Please complete the enclosed forms and bring with you on your appointment day to expedite the check-in process.

Thanks,

Vascular Clinic

VASCULAR CLINIC

Jon V. Schellack, M.D., F.A.C.S. - London C. Guidry, M.D., F.A.C.S. - Taylor S. Gwin, M.D., M.P.H

8585 Picardy Ave., Suite 310 Baton Rouge, LA 70809
Office (225) 767-5479 Fax (225) 767-5147

Vascular Clinic, A Peripheral Vascular Center of Excellence welcomes you and your family. We care about you, and are dedicated to providing the type of service that you deserve. We are committed to treating you and your family with dignity, respect and true compassion.

To assist us in providing you this level of care, we have enclosed the following forms to be completed PRIOR to your appointment.

- **REGISTRATION FORM** (Form P200)-Provides very important patient and billing information. It is vital to complete all questions. Please bring the completed forms with your insurance card on the day of your appointment.

- **INITIAL PATIENT HISTORY QUESTIONNAIRE** (Form P208)-Provides essential Medical information. Please complete all information on this form to assist the physician in his diagnosis and treatment plan. IT IS IMPORTANT TO COMPLETE THE CURRENT MEDICATION SECTION.

- **RELEASE AND INSURANCE AUTHORIZATION** (Form P218)-By signing this form, you are authorizing us to provide your health information to your insurance company and/or Medicare. You are also agreeing to pay any and all charges that are determined to be your responsibility.

- **NEW PATIENT CONSENT (HIPAA)** (Form P214)-This form is very important. Please read it carefully. Sign and date this form after you complete it in full. You will need to write your name on the first page, and on the second page please do the following:

PLEASE NOTE: You do not need to list your physician(s) on this form.
Only family members or friends you wish to have access to your information.

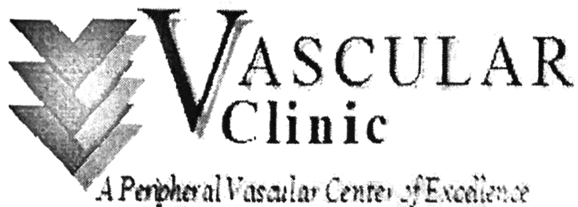
- **If you do authorize** a family member (spouse, child, mother, father, etc...) or friend, to receive all health information from our office concerning you, please sign your initials in the first (1st) line. And list all the names and phone numbers of the ones you are giving permission to receive your health information.

- **If you DO NOT authorize** a family member or friend to receive any information concerning your health information with our office, please sign your initials in the second (2nd) line.

Thank you for your time and patience in completing the New Patient Welcome Packet.

Be sure to bring the following with you at the time of your visit:

- All completed paperwork enclosed in this packet
- Your insurance Card(s)
- Your Driver's License or Photo ID
- A list of current medications



Jon V. Schellack, M.D., F.A.C.S.
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Taylor S. Gwin, M.D., M.P.H.

Drs. Schellack, Guidry and Gwin have an affiliation with the LSU Health Care Services Division and the Department of Surgery at LSU Health Sciences Center New Orleans. As part of your care with us you may be seen and/or treated by an LSU surgical resident in training or an LSU or Tulane Medical student. If you are uncomfortable with this arrangement please notify the staff. We are dedicated to training the future doctors of Louisiana.

Thanks,

Management

8585 Picardy Ave., Suite 310, Baton Rouge, La 70809

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DRIVING DIRECTIONS

From Gonzales, LA
Merge onto I-10 W toward Baton Rouge.
Take the exit toward 162B-A/Mall of Louisiana Blvd/LA-1248/Bluebonnet Blvd.
Keep right at the fork in the ramp.
Keep left at the fork in the ramp.
Turn left onto LA-1248/Bluebonnet Blvd.
Turn right onto Picardy Ave.
8585 PICARDY AVE is on the right.
Office is located on the right in Medical Tower 2, 3rd floor, Suite 310.

From Denham Springs, LA
Merge onto I-12 W toward Baton Rouge.
Merge onto US-61 S/Airline Hwy via EXIT 2A.
Turn right onto Bluebonnet Blvd.
Turn right onto Picardy Ave.
8585 PICARDY AVE is on the right.
Office is located on the right in Medical Tower 2, 3rd floor, Suite 310.

From Alexandria, LA
Merge onto I-10 E toward Baton Rouge.
Keep right to take I-10 E toward New Orleans.
Merge onto Bluebonnet Blvd/LA-1248 via EXIT 162A.
Turn right onto Picardy Ave.
8585 PICARDY AVE is on the right.
Office is located on the right in Medical Tower 2, 3rd floor, Suite 310.

VASCULAR CLINIC

Initial Patient History Questionnaire

Please complete and bring this form with you to your first appointment.

Patient Name:______________________________ Today's Date:__________

Referring Physician:______________________ Birth Date:__________ Age:_____

Any/All other doctors you see:______________________________

Reason for your visit:______________________________

HISTORY OF PRESENT ILLNESS (HP1)

◊ Location:______________________
(Where on the body symptom occurs)

◊ Duration:______________________
(How long have you had symptom? How long does it last?)

◊ Severity:______________________
(Severe, worse, slightly. Pain scale 1-10)

◊ Quality:______________________
(Character of symptom…burning, gnawing, stabbing)

◊ Timing:______________________
(When symptoms occur)

◊ Context:______________________
(Situation associated with symptom)

◊ Modifying Factors:______________________________
(Things make symptoms better or worse)

◊ Associated Signs/Symptoms:______________________________
(Other things that happen when this symptom occurs)

Past, Family History & Social History

Medical History: *Please circle the correct answer for the following medical conditions.*

High Blood Pressure	Yes	No	Diabetes	Yes	No	Heart Trouble	Yes	No
Respiratory Problems	Yes	No	Stroke	Yes	No	Cancer	Yes	No
Bleeding Problems	Yes	No	Other Problems ______________________					

What is your current weight? ________

Current Medications: ____________ ____________ ____________

DRUG ALLERGIES: ____________ ____________ ____________

Past Hospitalizations/Surgeries/Injuries and Approximate Dates:

____

____

Family History: Please list any medical problems in your relatives.

Father:______________ Mother:______________ Siblings:______________

Others:______________ ______________ ______________

PATIENT HISTORY (Cont)

Patient Name:______________________________ Today's Date:__________

Social History: Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Tobacco Use: ☐ Never ☐ Quit / When? ________ ☐ Smoker/How Much? ________

Alcohol Use: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily/How Much? ________

Drug Use: ☐ Never ☐ Type and Frequency ______________________

Occupation:______________________ Other:______________________

Review of Systems: *Please circle the correct answer for the following medical conditions.*

◊ **Constitutional**			◊ **Ears/Nose/Mouth/Throat**			◊ **Eyes**		
Good General Health	Yes	No	Hearing loss or ringing	Yes	No	Wear glasses/contacts	Yes	No
Recent weight change	Yes	No	Sinus problems	Yes	No	Blurred/double vision	Yes	No
Night sweats/fevers	Yes	No	Nose bleeds	Yes	No	Eye Disease or injury	Yes	No
Fatigue	Yes	No	Sore throat/voice change	Yes	No	Glaucoma	Yes	No
◊ **Cardiovascular**			◊ **Respiratory**			◊ **Gastrointestinal**		
Chest Pain	Yes	No	Shortness of breath	Yes	No	Nausea/vomiting	Yes	No
Palpitations	Yes	No	Cough	Yes	No	Abdominal pain	Yes	No
Heart Trouble	Yes	No	Wheezing/asthma	Yes	No	Rectal bleeding	Yes	No
Swelling hands/feet	Yes	No	Coughing up blood	Yes	No	Bowel problems	Yes	No
◊ **Musculoskeletal**			◊ **Neurological**			◊ **Integumentary (Skin/Breast)**		
Muscle pain or cramp	Yes	No	Frequent headaches	Yes	No	Change in hair or nails	Yes	No
Stiffness/swelling joints	Yes	No	Paralysis or tremors	Yes	No	Rashes or itching	Yes	No
Joint pain	Yes	No	Convulsions/Seizures	Yes	No	Breast lump	Yes	No
Trouble walking	Yes	No	Numbness/tingling	Yes	No	Breast pain/discharge	Yes	No
◊ **Endocrine**			◊ **Hematologic/Lymphatic**			◊ **Allergic/Immunologic**		
Excessive thirst/urination	Yes	No	Bruise easily	Yes	No	Food Allergies	Yes	No
Thyroid disease	Yes	No	Slow to heal	Yes	No	Aspirin allergies	Yes	No
Hormone problem	Yes	No	Enlarged glands	Yes	No	Antibiotic allergies	Yes	No
◊ **Genitourinary –Male Only**			◊ **Genitourinary –Female Only**			◊ **Psychiatric**		
Blood in urine	Yes	No	Blood in urine	Yes	No	Insomnia	Yes	No
Kidney stones	Yes	No	Kidney stones	Yes	No	Confusion/memory loss	Yes	No
Sexual problems	Yes	No	Sexual problems	Yes	No	Depression	Yes	No
Testicle pain	Yes	No	Menstrual problems	Yes	No			

PATIENT STATEMENT:	**To the best of my knowledge, the above information is accurate and complete.** **Signed:**______________________ **Date:**__________
PHYSICIAN STATEMENT:	**I have reviewed the questionnaire with the patient.** **Signed:**______________________ **Date:**__________

VASCULAR CLINIC

REGISTRATION FORM

(Please Print)

Today's Date ______/______/______ **PCP** ____________________

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms. ❑ Dr.	Marital Status(Circle One) Single / Mar / Div Sep / Wid
Physical Address	City,	State, Zip	Birth Date / /	Age	Sex ❑ M ❑ F
Mailing Address	City,	State, Zip	Social Security Number	

Occupation	Employer	Employer Address:
Home Phone Number ( )	Cell Phone Number ( )	Business Phone Number ( )

Referred to Clinic by (Please check one box)
❑ Dr. ____________ ❑ Hospital ❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other ____________

Email Address	Other Family Members Seen Here

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

PRIMARY INSURANCE (Please check appropriate box)

❑ Medicare ❑ BlueCross/BS ❑ United Health ❑ Benefit Mgmt ❑ Aetna ❑ Cigna ❑ LA State Group ❑ LA Medicaid
❑ Other Insurance Name and Address: ____________

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ❑ **Self** ❑ **Spouse** ❑ **Child** ❑ **Other:** ____________

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Is this person a patient here? ❑ Yes ❑ No			
Occupation	Employer	Employer Address	Employer Phone No. ( )

SECONDARY INSURANCE
Name of Secondary Insurance:

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ❑ **Self** ❑ **Spouse** ❑ **Child** ❑ **Other:** ____________

IN CASE OF EMERGENCY

Name of Local Friend or Relative (Not living at same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Vascular Clinic or insurance company to release any information required to process my claims.

X ____________________

PATIENT/GUARDIAN SIGNATURE DATE

Form P200 – 06/01/06

<u>Vascular Clinic</u>

8585 Picardy Ave., Suite 310
Baton Rouge, LA 70809
(225) 767-5479

AUTHORIZATION TO RELEASE INFORMATION:

I authorize release of information related to my medical history to my insurance company and to CMS (Medicare).

AUTHORIZATION TO PAY INSURANCE BENEFITS:

I assign claim payments directly to **Vascular Clinic** and **Proactive Vascular Lab** for all insurance benefits and I understand I am financially responsible to **Vascular Clinic** and **Proactive Vascular Lab** for charges not covered. I understand that Medicare and/or other insurance may not cover certain services and that I am financially responsible for non-covered charges. I agree to pay any and all charges that exceed or that are not covered by insurance.

AUTHORIZATION TO HAVE PHOTOGRAPH TAKEN:

I authorize **Vascular Clinic** to take necessary photographs for the purpose of documentation, wound healing and teaching purposes.

PRINT NAME: ______________________________ DATE: ____________

SIGNATURE: ______________________________ DATE: ____________

Financial Policy

PROOF OF INSURANCE

- Patients please bring your Insurance Card to every visit.
- Without proof of insurance it will be considered Self-Pay.
- It is your responsibility to let us know who to bill.

PAYMENT DUE AT TIME OF SERVICE

- We accept cash, personal check, debit and credit cards.
- Non-covered services are payable at time of service.

OUR RESPONSIBILITY TO REPORT NON-COMPLIANCE

- You may be reported to your insurance carrier for refusal to pay your co-pay or co-insurance.
- Please contact your Human Resources Department for more information.

FINANCIAL ASSISTANCE

- We treat all patients regardless of financial status.
- Please see the Office Manager for assistance if you have no insurance.
- Bring your current pay check stub and last year's tax returns.

PAST DUE AND DELINQUENT ACCOUNTS

- Unforeseen patient balances will be billed to address given.
- ALL balances are due within 30 days of the billing date.
- Please contact our office if you cannot pay the balance in full.
- If you do not pay on your account, you may be reported to our collection agency and /or dismissed from Vascular Clinic.

PATIENT ACKNOWLEDGEMENT

By signing this document I understand and agree to adhere to the financial policy of the Vascular Clinic. I do understand that it my responsibility to keep this practice updated in any change of insurance coverage and address.

______________________ (Patient or Responsible Party)	____________ (Date)
______________________ (Relationship to patient if signed by responsible party	____________ (Date)
______________________ (Staff signature presenting this document)	____________ (Date)

VASCULAR CLINIC

New Patient Consent to the Use and Disclosure of Health Information For Treatment, Payment, of Healthcare Operations

- I, ________________________, understand that as part of my health care, VASCULAR CLINIC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care and treatment. I understand that this information serves as:
- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Policies* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that VASCULAR CLINIC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organizations has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that VASCULAR CLINIC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should VASCULAR CLINIC change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, E-mail).

SIGN YOUR INITIALS IN ONLY ONE OF THE FOLLOWING
(NOT BOTH)

______ **I do not authorize** the following information to be disclosed to any other parties except to me as the patient.

______ **I authorize** the person(s) listed below to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at VASCULAR CLINIC.

Please list **Name, and Phone Number of the Person** you are giving permission for VASCULAR CLINIC to release information to:

SPOUSE: ______________________________

CHILD: ______________________________

FAMILY: ______________________________

FRIEND: ______________________________

FRIEND: ______________________________

OTHER: ______________________________

OTHER: ______________________________

I fully understand and accept the terms of this consent.

____
Patient's Signature

____
Date

FOR OFFICE USE ONLY

[ ] Consent received by ______________________ on ______________

[ ] Consent refused by patient, and treatment refused as permitted.

Form P214 – 8/05