Intake Form

Patient Name:_____

Date of Birth: _____

DEMOGRAPHICS INFORMATION			
Gender		SSN#	
Address		MR#	
City		Occupation	
State/Zip		Employer	
Cell No			
Phone No			

INSURANCE INFORMATION						
Payor Name	Payor Number	Category	Factor	Group Number	Subscriber Name	Relationship

EMERGENCY CONTACTS							
Name:		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 Duval Vascular Center, LLC or to release any information required to process my claims.

_____ _____

Patient / Guardian Signature Date

Patient Assignment of Benefits

PATIENT NAME

SOCIAL SECURITY NUMBER

DATE

I hereby assign to Duval Vascular Center, LLC and/or Duval Vascular Center, LLC payment of all authorized Medicare Medicaid or other insurance benefits for any and all services furnished to me by Duval Vascular Center, LLC and/or Duval Vascular Center, LLC and direct that such benefits be paid directly to Duval Vascular Center, LLC and/or Duval Vascular Center, LLC and not to me. If these benefits are sent to me in error, I recognize that these benefits are owed to the practice listed above and I will immediately forward the benefit payment.

I, hereby, authorize Duval Vascular Center, LLC and/or Duval Vascular Center, LLC to use my information for a range of purposes including: insurance/payment eligibility verification; billing and collecting money due from, private and public payers or their agents including insurance companies, managed care entities, my employer, state and federal government programs and the Bureau of Workers' Compensation; obtaining pre-admission or continued care certification; quality of care assessment and improvement activities, evaluation of the performance or qualifications of physicians and health care workers; conducting healthcare staff training and education programs, ensuring compliance with legal, regulatory and accreditation requirements, and public health activities. I authorize Duval Vascular Center, LLC to utilize or release my health information, whether written, verbal, electronic, or by facsimile to such employees, agents or third parties as are necessary for these purposes and to companies who provide billing services for physicians involved in my medical care.

Patient Signature

Date

Patient / Guardian Signature

Date

PLEASE NOTE: If the patient is physically or mentally unable to sign, a representative may sign on the patient's behalf. In this event, the statement's signature line must indicate the patient's name followed by the representative's name, address, relationship to the patient, and the reason the patient cannot sign. The authorization is effective indefinitely unless patient or patient's representative revokes this arrangement.

POLICY REGARDING PATIENT FINANCIAL RESPONSIBILITY

Providing quality medical care to our patients is our primary concern. The following is a summary of our financial policy. We would be happy to provide further clarification if necessary. We ask that you read and sign the following to acknowledge that you have been advised of your financial responsibility for medical services provided here at Duval Vascular Center, LLC.

We have contracts with many insurance companies, and we will bill them as a service to you. We will let you know if your plan is one for which we are a designated provider. If you wish to be seen at Duval Vascular Center, LLC, you are responsible for payment of all co-pays and/or deductible charges at the time of service. If your insurance is a plan for which we are not a designated provider, we are more than willing to provide care and you will be responsible for payment at the time of service. As the responsible party, you are responsible if your insurance company declines to pay for any reason.

The person signing on behalf of the Patient as the Responsible Party must:

- Inform Duval Vascular Center, LLC of the current address and phone number for the patient and the responsible party.
- Present all current insurance cards prior to each office visit.
- Verify at each visit that the information is current by signing our data sheet.
- Pay any required co-pay at the time of the visit.
- Pay any additional amount owing within 30 days of receiving a statement from our office. (When receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you.)

We accept payment in the form of credit card, cash or check. Any checks returned to us due to insufficient funds; or any other reason, will result in a fee of $25.00 each.

I have read this financial policy and understand that I have financial responsibility for payment of medical services provided by Duval Vascular Center, LLC, and hereby assume and guarantee payment of all expenses incurred during my office visit. Should legal action be required to secure payment of this account, I agree to pay the legal expenses incurred by this office.

Signature of Patient / Responsible Party

Date

"No Show" and "Cancellation" Policy for Office Visits and Procedures

At Duval Vascular, our goal is to provide quality vascular care in a timely manner. We have implemented a no show and cancellation policy which enables us to better utilize available appointments for our patients in need of vascular care. The following policy is with regard to patients who fail to keep their scheduled office visit appointment, or procedure appointment.

Please be courteous and call Duval Vascular Center promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. Available appointments are in high demand and your early cancellation will give another person the possibility to have access to timely vascular care.

- Patients who fail to show for their scheduled appointment or did not notify the office within 24 hours of their scheduled appointment time, shall be subject to a "No Show/Cancellation" fee of $25.00. In the event of an actual emergency and prior notice could not be given, consideration will be given, and a one-time exception may be granted.
- Patients who fail to show for their scheduled office procedure appointment or did not notify the office within 48 hours of their scheduled appointment time, shall be subject to a "No Show/Cancellation" fee of $150.00.
- If cancelled by the physician as a medical necessity, then the patient is not subject to this charge. Insurance authorization denials are also an exemption of the fees.
- These fees are not covered by insurance and is therefore the sole responsibility of the patient.

How to Cancel Your Appointment

To cancel or reschedule appointments call Duval Vascular Center at 904-518-1398. If you have any problems getting through, you can leave a message with your name, appointment date and cancellation reason or request for rescheduling.

Patient Signature	Date
Patient Printed Name	Date
Witness Signature	Date

Patient Consent for the use and Disclosure of Protected Health Information

With my consent, Duval Vascular Center, LLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). Please refer to Duval Vascular Center, LLC Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

I understand that Duval Vascular Center, LLC reserves the right to revise its Notice of Privacy Practices in accordance with Section 164.520 of the Code of Federal Regulations. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer, Duval Vascular Center, LLC, 915 West Monroe Street Suite 100, Jacksonville, Florida 322041177.

As a patient, you have a right to inspect copy, amend, request a restriction or revoke a prior restriction on the use and disclosure of your Protected Health Information (PHI). You may also request a copy of an accounting of disclosures, which will detail all disclosures made for reasons other than treatment, payment, or health care operational purposes. Duval Vascular Center, LLC is not required to agree to the restrictions that I may request. However, if Duval Vascular Center, LLC agrees to a restriction that I request, the restriction is binding on the Duval Vascular Center, LLC.

I have the right to revoke this consent, in writing at any time, except to the extent that Duval Vascular Center, LLC has taken action in reliance on this consent.

By signing this form, I am consenting to Duval Vascular Center, LLC use and disclosure of my PHI to carry out TPO. I am also acknowledging that I have been presented with the Duval Vascular Center, LLC Notice of Privacy Practices.

If I do not sign this consent, Duval Vascular Center, LLC may decline to provide treatment to me.

Signature of Patient, Legal Guardian or Representative

Date

Patient's Name (Please Print)

Authorization for Release of Medical Records

Name: _____ Date of Birth: _____

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

RELEASE MY MEDICAL RECORDS TO:

Duval Vascular Center, LLC
915 West Monroe Street Suite 100
Jacksonville, Florida 322041177
9045181398 Fax 9045130231

FROM: Duval Vascular Center, LLC

Please release a copy of:

PATIENT INFORMATION (Please Print):

BY MY SIGNATURE, I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient: _____ Date: _____

Duval Vascular Center, LLC

PERSONAL REPRESENTATIVE AUTHORIZATION FOR MEDICAL RELEASE FORM

I authorize this facility to speak *to* the following family memebrs or my personal representative regarding

- All medical information, including but not limited to records pertaining to examinations, treatments, consulatations, billing re and reports, history, laboratory findings, admissions and discharge reports, treatment records diagnosis and prognosis and rec and doctor's notes and any other non-medical information in my file.

- Only the following types of information:

_____

_____

_____

The above medical information shall only be released to the following persons:

Family Member / Personal Representative	Relationship

I understand that I may terminate this Medical Authorization form. I must notify this facility in writing regarding termination and ef

This authorization shall remain valid (check one)

☐ Untill revokedin writing.

☐ Until _____ _____

I know that I am entitled to receive a copy of this agreement.

Name _____

Signature _____

Signed this _____ _____

DNR POLICY

It is the policy of Duval Vascular Center, LLC to always perform CPR when indicated. you have a DNR order in place and it is your wish to have your DNR order honored, you will need to have procedure scheduled at another facility.