☐ Text ☐ Email ☐ Regular Mail

☐ I do not consent to messages being left at home, on my cell phone or by any other method

Important Note: By permitting us to contact you via mobile phone or email address, you are permitting Kansas City Vascular Institute to communicate with you by **email, voice, and text**. These communications may include your personal or health information. **At any future time, you may opt out of receiving communications via email and/or text by contacting our office or by following the steps for this included our emails and text messages.**

Insurance Information

Are you insured? ☐ Yes, my information is below ☐ No

Primary Insurance:

Company: _____

Member ID: _____

Group ID: _____

Secondary Insurance:

Company: _____

Member ID: _____

Group ID: _____

Is someone other than yourself the primary subscriber on your insurance? If so, complete:

Subscriber Name: _____ Relationship: _____

Date of Birth: _____

Home Address if different than patient: _____

City: _____ State: _____ Zip: _____

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Notice of Privacy Practices and Release of Information

In order to protect your privacy and to comply with government regulations (HIPAA), we are required to obtain authorization from you in order to release messages and/or provide information regarding your care with any person(s) other than yourself.

Notice of Privacy Practices: As a condition of providing treatment to you, Kansas City Vascular Institute obtains your consent to use and disclose protected health information about you to carry out treatment and payment, to receive payment for the care we provide and for other health care operations. Health care operation generally include those activities we perform to improve the quality of care. You may revoke this at any time by notifying us in writing. Please refer to the Notice of Privacy Practices for Protected Health Information for a more complete description of the uses and disclosures that Kansas City Vascular Institute may use of your protected health information. The Privacy Policy is available on our website and available for distribution, if requested.

Release of Information:

☐ I hereby authorize **Kansas City Vascular Institute** to disclose my entire medical record including information regarding my billing, condition, treatment and diagnosis to the following **Medical Providers/Individuals/Family members:**

Primary Care Physician: _____ Relationship: _____

Specialist: _____ Relationship: _____

Specialist: _____ Relationship: _____

Specialist: _____ Relationship: _____

Emergency Contact 1:

Name: _____ Home Phone: _____

Relationship: _____ Mobile Phone: _____

Emergency Contact 2:

Name: _____ Home Phone: _____

Relationship: _____ Mobile Phone: _____

I understand that Kansas City Vascular Institute cannot guarantee that the recipient identified above will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

HIPAA consent to view prescriptions and utilize the Health Information Exchange system

☐ I consent that Kansas City Vascular Institute can obtain my prescription medication history from other healthcare providers, insurance companies, and pharmacies. I acknowledge that Kansas City Vascular Institute may use health information exchange systems to electronically transmit, receive and/or access my prescription history.

Signature: _____ **Date_____**

KANSAS CITY VASCULAR INSTITUTE

INITIAL PATIENT QUESTIONNAIRE

Patient's Full Name: _____ **Date of Birth:** _____

Referring Physician: _____

Briefly List the Reason for Visit Today:

_____

Recent Imaging: ☐ Ultrasound ☐ CT scan ☐ MRI/MRA **If so, where and when?:**

_____

Current Medications:

If you are taking any medications, you may also complete the Prescription Medication History Consent in this packet to obtain your prescription history from your pharmacy. Additionally, please complete the below or bring all of your medications to your appointment.

Medication:	Dosage:	Times per day:	Medication:	Dosage:	Times per day:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Medical History:

☐ Atrial fibrillation	☐ Blood clots (ex: legs, lungs)	☐ COPD ☐ Oxygen Use	☐ Kidney disease/dialysis
☐ Coronary artery disease	☐ Carotid artery disease	☐ Diabetes	☐ Thyroid disease
☐ Coronary stenting	☐ Artery blockages in leg(s)	☐ High blood pressure	☐ Liver disease
☐ Heart attack	☐ Stroke/TIA	☐ High cholesterol	☐ Cancer
☐ Heart failure	☐ Previous amputation	☐ Other: _____	

Allergies: ☐ No ☐ Yes (Include IV dye and/or egg): _____

_____

Surgical History: ☐ No surgical history

Surgery: Month/Year: _____

_____

Surgery: Month/Year: _____

_____

Recent Hospitalizations (within last 12 months): ☐ No recent hospitalizations

Reason: Month/Year: _____

_____

Reason: Month/Year: _____

_____

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KANSAS CITY VASCULAR INSTITUTE

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Patient Name: _____ **Responsible Party**: _____

Family History: List member relation to you and all major medical problems including cancer, diabetes, heart disease, blood clots etc.

_____

Social History:

Do you drink alcohol? ☐ Yes ☐ No

How often? _____

How many drinks? _____

Recreational Drug Use: ☐ Yes ☐ No

Cannabis (Marijuana) Use: ☐ Yes ☐ No

Tobacco Use: ☐ Current ☐ Former ☐ Never

How many packs a day? _____

Age Started/Stopped: _____

Do you exercise regularly? ☐ Yes ☐ No

Frequency/type of exercise:

_____

Review of Systems: Please indicate which symptoms you are experiencing or have experienced in the last 6 months.

Chest pain	☐ Yes	☐ No	Heat or cold intolerance	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No	Excessive thirst	☐ Yes	☐ No
Difficulty lying flat	☐ Yes	☐ No	Abdominal pain	☐ Yes	☐ No
Leg swelling	☐ Yes	☐ No	Nausea or vomiting	☐ Yes	☐ No
Varicose veins/Spider Veins (in legs)	☐ Yes	☐ No	Recurrent infections	☐ Yes	☐ No
Recent weight change	☐ Yes	☐ No	Shortness of breath	☐ Yes	☐ No
Fever	☐ Yes	☐ No	Recurring cough	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No	Easy bruising/bleeding	☐ Yes	☐ No
Sinus problems or rhinitis	☐ Yes	☐ No	Enlarged glands	☐ Yes	☐ No
Muscle weakness	☐ Yes	☐ No	Numbness/Tingling	☐ Yes	☐ No
Joint Pain	☐ Yes	☐ No	Slow healing wounds	☐ Yes	☐ No
Back Pain	☐ Yes	☐ No			

_____ _____

Patient/Responsible Party Signature Date/Time

KANSAS CITY VASCULAR INSTITUTE

INITIAL PATIENT QUESTIONNAIRE

Patient Name: _____ Responsible Party: _____

I, the patient (and/or responsible party) identified above, hereby agree as follows:

Assignment of Insurance Benefits: I assign directly to Kansas City Vascular Institute all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions and claims. I understand I am financially responsible for all charges whether or not covered by my insurance. I understand I am also responsible for providing up to date and accurate insurance information. I certify I will pay to Kansas City Vascular Institute and co-payments, co-insurance, deductibles, or cost of non-covered products or services. The patient shall fully and unconditionally cooperate with the facility if and when requested to provide additional information, contact his/her insurer, and/or endorse for the benefit of the facility any payment received for the facility's services. In some instances, the patient's insurer may send reimbursement for the facility's services directly to the patient. Such payments are deemed assigned to the facility. If any payment received by the patient is not transferred to the facility within ten (10) days of the receipt thereof, the patient shall be liable to the facility for the full amount billed for the facility's services, plus all costs incurred in connection with collection, litigation, and enforcement of such liability. I will also be responsible for any amounts not paid by insurance if I fail to provide appropriate insurance information for billing.

Medicare Patient's Release of Information. I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made on my behalf. I understand it is mandatory to notify the health care provider of any other party who may be responsible in part for my treatment.

Billing for Other Services. The patient will be billed for diagnostic or ultrasound services obtained in connection with the patient's treatment at the facility**.**

Financial Policies

- Outstanding balances are due when you receive your statement or at your next visit, whichever is sooner. Your co-pay is due at each visit prior to seeing the doctor.
- Prior to your appointment, you must notify us if your injury is the result of a work-place injury. Your employer, workers compensation insurance company, or attorney must authorize your treatment in writing before your appointment.

Appointment Cancellation Policy

At Kansas City Vascular Institute, we understand circumstances can change, and we request patients notify us at least 24 hours in advance if they need to cancel or reschedule an appointment. This allows us to manage our schedule effectively and offer the time slot to another patient in need of care. **If you must be late, please, contact us as soon as possible so we can determine if we need to reschedule your appointment.**

Cancellations or rescheduling requests with less than 24 hours' notice may result in a cancellation fee of $25 charged to your account. If a patient does not notify the clinic that they are not able to make an appointment they will be considered a no-show and a no-show fee of $50 may be charged to your account. This fee is not covered by insurance. We also reserve the right to terminate our relationship with you after three (3) or more occurrences and/or if you continually cancel or reschedule your appointments.

We appreciate your understanding and cooperation in ensuring we can provide timely and efficient care to all of our patients. Please note we consider exceptions for unavoidable emergencies on a case-by-case basis.

Termination of provider/patient relationship

I understand that Kansas City Vascular Institute has the right to discharge any patient from the practice at any time due to repeated non-compliance, failure to meet financial obligations, or threatening/violent/repetitive rude or offensive behavior. If this occurs, records will be released to a physician of my choice after a signed release of information is received by this office. I understand that this policy is to keep the provider/patient relationship trustworthy and respectful.

_____ _____

Patient/Responsible Party Signature Date

KANSAS CITY VASCULAR INSTITUTE

INITIAL PATIENT QUESTIONNAIRE

Patient Name: _____ Responsible Party: _____

I, the patient (and/or responsible party) identified above, hereby agree as follows:

Consent to Treatment and Procedures. You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment.

By signing below, you are indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

Consent to Telemedicine Services. I consent to my appointment being performed through telemedicine, defined as "the interactive use of audio, video or other electronic media for the purpose of diagnosis, consultation or treatment" if and when expressly discussed with me.

Patient's Bill of Rights

I have been given a copy of the Patient Bill of Rights and have been given the opportunity to ask questions.

Advance Directives. Kansas City Vascular Institute's advance directive policy is as follows: All patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Powers of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes. When the patient is unable to make decisions or unable to communicate decisions Kansas City Vascular Institute respects and upholds those rights.

However, unlike in an acute care hospital setting, Kansas City Vascular Institute does not routinely perform "high risk" procedures. While no surgery is without risk, the procedures performed in this facility are considered to be of minimal risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risk, your expected recovery, and care after your surgery. Therefore, it is our policy, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney-in-fact, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital further treatments or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or health care power of Attorney. Your agreement with this facility's policy will not revoke or invalidate any current health care directive or health care power of attorney.

☐ I acknowledge Kansas City Vascular Institute's advance directive policy and I have an advance directive, which I am submitting or have submitted to the facility.

☐ I acknowledge Kansas City Vascular Institute's advance directive policy and I do not have advance directive; I have been given the opportunity to ask the facility to provide me with blank forms so that I may consider completing them. (I understand that the facility cannot and will not advise me on any matter relating to advance directive choices.)

☐ I acknowledge Kansas City Vascular Institute's advance directive policy and I do not have an advance directive form and am not interested in receiving one from the facility.

The Privacy Policy, Financial Policy and Appointment Cancelation Policy are available on our website and copies are available upon request.

_____ _____

Patient/Responsible Party Signature Date