KANSAS CITY VASCULAR INSTITUTE

Tell Us About Yourself:

Patients Full Name: _____ SSN: _____

Date of Birth: _____ Gender: _____

Race: _____ Ethnicity _____

Marital Status: _____ Language _____

Is the person completing these forms the patient or another authorized party?

☐I am the patient ☐I am the patient's authorized representative, named: _____

How Can We Reach You?

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Mobile Phone: _____

Work Phone: _____

Email: _____

Important Message

Communications between a doctor and a patient are integral to proper care. Kansas City Vascular Institute communicates to patients on a variety of issues: appointments, reminders, patient surveys, promotions, etc. We frequently use applications such as eClinicalWorks deliver messages efficiently and securely.

How would you like to be contacted? (You may check multiple boxes)

☐Phone ☐ Text ☐ Email ☐ Regular Mail

Important Note: By permitting us to contact you via mobile phone or email address, you are permitting Kansas City Vascular Institute to communicate with you by **email, voice, and text**. These communications may include your personal or health information. **At any future time, you may opt out of receiving communications via email and/or text by contacting our office or by following the steps for this included our emails and text messages.**

Do You Have a Pharmacy You Prefer?

Pharmacy Name: _____ Cross Streets: _____

Insurance Information

Are you insured? ☐ Yes, my information is below ☐ No

Primary Insurance:

Company: _____

Member ID: _____

Group ID: _____

Secondary Insurance:

Company: _____

Member ID: _____

Group ID: _____

Is Someone Other that Yourself the Primary Subscriber on Your Insurance? If so, Complete:

Subscriber Name: _____ Relationship: _____

Date of Birth: _____

Home Address if different than patient: _____

City: _____ State: _____ Zip: _____

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Authorization to Release Protected Health Information to Third Parties

☐ I hereby authorize **Kansas City Vascular Institute** to disclose my entire medical record including information regarding my billing, condition, treatment and diagnosis to the following **Medical Providers/Individuals/Family members:**

Primary Care Physician: _____ Relationship: _____

Specialist: _____ Relationship: _____

Specialist: _____ Relationship: _____

Specialist: _____ Relationship: _____

Emergency Contact 1:
Name: _____ Home Phone: _____
Relationship: _____ Mobile Phone: _____
Home Address: _____
City: _____ State: _____ Zip: _____

Emergency Contact 2:
Name: _____ Home Phone: _____
Relationship: _____ Mobile Phone: _____
Home Address: _____
City: _____ State: _____ Zip: _____

I understand that Kansas City Vascular Institute cannot guarantee that the recipient identified above will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

OR

☐ I am declining to authorize Kansas City Vascular Institute to disclose my medical information to anyone. I understand that this includes any other physicians I may be seeing, including my primary care physician, who will therefore not be able to acquire any information about any medication, treatment, or procedures I may receive from Modern Vascular.

Signature: _____ **Date_____**

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Patient's Full Name: _____ **Date of Birth:** _____

Referring Physician: _____

Briefly List the Reason for Visit Today:

_____

Recent Imaging: ☐ Ultrasound ☐ CT scan ☐ MRI/MRA **If so, where and when?:**

_____

Current Medications:

If you are taking any medications, you may also complete the Prescription Medication History Consent in this packet to obtain your prescription history from your pharmacy. Additionally, please complete the below or bring all of your medications to your appointment.

Medication:	Dosage:	Times per day:	Medication:	Dosage:	Times per day:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Medical History:

☐ Atrial fibrillation	☐ Blood clots (ex: legs, lungs)	☐ COPD ☐ Oxygen Use	☐ Kidney disease/dialysis
☐ Coronary artery disease	☐ Carotid artery disease	☐ Diabetes	☐ Thyroid disease
☐ Coronary stenting	☐ Artery blockages in leg(s)	☐ High blood pressure	☐ Liver disease
☐ Heart attack	☐ Stroke/TIA	☐ High cholesterol	☐ Cancer
☐ Heart failure	☐ Previous amputation	☐ Other: _____	

Allergies: ☐ No ☐ Yes (Include IV dye and/or egg): _____

_____

Surgical History: ☐ No surgical history

Surgery: Month/Year: _____

_____

Surgery: Month/Year: _____

_____

Recent Hospitalizations (within last 12 months): ☐ No recent hospitalizations

Reason: Month/Year: _____

_____

Reason: Month/Year: _____

_____

KANSAS CITY VASCULAR INSTITUTE

Patient Name: _____ **Responsible Party**: _____

Family History: List member relation to you and all major medical problems including cancer, diabetes, heart disease, blood clots etc.

_____

Social History:

Do you drink alcohol? ☐ Yes ☐ No

How often? _____

How many drinks? _____

Recreational Drug Use: ☐ Yes ☐ No

Cannabis (Marijuana) Use: ☐ Yes ☐ No

Tobacco Use: ☐ Current ☐ Former ☐ Never

How many packs a day? _____

Age Started/Stopped: _____

Do you exercise regularly? ☐ Yes ☐ No

Frequency/type of exercise:

_____

Review of Systems: Please indicate which symptoms you are experiencing or have experienced in the last 6 months.

Chest pain	☐ Yes	☐ No	Heat or cold intolerance	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No	Excessive thirst	☐ Yes	☐ No
Difficulty lying flat	☐ Yes	☐ No	Abdominal pain	☐ Yes	☐ No
Leg swelling	☐ Yes	☐ No	Nausea or vomiting	☐ Yes	☐ No
Varicose veins/Spider Veins (in legs)	☐ Yes	☐ No	Recurrent infections	☐ Yes	☐ No
Recent weight change	☐ Yes	☐ No	Shortness of breath	☐ Yes	☐ No
Fever	☐ Yes	☐ No	Recurring cough	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No	Easy bruising/bleeding	☐ Yes	☐ No
Sinus problems or rhinitis	☐ Yes	☐ No	Enlarged glands	☐ Yes	☐ No
Muscle weakness	☐ Yes	☐ No	Numbness/Tingling	☐ Yes	☐ No
Joint Pain	☐ Yes	☐ No	Slow healing wounds	☐ Yes	☐ No
Back Pain	☐ Yes	☐ No			

KANSAS CITY VASCULAR INSTITUTE

Patient Name: _____

Tell us about any pain you feel in your in your legs or feet:

I experience pain, tiredness, heaviness, or cramping in the: ☐ Buttock ☐ Thigh ☐ Calf ☐ Foot ☐ Toes

This pain is in the: ☐ Right leg ☐ Left Leg ☐ Both

When I walk, my pain becomes: ☐ Better ☐ Worse ☐ No change

I start feeling pain after walking: _____ (miles, feet, blocks – any measure of distance)

I experience numbness or tingling in the: ☐ Buttock ☐ Thigh ☐ Calf ☐ Foot ☐ Toes

The numbness or tingling is on the: ☐ Right leg ☐ Left Leg ☐ Both

Does this pain limit any other life activity? ☐ Yes ☐ No If yes, briefly describe: _____

_____

_____

Tell us if you have Rest Pain:

I feel pain in my legs when I am resting: ☐ Yes ☐ No

Is this pain strong enough to wake you up? ☐ Yes ☐ No

When you elevate legs, does this pain: ☐ Increase ☐ Decrease ☐ Doesn't change

When I dangle legs off the bed or stand up, does this pain: ☐ Increase ☐ Decrease ☐ Doesn't change

Tell us if you had Wounds, Ulcers, etc.:

I have/had wound or ulcer that is/was healing slowly or not at all on: ☐ Calf/shin ☐ Foot ☐ Toe(s)

This wound/ulcer is/was on the: ☐ Right leg ☐ Left Leg ☐ Both

This wound/ulcer is: ☐ Current If you had non-healing wound/ulcer in the past, when? _____

I have open skin, callouses, or fissures on my: ☐ Right foot ☐ Left foot ☐ Both

I have discoloration on my: ☐ Calf/shin ☐ Foot ☐ Toe(s)

The discoloration is on the: ☐ Right leg ☐ Left Leg ☐ Both

Tell us about prior treatment of your vascular problems:

Has any doctor ever told you that you have peripheral artery disease (PAD)?	☐ Yes ☐ No	If yes, when: _____	Which doctor? _____
Has any doctor ever told you that you have critical limb ischemia (CLI)?	☐ Yes ☐ No	If yes, when: _____	Which doctor? _____
Has any doctor told you that you have a gangrene on your feet/toes?	☐ Yes ☐ No	If yes, when: _____	Which doctor? _____
Has any doctor recommended you to have an amputation of your feet/toes?	☐ Yes ☐ No	If yes, when: _____	Which doctor? _____
Have you had prior surgery or procedure to improve blood flow in legs or feet?	☐ Yes ☐ No	If yes, when:	_____
Have you had prior amputation on your legs or feet?	☐ Yes ☐ No	If yes, when: _____	What was amputated? _____
Have you tried taking medications to control your vascular condition?	☐ Yes ☐ No	If yes, when: _____	Improvement seen? ☐ Yes ☐ No
Have you tried a walking program or other exercise to control your vascular condition?	☐ Yes ☐ No	If yes, when: _____	Improvement seen? ☐ Yes ☐ No
If you are a smoker, did you try to quit smoking?	☐ Yes ☐ No	Did you quit? ☐ Yes ☐ No	Improvement seen? ☐ Yes ☐ No

_____ _____

Patient/Responsible Party Signature Date/Time

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Conditions of Service

PATIENT NAME: _____ RESPONSIBLE PARTY: _____

1. **Release of Information. Kansas City Vascular Institute** (the "*facility*") will obtain the patient's consent and authorization to release medical information, other than basic information, concerning the patient, except in those circumstances when the facility is permitted or required by law to release information. The facility is authorized, without further action by or on behalf of the patient, to disclose all/or any part of the patient record to any entity to which is or may be liable to the facility, patient, or any entity affiliated with patient for all or part of the facility or facility-based physician's charges for the patient's services (including, without limitation, facility or medical service companies, insurance companies, workers' compensation carriers, welfare funds, patient's employer, or medical utilization review organization designated by of the foregoing.)

2. **Insurance and Payment Policy.** The facility participates with most insurance plans ("*insurers*") including Medicare. It is a standard practice for the facility to obtain the patient's personal identification and insurance information, after which the facility bills the patient's insurer directly. If the facility is not contracted with the patient's insurer, the patient has an option to utilize his/her out-of-network benefits. In all cases, co-payments, deductibles and co-insurance required under the patient's plan must be paid. The patient shall fully and unconditionally cooperate with the facility if and when requested to provide additional information, contact his/her insurer, and/or endorse for the benefit of the facility any payment received for the facility's services. In some instances, the patient's insurer may send reimbursement for the facility's services directly to the patient. Such payments are deemed assigned to the facility. If any payment received by the patient is not transferred to the facility within ten (10) days of the receipt thereof, the patient shall be liable to the facility for the full amount billed for the facility's services, plus all costs incurred in connection with collection, litigation, and enforcement of such liability. The patient shall personally pay any and all bills pertaining to the services performed at the facility to the extent the patient is uninsured, no out-of-network benefits are available to the patient, and/or the facility's request for reimbursement by the patient's insurer is denied for any reason, including without limitation the purported lack of medical necessity.

3. **Billing for Other Services.** The patient will be billed for diagnostic or ultrasound services obtained in connection with the patient's treatment at the facility**.**

4. **Duty to Inform of Changes.** The patient shall inform the facility as early as commercially reasonable in case of change of the patient's circumstances, health condition, and/or insurance coverage.

5. **Personal Valuables.** It is understood and agreed that the facility shall not be liable for the loss or damage to any money, jewelry, documents, personal garments, dentures, eye glasses, hearing aids, prosthetics, or other garments of unusual value or size, and shall not be liable for loss or damage to any other personal property, even if deposited with the facility for safe keeping.

6. **Agreement to Conditions of Service.** The patient, and/or the undersigned Patient's Representative (if any), hereby accepts the foregoing Conditions of Service and agrees to be bound by them.

_____ _____

Patient/Responsible Party Signature Date

KANSAS CITY VASCULAR INSTITUTE

Consent to Treatment & Assignment of Benefits

PATIENT NAME: _____ RESPONSIBLE PARTY: _____

I, THE PATIENT (AND/OR RESPONSIBLE PARTY) IDENTIFIED ABOVE, HEREBY AGREE AS FOLLOWS:

1. **Consent to Treatment and Procedures.** I consent to treatment and procedures which may be performed during my outpatient visit(s) at Kansas City Vascular Institute (the "facility"), including ultrasound and/or x-ray examination, medical and surgical treatment or procedures, anesthesia, or other services rendered under the instructions of the facility's professional personnel.
2. **Consent to Telemedicine Services.** I consent to my appointment being performed through telemedicine, defined as "the interactive use of audio, video or other electronic media for the purpose of diagnosis, consultation or treatment" if and when expressly discussed with me.
3. **Assignment of Insurance or Health Plan Benefits to the Facility.** I hereby authorize direct payment to the entity(ies), identified in the Notice of Provider's Legal Name attached hereto and incorporated by reference herein, of all insurance and plan benefits otherwise payable to/or on behalf of the above-referenced patient for any and all services to be provided by the facility's personnel, at the rate not to exceed the facility's regular charges. I agree that payment to the facility pursuant to this authorization by any insurance company or health plan shall discharge said insurance company or health plan of any or all obligations under the policy to the extent of such payment. I further agree that I am financially responsible for charges not covered by this assignment.
4. **Medicare Patient's Release of Information.** I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made on my behalf.
5. **Obligation for Balance.** I understand I am responsible for any remaining balance not covered by insurance.
6. **Certification by Responsible Party**. To the extent I am a "Responsible Party", I hereby certify that I am duly authorized as the patient's agent and/or attorney-in-fact to execute any and all agreements, consents, and acknowledgements required by the facility in connection with the services to be provided for the above-referenced patient and/or the receipt of payment/compensation therefor.
7. **Advance Directives.** Kansas City Vascular Institute advance directive policy is as follows: All patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Powers of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes. When the patient is unable to make decisions or unable to communicate decisions Kansas City Vascular Institute respects and upholds those rights.

   However, unlike in an acute care hospital setting, Kansas City Vascular Institute does not routinely perform "high risk" procedures. While no surgery is without risk, the procedures performed in this facility are considered to be of minimal risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risk, your expected recovery, and care after your surgery.

   Therefore, it is our policy, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney-in-fact, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital further treatments or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or health care power of Attorney. Your agreement with this facility's policy will not revoke or invalidate any current health care directive or health care power of attorney.

   ☐ I acknowledge Kansas City Vascular Institute advance directive policy and I have an advance directive, which I am submitting or have submitted to the facility.

   ☐ I acknowledge Kansas City Vascular Institute advance directive policy and I do not have advance directive but would like the facility to provide me with blank forms so that I may consider completing them. (I understand that the facility cannot and will not advise me on any matter relating to advance directive choices.)

   ☐ I acknowledge Kansas City Vascular Institute advance directive policy and I do not have an advance directive form and am not interested in receiving one from the facility.
8. **Media Release.** I consent to the photographing, filming, or videotaping of the treatment or procedure for diagnostic, documentation or educational use. I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, the Facility may disclose portions of my financial and/or medical records to any person or entity which is or may be liable for all or any portion of the Facility's charges, including but not limited to insurance companies, health care service plans, or worker's compensation carrier(s) as well as to those individuals the Governing Body may deem appropriate to review the medical record for purposes of medical quality assurance/improvement and peer review.

_____ _____

Patient/Responsible Party Signature Date

KANSAS CITY VASCULAR INSTITUTE

Patient's Bill of Rights

PATIENT NAME: _____ RESPONSIBLE PARTY: _____

EACH PATIENT OF Kansas City Vascular Institute HAS THE FOLLOWING RIGHTS:

1. To be informed of the patient's bill of rights, by being offered a written copy of this document and given a written or verbal explanation of your rights in terms you can understand. We will make efforts to have a written copy in the patient's primary language or large print available upon request. If translation is unavailable, an interpreting service will be used.
2. To be informed of services available in this facility, of the names and professional status of the personnel providing and/or responsible for the patient's care, and of fees and related charges, including the payment, fee deposit and refund policy of the facility and any charges for services not covered by sources of third-party payment or not covered by the facility's basic rate.
3. To be informed if the facility has authorized other health care and educational institutions to participate in the patient's treatment. The patient also shall have a right to know the identity and function of these institutions, and to refuse to allow their participation in the patient's treatment.
4. To receive, in terms the patient understands, an explanation of his or her recommended treatment, risk(s) of the treatment, expected results and reasonable diagnostic alternatives. If the patient is not capable of understanding the information, the explanation shall be provided to his or her next of kin or guardian and documented in the patient's medical record.
5. Except in an emergency, to be informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure.
6. To participate in the planning of your own care and treatment, and to refuse medication and treatment.
7. To be included in experimental research only when you give written consent to such participation, or when a guardian gives such consent in accordance with law, rule and regulation. You may refuse to participate in experimental research, including the investigation of new drugs and medical devices.
8. To be informed of the patient complaint process and voice grievances or recommend changes in policies and services to facility personnel, the governing authority, and/or outside representatives of the patient's choice either individually or as a group, and free from restraint, interference, coercion, discrimination, or reprisal.
9. To be free from mental and physical abuse, neglect, exploitation, coercion, manipulation, sexual abuse and sexual assault and free from use of restraints unless they are authorized by a physician for a limited period of time to protect the patient or others from injury. Drugs and other medications shall not be used for discipline of patients or for convenience of facility personnel. Personal property of patients shall be preserved at all times while in custody of the Clinic.
10. To confidential treatment of information about the patient. Information in the patient's medical record and financial record shall not be released to anyone outside the facility without the patient's approval, unless another health care facility to which the patient was transferred requires the information, or unless the release of the information is required and permitted by law, a third-party payment contract, or a peer review, or unless the information is needed by the State Department of health for statutorily authorized purposes. The facility may release data about the patient for studies containing aggregated statistics when the patient's identity is masked. The patient has the right, upon written request, to review his or her own medical record.
11. To be treated with courtesy, consideration, respect, and recognition of the patient's dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy. The patient's privacy shall also be respected when facility personnel are discussing the patient.
12. To not be required to work for the facility unless the work is part of the patient's treatment and is performed voluntarily by the patient. Such work shall be in accordance with local, State, and Federal laws and rules.
13. To exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, or any attendance at religious services, shall be imposed upon any patient.
14. To treatment and medical services without discrimination based on race, age, religion, national origin, sex, sexual preferences, handicap, diagnosis, ability to pay or deprived of any constitutional, civil and/or legal rights solely because of receiving services from the facility.
15. To consent to photographs before the patient is photographed, except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes.
16. To receive a referral to another health care institution if the outpatient treatment center is not authorized or not able to provide physical health services or behavioral health services needed by the patient.
17. To refuse or withdraw consent for treatment before treatment is initiated.

_____ _____

Patient/Responsible Party Signature Date

KANSAS CITY VASCULAR INSTITUTE

Prescription Medication History Consent

PATIENT NAME: _____ RESPONSIBLE PARTY: _____

With your consent, Kansas City Vascular Institute can obtain your prescription medication history for you from other healthcare providers, insurance companies, and pharmacies. If you agree to allow us to obtain your prescription medication history, you agree to the following:

- I hereby consent to Kansas City Vascular Institute obtaining access to my prescription medication history from other healthcare providers, insurance companies, and pharmacies.
- I agree that my prescription history (which includes but is not limited to prescriptions, labs, and other health care drug historical information) may be viewed and used by Kansas City Vascular Institute personnel for diagnostic and treatment purposes in compliance with privacy protections set forth in Kansas City Vascular Institute Patient's Bill of Rights.
- I acknowledge that Kansas City Vascular Institute may use health information exchange systems to electronically transmit, receive and/or access my prescription history.
- I understand that this Prescription History Consent will remain in full force and effect as long as I am a patient of Kansas City Vascular Institute provided that I may revoke it at any time in writing. This revocation can be delivered to my Kansas City Vascular Institute clinic or mailed to: Kansas City Vascular Institute 5320 College Blvd, Overland Park, KS 66211, Attn: Legal Department.

Please select one of the below:

☐ I, the patient (and/or responsible party) identified above, hereby consent to Kansas City Vascular Institute obtaining my (or, if responsible party is completing, the patient's) prescription medication history from other healthcare providers, insurance companies, and pharmacies, and I agree to the conditions explained above.

OR

☐ I decline to allow Kansas City Vascular Institute to obtain my prescription medication history from other healthcare providers, insurance companies, and pharmacies.

_____ _____

Patient/Responsible Party Signature Date

THIS PORTION OF PAGE FOR OFFICE USE ONLY:

I, employee of Kansas City Vascular Institute checked this patient's paperwork for completeness.

_____ _____

Staff Member Signature Date

_____

Staff Member Name