David Vogel, MD • Gregory Gordon, MD
John Elsaesser, APRN, NP-C • Alicia Hanson, PA-C, RVT
17404 Burke St, Ste 102 & 106
Omaha, NE 68118
Ph (531) 466-4260 • Fax (531) 466-4304

Patient Demographics

Name: ______________________________ ___________________ ____________________________________
(First) (M.I) (Last)

DOB: _______/_______/_________ Age: ____________ SS#: __________-_________-__________

Address: ____

__________________________ , __________ ______________________
(City) (State) (Zip)

Home Phone: ( ) __________-_____________ Cell Phone: ( ) __________-_____________

Email Address:____

Preferred Language: ________________________ Preferred Name: __________________________

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Race: ☐ White ☐ American Indian ☐ Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic
☐ Native Hawaiian/Pacific Islander ☐ Other

Employer Information

Employment Status: ☐ Full time ☐ Part time ☐ Retired ☐ Unemployed ☐ Other: _____________________

Patient Employer: ____ Occupation: _________________________

Work Address: ____

________________________ __________ ____________________ Work Phone: ( ) __________-______________
(City) (State) (Zip)

Emergency Contact Information

Name: ____ Relationship: ______________________

Contact Number: ( ) __________-______________

Name: ____ Relationship: ______________________

Contact Number: ( ) __________-______________

Name: ____ Relationship: ______________________

Contact Number: ( ) __________-______________

Patient Name: ______________________________________ **DOB:** _____________________

Reason for today's visit: ____

Referring Doctor or Office: _________________________ Primary Care Doctor: __________________________

Please check any of the following health problems you have had or have now:

☐ High Blood Pressure	☐ Cataracts	☐ Thyroid Problems
☐ High Cholesterol	☐ Pneumonia	☐ Seizure Disorder
☐ Stroke or Mini Stroke	☐ Emphysema (COPD)	☐ Stomach Ulcers
☐ Pain in legs with walking	☐ Stomach Reflux/Heartburn	☐ Aneurysm Location: ____________________
☐ Heart Attack	☐ Kidney Problems/Failure	☐ HIV/AIDS
☐ Angina/Chest Pain	☐ Prostate Problems	Diabetes Mellitus ☐ Type I ☐ Type II
☐ Congestive Heart Failure (CHF)	☐ Hepatitis	☐ Asthma
☐ Pacemaker/ICD	☐ Bleeding or Clotting Problems	☐ Anemia
☐ Varicose Veins/Vein Stripping	☐ Abnormal Heart Rhythm/Atrial Fibrillation	☐ Other: ______________________

List previous surgeries/procedures and when:

Year	Surgery	Year	Surgery

Family History: Please check if the following health problems affect your family and identify their relationship to you

Asthma/Chronic Lung Disease	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son	**High Cholesterol**	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son
Bleeding Problem	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son	**Kidney Disease**	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son
Blood Clots	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son	**Obesity**	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son
Depression	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son	**Stroke**	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son
Diabetes Type I	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son	**Thyroid Problems**	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son
Diabetes Type II	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son	**Varicose Veins**	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son
Dialysis	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son	**Cancer** **Type:**	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son
Heart Disease	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son		
High Blood Pressure	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son		

Smoking Status: ☐ Never ☐ Quit, when? _________ How many years did you smoke? _________

☐ Current Smoker; how many packs per day? _________ How many years? _________

If current or past, what type? ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chewing Tobacco

Patient Name: ______________________________ **DOB:** ____________________

Do you use any recreational drugs? ☐ No ☐ Yes; which ones? ____________________

Do you drink alcohol? ☐ No ☐ Yes; what type? ☐ Wine ☐ Beer ☐ Liquor
How many per day? ____________________

What are you allergic to? Please list all medications or other substances and the reaction.

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

What medications do you currently take? Please list prescription and non-prescription medications, vitamins, cold remedies, and herbals. (DO NOT FILL OUT IF YOU PLAN TO BRING A COPY OF YOUR MED LIST TO THE APPOINTMENT)

Medication Name	Dosage (Amount)	Frequency (How often)

Do you take any of the following: ☐ Coumadin/Warfarin Who manages lab work? ____________________
☐ Clipidogrel/Plavix ☐ Apixaban/Eliquis ☐ Aspirin ☐ Pradaxa ☐ Other: ______________

Preferred Pharmacy: ______________________________ Location: ____________________

Are you currently on dialysis? ☐ No ☐ Yes (If yes, please complete the information below)

Name of dialysis center: ____________________ Dialysis Doctor: ____________________

Dialysis center address: ____

Dialysis Days: ☐ M/W/F ☐ T/Th/Sa

Patient Name: ____ **DOB:** ______________________

Please check if you have experienced any of the following symptoms:

	Endocrine	
☐ Intolerant to Heat or Cold	☐ Hair Loss	☐ Sweating (Night Sweats)
	Cardiovascular	
☐ Chest Pain	☐ Blood Clots	☐ Ankle Swelling
If yes, please specify:	☐ Fainting	
☐ with exercise ☐ at rest		
	Eyes, Ears, Nose & Throat	
☐ Blindness in one eye	☐ Change in vision	☐ Lack of vision in visual field
	Gastrointestinal	
☐ Abdominal Pain	☐ Change in appetite	☐ Weight loss
	Hematological	
☐ Blood clotting	☐ Easy bruising	☐ Prolonged bleeding
If yes, please specify:		
☐ Artery ☐ Vein		
	Musculoskeletal/Skin	
☐ Back pain	☐ Cramping with exercise	☐ Heaviness/Achiness in Legs
☐ Numbness and/or Tingling	☐ Skin color changes	☐ Sores on legs and/or feet
☐ Leg pain at rest and/or night	☐ Arm discomfort with activity	

How far can you walk? _______ feet, _______ yards, _______ blocks

Location of your leg pain? ☐ Buttock ☐ Thigh ☐ Calf ☐ Foot

	Neurological (Dominant Side: ☐ Right ☐ Left)	
☐ Difficulty moving a side or limb	☐ Numbness of a side or limb	☐ Paralysis
If yes, please specify:	If yes, please specify:	☐ Slurred Speech
☐ Right ☐ Left ☐ Both	☐ Right ☐ Left ☐ Both	☐ Seizures
	Respiratory	
☐ Cough	☐ Shortness of breath	☐ Snoring
	If yes, please specify:	
	☐ At rest ☐ with exertion	
	Psychological	
☐ Change in sleeping patterns	☐ Depression	☐ Difficulty concentrating
☐ Hearing voices		
	Urological	
☐ Kidney stones	☐ Frequent urination	☐ Pain with urination

GYN (Females Only)

Date of last menses: __________________________ Menses: ☐ Regular ☐ Irregular

Date of last mammogram: __________________________ Hormone Therapy: ☐ Current ☐ Past

Patient Name: ____ **DOB:** _________________________

Insurance Information

PLEASE HAVE YOUR PHOTO ID & INSURANCE CARDS AVAILABLE FOR COPYING AT EACH VISIT. ALL COPAYS ARE DUE AT THE TIME OF THE SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

Primary Insurance

Insurance Carrier:	Effective Date:
Member ID:	
Group:	
Policy Holder Name:	Policy Holder DOB:
Policy Holder SSN:	Policy Holder Employer:

Secondary Insurance

Insurance Carrier:	Effective Date:
Member ID:	
Group:	
Policy Holder Name:	Policy Holder DOB:
Policy Holder SSN:	Policy Holder Employer:

Tertiary Insurance

Insurance Carrier:	Effective Date:
Member ID:	
Group:	
Policy Holder Name:	Policy Holder DOB:
Policy Holder SSN:	Policy Holder Employer:

Information Release and Consent to Treatment
Private Insurance Authorization for Assignment of Benefits

I, the undersigned, authorize payment of medical services to Advanced Vascular and Vein Center for any services furnished to me by the physician/s. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

I, knowing that I have a condition requiring diagnosis, treatment, or related medical care do hereby consent to such care, medical examinations, operations, procedures, therapy sessions, photographs, and/or treatment by my attending physician, their assistants, or designees as may be necessary in their professional judgment. I further acknowledge that no guarantees have been made to me as to the results of such care, medical examinations, operations, procedures, therapy sessions and/or treatments.

Patient Name: ______________________________________ **DOB:** ______________________

Patient Financial Policy

We are committed to providing you with the best possible care, and will help you receive your maximum allowable insurance benefits. However, we need your assistance and your understanding of our payment policy. Your insurance contract is between YOU/YOUR INSURANCE COMPANY/YOUR EMPLOYER. (Please refer to enclosed document-"Understanding Your Insurance Coverage") Not all services are covered by all contracts.

We participate and accept assignment from most major payers, which means covered charges, will be paid directly to us. If we do not participate in your insurance plan, you may still choose to be seen by the practice. As a courtesy to you, we will file a claim with your insurance carrier on your behalf. Any remaining balance will be billed to you once we have received a remittance from your insurance carrier.

Due to current federal and insurance regulations, ALL co-payments, co-insurance and deductibles are collected at the time of service. We accept cash or checks, and for your convenience, Visa, MasterCard, and Discover. Additional fees, which typically are not covered by insurance plans, will be charged for services such as copying of medical records and completion of disability forms. A fee of $35.00 will be charged for checks returned for insufficient funds. An additional monthly fee may be charged on all past due accounts and co-pays not paid at time of visit. We encourage you to contact our **Billing Company** promptly for assistance in the management of your account. We are here to help you and will be happy to answer any questions you may have about your treatment or insurance coverage.

Billing Company:
USMD Billing
13036 SE Kent-Kangley Rd, Suite 360
Kent, WA 98030
Toll Free (844) 218-1178 (Option #5)

Patient Financial Agreement

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for ANY professional services rendered. I have read the above Patient Financial Policy and have provided the Practice with true and correct insurance information. I will notify you of any changes in my health insurance coverage.

A copy of this agreement may be used in place of the original.

______________________________________ ______________________
(Signature of Patient, Policy Holder or Legal Guardian) (Date)

____
(Printed Name)

Patient Name: ____ **DOB:** ______________________

Understanding Your Insurance Coverage

Your insurance policy is an agreement between you and your insurance company. The policy lists a package of medical benefits such as tests, drugs, and treatment services. The insurance company agrees to cover the cost of certain benefits listed in your policy. These are called "covered services".

Your policy also lists the kinds of services that are not covered by your insurance company. You have to pay for any uncovered medical care that you receive. Keep in mind that a medical necessity is not the same as a medical benefit. A medical necessity is something that your doctor has decided is necessary. A medical benefit is something that your insurance plan has agreed to cover. In some cases, your doctor might decide that you need medical care that is not covered by your insurance policy.

Insurance companies determine what tests, drugs and services they will cover. These choices are based on their understanding of the kinds of medical care that most patients need. Your insurance company's choices may mean that the test, drug or service you need isn't covered by your policy.

Your doctor will try to be familiar with your insurance coverage so he/she can provide you with covered care. However, there are so many different insurance plans that it is not possible for your doctor to know the specific details of each plan. By understanding your insurance coverage, you can help your doctor recommend medical care that is covered in your plan.

- ✓ Take the time to read your insurance policy. It's better to know what your insurance company will pay for before your receive a service, get tested or fill a prescription. Some kinds of care may have to be approved by your insurance company before your doctor can provide them.
- ✓ If you still have questions about your coverage, call your insurance company and ask a representative to explain it.
- ✓ Remember that your insurance company, not your doctor, makes the decisions about what will be paid for and what will not.
- ✓ Remember that your doctor, not your insurance company, makes medical decisions and recommendations about what will benefit your health status.

Most of the things your doctor recommends will be covered by your plan, but some may not. When you have a test or treatment that isn't covered, or you get a prescription filled for a drug that isn't covered, our insurance company won't pay the bill. This is often called "denying the claim". You can still obtain the treatment your doctor recommended, but you will have to pay for it yourself.

If your insurance company denies your claim, you have the right to appeal (challenge) the decision. Before you decide to appeal, know your insurance company's appeal process. This should be discussed in your plan book.

____
(Patient Initials)

____
(Date)

Patient Name: ____ **DOB:** __________________________

Notice of Health Information Practices
Notice of Privacy Policies

Acknowledgement of Understanding Statement

I,____, have had access to the Advanced Vascular and Vein Center, LLC, Notice of Privacy Policies.

I understand:

Each time I visit Advanced Vascular and Vein Center, LLC, a record of my visit is made. Typically, this record contains my symptoms, examination, test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as my health or medical record, serves as:

- Basis for planning my care and treatment.
- Means of communication among the many health professionals who contribute to my care.
- Legal document describing the care I received.
- Means by which I or a third-party payer can verify that services billed were actually provided.
- A tool in educating health professionals.
- A source of data for medical research, a source of information for public health officials charged with improving the health of this state and the nation.
- A source of data for Advanced Vascular and Vein Center, LLC's planning and marketing.
- A tool which Advanced Vascular and Vein Center, LLC, can assess and continually work to improve the care rendered and the outcomes achieved.

Authorized Release:
I understand that Advanced Vascular and Vein Center, LLC, is only allowed to release medical information to the individual patient with the exceptions of minors, Worker Compensation cases, and any individual designated by patient, in writing, to access his/her medical records. This includes picking up medication, prescriptions, DME products and x-rays. I give permission to the following individual/s to have access to this information. Proof of ID must be shown any time information is received.

_____________________________________ _____________________________
(Name) (Relationship)

_____________________________________ _____________________________
(Name) (Relationship)

_____________________________________ _____________________________
(Name) (Relationship)

I can change this information at any time by notifying Advanced Vascular and Vein Center, LLC, in writing of the changes.

_____________________________________ ______________________
(Patient/Responsible Party Signature) (Date)