PATIENT DEMOGRAPHICS

Patient Information		
Name:	Today's Date:	
Address:		
City:	State:	Zip Code:
Preferred Contact (Personal Phone, Work Phone, Mail, or Email):		
Preferred Phone Number (Personal, Work, or Other):		
Alternate Phone Number (Personal, Work, or Other):		
Email Address (to the extent that you would like us to potentially communicate with you by email):		
Date of Birth:	Social Security Number:	
Sex:	Ethnicity:	
Race:	Preferred Language:	
Marital Status (Circle One): Married, Single, Widowed, Divorced		
Do you live alone (Circle One): Yes, No If not, list who you live with:		
Religion:		
Highest Education Level (Circle One): College or Above, High School, Grade School		
Referring Physician (Name, Specialty, Office Name, Address, Phone Number):		
Primary Physician or Provider (If different than referring physician):		

Patient Employment	
Circle One: Employed, Retired, Unemployed, Other	
Employer's Name:	Occupation:

Emergency Contact(s)
List Name(s), Relationship(s), and Phone Number(s) for your emergency contact(s):

Responsible Party (If patient is under 18 years old)
List Name, Relationship to patient, Address, City/State/Zip, Phone Number, SSN, DOB for responsible party (if applicable):

Pharmacy Information	
Pharmacy Name:	Pharmacy Phone Number:
Pharmacy Address:	

Advanced Directives
Circle One: None, healthcare power of attorney, living will, healthcare proxy, DNR/DNI, guardian

PATIENT AGREEMENTS

Acknowledgement of Medical Issue Review

Additional Information:

Is there anything else that you would like your provider to know about you or your health, or that your provider should otherwise be aware of to provide you with appropriate medical care?

_____

Acknowledgement and Attestation:

I acknowledge that I reviewed the New Patient Packet, which includes all the forms and agreements listed above on page 2. I also certify that I read and understand SLVSS' expectations of me as a patient and accept the same as terms of receiving treatment at SLVSS. I have had had the opportunity to review in person the packet and ask questions.

I attest that the information I have given above is full, correct, and true to the best of my knowledge. I understand and acknowledge that providing a full, correct, and true medical history is essential for SVSS to provide me with appropriate treatment.

Patient Name:_____

Patient Signature:_____

Date:_____

General Consent for Treatment

As a patient, you have the right to be informed about your condition(s) and the recommended surgical, medical, or diagnostic testing or treatment, including the risks and hazards involved, so that you may make an informed decision whether to undergo the suggested testing or treatment(s). At this point in your care, no specific treatment plan has been recommended. By signing this agreement, you provide your consent to perform the evaluation necessary to identify appropriate treatment(s) and/or procedure(s) for any identified condition(s).

This agreement also provides us with your general permission to perform any and all reasonable and medically necessary examinations, testing, and treatments that you agree to in your discretion. 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 specific treatment recommended. Your consent will remain fully effective until it is revoked in writing and will therefore apply to each visit that you have with any of our providers, including for any future medical care or treatment which may be needed but which is not known at the time that you sign this agreement. You may at any time choose to discontinue our services or revoke this consent by written notice to us.

You have the right to discuss any aspect of your treatment plan with your physician or other appropriate provider(s), including the purpose and potential risks and benefits of any treatment(s) or test(s) ordered for you. If you have any concerns or confusion regarding any test or treatment recommended by your physician or other appropriate provider, we encourage and expect you to ask questions. Please also see your New Patient Intake Package for self-education resources, which we also encourage and expect you to utilize.

In consideration of receiving treatment from St. Louis Vascular Surgical Specialists, PC ("SVSS") and its providers, I affirmatively state or otherwise agree to the following:

A. I have and will continue to provide truthful, accurate, and complete information regarding my health and medical history, and I understand and acknowledge that SVSS and its physicians and providers will rely upon such information in determining and recommending medical treatment(s) to me. I take responsibility for any adverse outcome for failing to do so.

B. I authorize and consent to assessment, care, examination, and treatment (including, without limitation, any medications, laboratory tests, imaging studies, diagnostic or other procedures, services, and supplies) as SVSS, its physicians and other providers, may determine in their judgment to be necessary, appropriate, or desirable for me. I understand that if additional testing or procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

C. I understand that it is not possible to list each and every risk for every type of health care service which may occur in relation with my medical treatment and that there may be material risks associated with medical treatments that will be provided to me.

D. I understand that the practice of medicine is not a perfect science, and that every test, treatment, surgery, or other procedure carries inherent risks, including without limitation unsuccessful results, complications, and/or injuries, from both known and unforeseen causes. I acknowledge that fact and certify that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** or otherwise implied regarding the results of my medical treatment(s) or cure of my medical condition(s).

E. I understand and acknowledge that receiving medical treatment does **NOT** ensure healing or otherwise prevent my medical condition(s) from getting worse.

F. I understand my responsibilities as SVSS' patient that are reflected in my New Patient Intake Package.

G. I understand that there are many variables and circumstances out of SVSS' control that can negatively affect my health or worsen my medical condition(s), including, without limitation, my lifestyle choices, medications, infections, age, deformities, circulation issues, diabetes, edema, mental cognition or communication, mental health, and general drive to get better.

H. <u>If I am a patient with chronic wounds</u>, I understand that there are additional variables or circumstances out of SVSS' control that can prevent my wounds from healing or otherwise that can make my wounds get worse, including without limitation the location of my wounds, my activity level, my ability to move or reposition myself, incontinence problems, pressure problems, cleanliness, blood thinning medications, and bleeding or clotting problems.

I. I understand and acknowledge that things may not go as intended in my treatment plan. If I have an adverse and/or unexpected result, I understand that fact does not mean that SVSS or any of its providers did anything wrong.

I certify that I have read and fully understand the above General Consent for Treatment, that I adopt any statements attributed to me as my own statements, and that I fully and voluntarily agree and consent to the same.

Patient Name:_____

Patient Signature:_____

Date:_____

Financial Agreement and Authorization

For purposes of this agreement, "Insurance" means any policy, plan, product, network, employer benefit or plan, self-insured program, or government program or assistance applicable to me.

I understand that I am financially responsible for and obligated to pay all charges by St. Louis Vascular Surgical Specialists, PC ("SVSS") in connection with my medical treatment. I understand that SVSS may perform medically necessary services as well as elective services, which I have the right to consider or decline before those services are rendered. My consent to undergo such treatment and/or services evidences my agreement to pay for them.

At the time services for my care are rendered, I will pay any copayment, deductible, or coinsurance, if applicable, and will otherwise pay the amount for any services that are not covered by Insurance. If my Insurance plan requires an authorization or referral before I receive services from SVSS, I must obtain it prior to my visit. I understand that I am personally responsible for the costs of services rendered if I fail to comply with the terms of my Insurance plan or agreement.

I authorize and direct payments of my medical benefits under my Insurance to SVSS on my behalf for any services furnished to me by its physicians and providers. I agree to use my best, good faith efforts to cooperate with and assist SVSS in receiving payment in full for the services rendered to me, including, without limitation, by remitting to SVSS any payments I receive from an insurer or from any other source whatsoever relating to the care provided to me by SVSS, its physicians and providers.

In the event that my Insurance determines that a provided medical service is not covered by my plan, I will be responsible to SVSS for the complete charge and agree to pay the costs of all such services rendered.

I hereby authorize SVSS to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care all information or documentation necessary or otherwise requested to substantiate or facilitate payment for such medical care, including, without limitation, information or documentation regarding my diagnoses or records reflecting the treatments or examinations rendered to me. I further authorize SVSS to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care any information required for precertification, authorization, or referral to another medical provider.

I understand that I have the option to pay for a health care service personally without submitting a claim to Insurance, however, if I elect this option, I must notify SVSS, reach mutually agreeable terms for the same, and thereafter must pay SVSS for that health care service in full at the time that the service is rendered.

If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.

Unless otherwise agreed to in writing, whether I have Insurance or not, payment of my account balance is due within thirty (30) days of receipt of my billing statement. If my account is over sixty (60) days past due, my account will be in default and may be referred to a collection agency or an attorney, which may potentially result in judicial or nonjudicial action. I acknowledge that if my

account is referred to a collection agency or attorney and later to a credit reporting agency, it may have an adverse effect on my credit history.

If I am in default of my account with SVSS, I authorize SVSS to disclose to any outside collection agency or attorney all relevant personal and account information necessary to collect payment for the services rendered to me. If my account is referred to a collection agency or attorney, I am responsible for a $100.00 administrative default fee.

Once in default, interest on the principal balance of my account will begin to accrue at the highest applicable rate permitted by law.

I understand that I can make payments by check, money order, debit card, or credit card. However, if any of my payments fail for any reason, I am responsible to pay SVSS a surcharge of $50.00 for each failed payment, any costs or fees incurred by SVSS, and any other costs or fees assessed or charged to SVSS by the third-party company that handled my payment (3.5% for all Credit Card transactions).

By using a credit or debit card for any payment of any invoice or balance, I expressly represent that I am an authorized user of that card and that I authorize SVSS to charge the card for the total amount listed in the invoice or balance, unless otherwise indicated. If I use a credit or debit card to make any payment, and if the card that I used changes or expires, or if the payment is denied, rescinded, or refunded for any reason, I agree to immediately give SVSS a new, valid card, agree that SVSS may charge the new card over the phone, and agree that my previous authorization provides authorization to charge my new card. Alternatively, I can pay the failed payment amount using another allowable payment medium described above.

By using a credit or debit card, I also certify that I will not dispute the payment with my credit card company or bank, whichever is applicable, so long as the transaction corresponds to the terms of this Agreement and accurately relates to services provided to me by SVSS. I further agree that I am personally responsible to pay SVSS for any cost, fee, or any other expense that SVSS incurs as a result of my credit card company or bank failing to make any payment on my behalf, whether at my direction or not.

To the extent that I use a credit or debit card to make any payment and for any reason that payment is later disputed or cancelled, resulting in a non-payment to SVSS, I hereby expressly authorize SVSS to provide to my credit card company or bank, whichever is applicable, and subject to any applicable laws, and outside of any legal recourse that may also be available to SVSS, any information or documentation that evidences the medical care or treatment that it provided to me, including, without limitation, my personal health information, my medical records, my billing records, and other relevant agreements.

I am responsible for all costs and expenses incurred by SVSS in connection with any "chargebacks" or "refunds" if (1) I use a credit or debit card to make a payment, (2) I later dispute the payment, or my legal representative or another authorized card user disputes the payment, (3) the dispute results in the credit card company or bank rescinding or cancelling the payment to SLVSS, resulting in a "chargeback" or a "refund" to the benefit of the card holder(s), (4) I refuse

to pay SVSS for the full amount of the initial payment for whatever reason(s) for at least two weeks following SVSS' demand for a new payment, whether made orally or in writing, (5) because of my continued refusal to make the full payment, SVSS is forced to resolve the dispute with my credit card company or bank, or through a legal process, and (6) my credit card company or bank, or a court, or an arbitration panel, whichever is applicable, determines that SVSS' initial invoice or charge was accurate based on the medical care provided to me, including (a) any applicable late fees or charges described above, (b) $250.00 in additional liquidated damages, (c) interest accruing at the maximum allowable rate under Missouri law from the date that the initial payment was disputed to the date of final resolution, (d) SVSS' attorneys fees, (e) any court or arbitration costs, and (f) any other reasonable expenses incurred during the process.

If SVSS takes any action against me to enforce its right to payment for services rendered, whether through a collection agency or through an attorney, in addition to the principal balance and any other charges or fees already accrued, I am responsible for all costs and expenses associated with SVSS' collection efforts, including without limitation late fees, interest on my account balance, administrative charges, attorneys' fees (if SVSS is successful in a legal proceeding), and court and/or arbitration costs (if applicable). Furthermore, if any court or arbitration panel enters a final judgment or decision in favor of SVSS and against me, I agree to pay to SVSS any and all interest accruing at the maximum amount allowed under Missouri law that accrues from the date that judgment or decision is entered to when I pay off my entire account balance.

I understand that I am ultimately responsible for payment for the services that I receive at SVSS. I have had the opportunity to read this Financial Agreement and Authorization in its entirety and have had the opportunity to ask questions regarding its details. Any questions have been answered to my satisfaction. I consent and agree to the terms of the Financial Agreement and Authorization.

Patient Name:_____

Patient Signature:_____

Date:_____

Insurance and Authorization Assignment

Please read and sign:

I attest that the information I have given here is correct and true to the best of my knowledge. I authorize and hereby assign my insurance benefits to be paid directly to Dr. Robert Hacker and authorize him and St. Louis Vascular Surgical Specialists, PC (SVSS) to furnish any information regarding my health and medical care to my insurance carrier to process my claims, as further described in the Financial Agreement and Authorization. I understand that I am responsible for any amount not paid for by my insurance. I further authorize St. Louis Vascular Surgical Specialists to obtain medication history electronically from my pharmacy benefit administrator.

Patient Name:_____

Patient Signature:_____

Date:_____

PRIVACY PRACTICES - HIPAA

Name _____ Date of Birth _____

ACKNOWLEDGMENT OF THE NOTICE OF PRIVACY PRACTICES

I have been provided with or offered a copy of the Notice of Privacy Practices of St. Louis Vascular Surgical Specialists, PC. I acknowledge that this Notice of Privacy Practices may be revised by St. Louis Vascular Surgical Specialists, PC at any time and that I may request a copy of the current Notice from the practice.

_____ _____

Signature Date

INDIVIDUALS INVOLVED IN MY CARE

I authorize **St. Louis Vascular Surgical Specialists, PC** to disclose my Protected Health Information to the following individuals involved in my care for the purpose of facilitating their involvement.

Name	Relationship	Description of Involvement/Information to be Disclosed

- I understand that I may notify the practice of any changes to the individuals involved in my care at any time and that the authorization to share information described above will continue until I notify the practice of changes.
- I understand that this authorization is voluntary and I am not required to designate any individuals in order to receive services from the practice.
- I understand that I may revoke this authorization at any time. I understand that my revocation will have no effect on any actions taken pursuant to this authorization prior to the revocation.
- I understand that the information disclosed pursuant to this authorization may be further disclosed by the recipient and may no longer be protected under HIPAA.

_____ _____

Signature Date

_____ _____

If Personal Representative, Printed Name Relationship to Individual