SAVANNAH VASCULAR INSTITUTE

The Vein & Artery Experts

Date: _____

Dear _____,

Thank you for choosing Savannah Vascular Institute. Our physicians, nurses, and staff are dedicated to providing quality services in a compassionate and caring manner. We truly appreciate your trust and confidence.

Enclosed, you will find our Patient Information and Patient History forms. Please complete these forms prior to your appointment. Any information that you cannot complete, the staff will be glad to assist you once you arrive for your appointment. We also ask that you arrive 15 minutes prior to your scheduled appointment time in order to complete the necessary paperwork. Also, please bring your medications with you. **Please be aware our office charges a $25 fee for missed appointments**.

We do file all insurance plans and will be happy to do this for you. If your insurance requires a referral to a specialist, please have this prior to your visit. Also, please have your co-pay, if applicable, with you at the time of your visit. You will be responsible for your co-insurance or any other percentage that your insurance does not allow. We do accept cash, check, and all major credit cards.

We have scheduled your appointment with Dr. _____ on _____ at _____. If you cannot keep this appointment, please notify our office immediately. Your appointment will be at the following office location.

____ 4750 Waters Ave., Suite 500 Provident Building Savannah, GA 31404 **(on Memorial Hospital Campus)**
____ 11706 Mercy Blvd Plaza A, Bldg 7 Savannah, GA 31419 **(Southside Office, across the street from St. Joseph's Hospital)**
____ 23630 Unit B Hwy 80 E, Northside Drive, Statesboro, GA 30458 **(beside McCook's Pharmacy in Memorial Office)**
____8 Okatie Medical Center Suite 201 Bluffton, SC 29909 **(in Legacy Medical Center Complex)**
____3301 East 1st Street Vidalia, GA, 30474 (**beside Lowes)**
____166 Memorial Dr. Jesup, GA 31545 **(across from Wayne Memorial Hospital)**
____ 459 Hwy 119 South, Springfield, GA 31329 **(on Effingham Hospital Campus)**
____455 S Main St Suite 203 Hinesville, GA 31313- (**in Dr Tomus' Office)**

Please feel free to contact us for further directions or information regarding your appointment at (912) 629-7800 or 1-866-957-8346. We look forward to your visit with us at Savannah Vascular Institute.

Sincerely,
SVI Physicians and Staff

Date :_____

SAVANNAH VASCULAR INSTITUTE

PATIENT INFORMATION Please Print Clearly and use Black Ink Only

To All Patients: Payment is expected at the time of service. Please indicate your payment preference:

___Cash ___Check ___Credit Card

Demographics

Patient Name_____ Date of Birth _____Age_____ Marital Status ___Married ___Single Sex ____Male ____Female Race _____ SSN_____

Address_____ Apt # _____City _____State_____

Zip _____ Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ Employer _____

Employer Address _____ Preferred Language_____ Ethnicity_____

Religion _____ Church (if practicing)_____

Referred by ____Self _____Family/Friend (Name) _____ Dr (Name)_____

Policyholder Information:

Policyholder Name: _____ Relationship to Responsible Party_____

Address_____City_____State _____ Zip _____

Home Phone _____ Cell Phone _____ DOB: _____SSN _____

Employer _____ Work Phone _____

If patient is a dependent/minor, please complete the following:

Legal Guardian/Responsible Party _____ Relationship to Patient _____

Address _____ Date of Birth _____

Home Phone _____ Work Phone _____ SSN _____

PRIMARY Insurance Company _____ Insurance ID# _____

Insurance Address _____

Group# _____ Insured's Name _____

Insured Date of Birth _____ SSN _____ Sex _____

Relationship to Patient _____

Employer Name _____ Co-Pay Amount _____

Employer Address _____ Work Phone _____

SECONDARY Insurance Company _____ Insurance ID# _____

Insurance Address _____

Group# _____ Insured's Name _____

Insured Date of Birth _____ SSN _____ Sex _____

Relationship to Patient _____

Employer Name _____ Co-Pay Amount _____

Employer Address _____ Work Phone _____

WORKER'S COMPENSATION Insurance Company _____ ID# _____

Insurance Address _____ Group# _____ Insured's Name _____

Insured Date of Birth _____ SSN _____ Sex _____ Employer Name _____ Co-Pay Amount _____

Employer Address _____ Work Phone _____

Person who does not live with you to contact in emergency _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is, also, provided the right to request confidential communications of PHI to be made by alternative means, such as, sending correspondence to the individual's office instead of their home or allowing messages to be left on their home answering machine.

☐ **O.K. to see Nurse Practitioner or Physician Assistant if the provider is not available**

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):

Home Telephone: _____

☐ O.K. to leave detailed message

☐ Leave message with call back number only

Written Communication

☐ O.K. to mail to my home address

☐ O.K. to mail to my work/office

☐ O.K. to fax to number listed below

_____

Work Telephone: _____

☐ O.K. to leave detailed message on voice mail or with _____

☐ Leave message with call back number only

You give information as necessary with the following family members, friends or personal representatives. I understand that Savannah Vascular Institute will refuse to discuss my information with anyone not listed below, except in an emergency. I understand that this disclosure does not apply to Medical Providers. I may edit this list at anytime by providing any changes in writing to the practice. I understand that it is my responsibility to inform the office of any/all contact changes.

PLEASE PRINT:

1. _____
2. _____
3. _____
4. _____

_____ _____

Patient's Signature Date

_____ _____

Please Print Name **Date of Birth**

_____ _____

Witness Date

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PHYSICIAN PRACTICE FINANCIAL POLICY AND RELEASE OF INFORMATION

The following statement of our Financial Policy for services provided within our office and do not apply to any testing or diagnostic procedure performed outside of this physician practice. We require you to read and sign this document prior to treatment at this facility.

PATIENT RESPONSIBILITY

All professional services rendered are charged to the patient and are due at the time of service. As a courtesy this practice will file your claim with your insurance carrier; however, the patient or responsible party is ultimately responsible for the charges not covered by your contract with the carrier. Any co-payments or deductible amounts not satisfied with your carrier are due at the time of service.

INITAL_____

Insurance carriers typically do not cover all medical costs. Some pay fixed allowances for each procedure and office visit while others pay only a percentage of the costs. Surgical procedures, labs and other outpatient procedures may have a higher co-payment or fall under the deductible. It is your (the patient) responsibility to understand your insurance coverage.

INITAL _____

When you receive a statement from the Savannah Vascular Institute, you are required to pay the balance upon receipt of the statement. If for some reason you do not agree with the balance due amount, you are to contact a billing representative at the phone number noted on the statement. Do not ignore the bill. If no payment or communication has been received after two consecutive statements, your account will be reviewed for the collection process.

INITAL _____

AUTHORIZATION FOR TREATMENT AND TO RELEASE INFORMATION

The signature below serves as authorization for medical treatment by the physician, physician's assistant, Nurse Practitioner, or nurse for the named patient. It also provides authorization for Savannah Vascular Institute to furnish and/or release any information necessary to insurance carriers, third party administrators, self-insured plan administrator, and/or other health benefit payer representatives in order to process health care claims incurred at this office or for utilization review or quality assurance. This authorization also serves as permission to obtain a copy of your complete medical record from other physician practices or medical facilities. A copy of this authorization may be used in place of the original in obtaining medical records. I understand that I may withdraw this authorization to release medical information at any time, communicated to the practice either in writing or verbally, followed by a written withdrawal.

INITAL _____

I understand that I am financially responsible to the Savannah Vascular Institute for any balance not covered by my insurance carrier.

ASSIGNMENT OF BENEFITS

I hereby assign and authorize my insurance benefits to be paid directly to Savannah Vascular Institute

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Patient Name (Please print) **DOB:**

Signature of Patient or Responsible Party **Date**

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E-PRESCRIBING CONSENT FORM

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an EPrescribe program. These include:

- **Formulary and benefit transactions** – Gives the prescriber information about which drugs are covered by the drug benefit plan.

- **Medication history transactions** – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

- **Fill status notification** – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up or partially filled.

By signing this consent form, you are agreeing that any provider at Savannah Vascular Institute can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Savannah Vascular Institute to enroll me in the E-Prescribe Program and check my medication history for 3 years. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____ _____

Patient Name **Patient's Date of Birth** **Date**

_____

Signature of Patient or Guardian Relationship to Patient

Patient's Name: _____ **DOB**: _____ **Date of Visit**_____

Allergies: _____

Pharmacy name and number: _____

Please list all medications you are taking (to include prescription medications/over-the-counter medications/vitamins and/or herbal medicines or supplements)

Medication	Dosage	Frequency taken	Date last dose taken