I-Vascular Center New Patient Enrollment Packet

Our Physician

Anwar Gerges, M.D.

Our Location

I-Vascular Center
19234 Stone Hue
San Antonio, Texas 78258
Phone (210) 481-9544
Fax (210) 481-9545

PRIMARY DEMOGRAPHICS

Patient Name: _____ Allergies: _____

Date of Birth: _____ Age: _____SSN:_____

Circle one: Male/Female

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Address: _____ City: _____

State: _____ Zip: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____

Phone: _____

Emergency Contact Name: _____

Phone: _____

PHARMACY INFORMATION

Pharmacy Name: _____

Location: _____

Phone: _____

Fax: _____

REFERRING PHYSICIAN INFORMATION

Name: _____ Phone: _____

Fax: _____

Address: _____ City: _____

State: _____ Zip:_____

Reason for Referral**:**

_____

HEALTH INSURANCE INFORMATION

Primary Insurance: _____

Is this an HMO/Referrals Required? _____

Phone: _____

Policy and Group #:_____

Secondary Insurance: _____

Is this an HMO/Referral Required? _____

Phone: _____

Policy and Group #:_____

HEALTH HISTORY

HEIGHT: _____ WEIGHT: _____

CONTAGIOUS ILLNESS □ Measles □ Mumps □ Rubella □ Chicken Pox/Shingles
□ Rheumatic Fever □ Polio □ Other: _____

IMMUNIZATIONS: □ Tetanus □ Pneumonia □ Hepatitis A/B □ Chicken Pox
□ Influenza □ MMR □ Other:_____

ALLERGIES TO MEDICATIONS

NAME OF DRUG REACTION YOU HAD

_____

_____

_____

_____

Check if you have, or have had, any problems in the following areas:

□ Skin □ Head/Neck □ Thyroid Disease □ Lungs (asthma/emphysema) □ Diabetes
□ High Blood Pressure □ Chest Pain □ Heart Murmur □ Heart Attack
□ Bladder/Kidney/Urine Infections/Stones □ Bowels/Gall Bladder □ Swelling
□ Stroke □ Cancer □ Arthritis □Ability to Sleep □Exposure to Tuberculosis
□ Positive Skin Test for TB □ Malaria □ Typhoid
□ Other Pain/Discomfort: _____

List ALL Hospitalizations (use the back of this form if necessary) including child birth, surgeries, etc:

Year Reason Hospital

_____

_____

_____

_____

_____

HEALTH AND PERSONAL INFORMATION (CONTINUED)

Have you ever had a blood transfusion? ☐ Yes ☐ No
Reason:

_____

HEALTH CARE MANAGEMENT

Do you have an advanced directive to physicians (living will)? ☐ Yes ☐ No
If so, Please provide a copy for our records.

Do you have a durable power of attorney for healthcare? ☐ Yes ☐ No
If so, Please provide a copy for our records.

FAMILY HEALTH HISTORY

PARENTS

	Age	Age at Death	Health Problems
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers and Sisters			
M or F	_____	_____	_____
M or F	_____	_____	_____
M or F	_____	_____	_____
M or F	_____	_____	_____
M or F	_____	_____	_____

CHILDREN

	Age	Age at Death	Health Problems
M or F	_____	_____	_____
M or F	_____	_____	_____
M or F	_____	_____	_____

	Age	Age at Death	Health Problems
GRANDPARENTS (MOTHER'S SIDE)			
Male	_____	_____	_____
Female	_____	_____	_____
GRANDPARENTS (FATHER'S SIDE)			
Male	_____	_____	_____
Female	_____	_____	_____

List all prescribed drugs, Over-the-Counter Drugs, Vitamins, Herbal Remedies, and Inhalers you are taking now:

NAME OF DRUG STRENGTH FREQUENCY TAKEN

_____

_____

_____

_____

_____

MENTAL HEALTH

Have you ever been to a counselor or psychiatrist? …… ☐ Yes ☐ No
Have you ever been treated for a psychiatric disorder (depression, bipolar disorder or schizophrenia?) ……..... ☐ Yes ☐ No
Do you have trouble sleeping? ……..... ☐ Yes ☐ No

WOMEN ONLY

Number of pregnancies _____ Number of live births _____
Have you had a D&C, Hysterectomy or Cesarean section? …….. ☐ Yes ☐ No
Any urinary tract, bladder or kidney infections within the last year ….. ☐ Yes ☐ No
Any blood in your urine? ……. ☐ Yes ☐ No
Any problems with control of urination? ……..... ☐ Yes ☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge? ☐ Yes ☐ No
Date of last Pap Smear or Rectal Exam? _____
Date of last Mammogram? _____

MEN ONLY

Do you usually get up to urinate during the night? …….. □ Yes □ No
if yes, # of times _____
Do you feel pain or burning during urination? ……..... □ Yes □ No
Any blood in your urine? ……□ Yes □ No
Have you had any kidney, bladder, or prostate infections within
the last12 months? ……□ Yes □ No
Do you have any problems emptying your bladder completely? ……□ Yes □ No
Date of last prostate and rectal exam? _____

HEALTH HABITS AND PERSONAL SAFETY

Alcohol: Do you drink alcohol? ……..……. □ Yes □ No
If so, Date of last drink? _____
What kind? _____ How many drinks per day? _____ How many years? _____
Have you ever had any black outs? _____ Did you have any DT's? _____
Did you attend rehabilitation (AA or counseling)? ……□ Yes □ No
Tobacco: Do you use tobacco now? …… □ Yes □ No
If so, Date of last use _____
□ Cigarettes-Packs per day _____ □ Chew- #/day _____ □ Pipe- #/day _____
□ Cigars- #/day _____ □ # of year's _____
Did you use tobacco? ……...□ Yes □ No

Tattoos: Do you have any tattoos? …….□ Yes □ No
If so, are they □ Professional or □ Homemade?
Illegal Drugs: Do you use any illegal drugs (not given by a doctor or pharmacist?)
……..……..□ Yes □ No
Date last used? _____ Have you ever shared needles? ……. □ Yes □ No
Have you ever used any illegal drugs in the past? …… □ Yes □ No

CONSENT FOR TREATMENT

I authorize and direct Dr. Anwar Gerges and/ or other Allied Health Care Professionals to perform any necessary diagnostic tests and evaluations, as deemed medically indicated, on myself. I understand that any testing to be done and/or treatment to be given will be explained to me prior the performance of the exam, and that I may ask questions about such testing.

_____
SIGNATURE OF POLICY HOLDER

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to I-Vascular Center for all payment or reimbursements due from individual or group insurance benefits otherwise payable to me. I also understand I am financially responsible to I-Vascular Center for the charges not covered by the assignment of benefits and the 20% of the allowed charges not covered by Medicare.
All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our business office.

_____

SIGNATURE OF POLICY HOLDER

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize I-Vascular Center to release any information requested by my insurance company or representatives.

_____

SIGNATURE OF POLICY HOLDER

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. It explains how my medical information will be used And disclosed and how I can get access to my medical information. I know that I may have a copy of the Notice. I also know that from time to time, the Notice of Privacy Practices and Red Flag policy may be revised. If I want the revised Notice of Privacy Practices and Red Flag Policy, I know I must ask for it.

I have also read and understand the Red Flag Policy and agree to provide the requested documentation of my identity. I understand that if I do not have documentation of my identity, I may be denied services until that documentation is provided.

You agree to allow us to access your medical information for the purpose of the Research we are conducting, if you are eligible for said research, you agree to be contacted.

SIGNATURE OF PATIENT

_____

DATE:

_____

Authorization for Release of Medical Records

PATIENT INFORMATION:

Name: _____Date of Birth: _____

Social Security Number:

_____

Address: _____

City: _____ State: _____Zip: _____

Phone: _____

I consent to release my medical records from:

Name: _____
Tel: _____
Fax: _____

TO:
I-Vascular Center
19234 Stone Hue
San Antonio, TX 78258-3478
Telephone: (210) 481-9544
Fax: (210) 481-9545

Please send my medical records no later than:

_____

Please release a copy of all my medical records, including but not limited to, progress notes, operative notes, laboratory results and diagnostic tests.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

PATIENT: _____DATE: _____

FINANCIAL POLICY FOR I-VASCULAR CENTER

We are committed to providing you the best available medical care. Our personnel will be pleased to discuss our fees and this policy with you at any time. Our professional relationship will be enhanced by your clear understanding of our Financial Policy. Thank you for your review and acceptance of this policy.

- All new patients must complete our Patient Information Packet before seeing the doctor.
- Full payment for our services is due at the time of service, unless Other mutually agreed upon arrangements are made with our office staff.
- **Insurance**

  You are responsible for timely payment of your account. Insurance is a contract between you and your insurance company. We are NOT a party to this contract, nor can we become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary " charges, etc. We cannot be held responsible to know every plan and every payment that will be made. There are some procedures done in our offices that are not surgical procedures, but we are required by the insurance guidelines to report the procedure under an insurance code which your insurance company may classify as surgery. If these procedures go towards your deductable, you will be billed for the charges. Our involvement will be limited to supplying factual information to facilitate claim processing.

- **HMO and PPO**

  Co- payments will be required to be made at the time of your visit, as well as deductibles, when applicable.
- **Medicare**

  We are participating Medicare providers, thus we accept assignment on your claims. We are required by Medicare to file your claims for you. Medicare will pay us directly and provide you an (EOB) Explanation of Benefits detailing allowances, payments, or denials.
- **Third –Party (not HMO/PPO) or supplemental (secondary)**

  We do not file claims to companies for which we are not Providers or with which Medicare does not coordinate benefits. We will provide you with the information you need to submit your primary or secondary claim.

I have read and agree to accept to accept the Financial Policy as Set forth by **I-Vascular Center.**

_____ _____

Signature of responsible party *date*

_____ _____

Print Name *Social Sec #*

I-Vascular Center
Missed, Late and Cancelled Patient Appointment Policy

We strive to provide our patients with exceptional medical care and we make every effort to accommodate our patients' scheduling needs. Patients who: (i) do not show up for scheduled appointments, (ii) arrive late for scheduled appointments, or (iii) cancel scheduled appointments without providing at least **twenty-four** hours' advance notice inconvenience other patients who need timely access to medical care. We would like to remind our patients of our policy regarding missed, late and cancelled appointments.

If a patient is unable to keep his or her scheduled appointment, please notify us at least **twenty-four** hours in advance of the appointment by calling (**210) 481-9544**. Patients who do not reach a member of our staff should leave a detailed voicemail message on our answering machine or with our answering service and a member of our staff will promptly return each patient's call or email to reschedule his or her appointment.

No-Shows: Missed Appointments: A "no-show" is defined as a patient who fails to show up for a scheduled appointment without calling to cancel an appointment.

Late Cancellations: A patient is deemed to have cancelled late if a patient cancels his or her appointment with less than **twenty-four** hours' advance telephone or email notice.

Late Appointments: A patient is deemed to have arrived late to his or her appointment if such patient has not arrived by the scheduled appointment time, **regardless of whether a patient calls in advance to notify us that he or she may be late.**

We reserve the right to discontinue providing care to patients who miss **two** or more appointments or who cancel **two** or more appointments late by providing less than **twenty-four** hours' advance notice. There will be a $35.00 late cancelation fee as well as a $35.00 No Show fee. We also reserve the right to discontinue providing care to patients who are late **three** or more appointments. This policy is applicable to all of our patients, regardless of race, religion, color, sex, age, disability, national origin, sexual orientation, genetic makeup or any other basis or protected class covered by federal, state or local law.

\28911522.2