



INITIAL PATIENT QUESTIONNAIRE

Patient Information:

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?

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

How can we reach you?

Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____
Mobile Phone: _____
Work Phone: _____
Email: _____
Pharmacy Name and Location: _____

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 to deliver messages efficiently and securely.

Permission to contact via: TEXT MESSAGE &/or EMAIL? Yes No

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, EHR portal, and/or text by contacting our office.**

Insurance Policy Holder (if other than patient)

Subscriber Name: _____ Relationship: _____
Date of Birth: _____
Home Address if different than patient: _____
City: _____ State: _____ Zip: _____ Mobile Phone: _____



INITIAL PATIENT QUESTIONNAIRE

Notice of Privacy Practices and Release of Information

In order to protect your privacy and to comply with government regulations (HIPAA), we are required to obtain authorization from you in order to release messages and/or provide information regarding your care with any person(s) other than yourself.

Notice of Privacy Practices: As a condition of providing treatment to you, Kansas City Vascular Institute obtains your consent to use and disclose protected health information about you to carry out treatment and payment, to receive payment for the care we provide and for other health care operations. Health care operation generally include those activities we perform to improve the quality of care. You may revoke this at any time by notifying us in writing. Please refer to the Notice of Privacy Practices for Protected Health Information for a more complete description of the uses and disclosures that Kansas City Vascular Institute may use of your protected health information. The Privacy Policy is available on our website and available for distribution, if requested.

Release of Information:

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: _____

Specialist: _____ Specialty: _____

Specialist: _____ Specialty: _____

Specialist: _____ Specialty: _____

Emergency Contact 1:

Name: _____ Home Phone: _____

Relationship: _____ Mobile Phone: _____

Emergency Contact 2:

Name: _____ Home Phone: _____

Relationship: _____ Mobile Phone: _____

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 my medication, treatment, or procedures I may receive from Kansas City Vascular Institute.

HIPAA consent to view prescriptions and utilize the Health Information Exchange system

I consent that Kansas City Vascular Institute can obtain my prescription medication history from other healthcare providers, insurance companies, and pharmacies. I acknowledge that Kansas City Vascular Institute may use health information exchange systems to electronically transmit, receive and/or access my prescription history.

Signature: _____

Date _____



INITIAL PATIENT QUESTIONNAIRE

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:

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

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

Patient/Responsible Party Signature

Date/Time



INITIAL PATIENT QUESTIONNAIRE

Patient Name: _____

Responsible Party: _____

I, the patient (and/or responsible party) identified above, hereby agree as follows:

Assignment of Insurance Benefits: I assign directly to Kansas City Vascular Institute all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions and claims. I understand I am financially responsible for all charges whether or not covered by my insurance. I understand I am also responsible for providing up to date and accurate insurance information. I certify I will pay to Kansas City Vascular Institute and co-payments, co-insurance, deductibles, or cost of non-covered products or services. 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. I will also be responsible for any amounts not paid by insurance if I fail to provide appropriate insurance information for billing.

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. I understand it is mandatory to notify the health care provider of any other party who may be responsible in part for my treatment.

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.

Financial Policies

- Outstanding balances are due when you receive your statement or at your next visit, whichever is sooner. Your co-pay is due at each visit prior to seeing the doctor.
- Prior to your appointment, you must notify us if your injury is the result of a work-place injury. Your employer, workers compensation insurance company, or attorney must authorize your treatment in writing before your appointment.
- I have been given a copy of the Financial Policy and have been given the opportunity to ask questions.

Missed Appointment Policy

At Kansas City Vascular Institute (KCVI), we understand circumstances can change, and we request patients notify us at least 24 hours in advance if they need to cancel or reschedule an appointment. This allows us to manage our schedule effectively and offer the time slot to another patient needing care. If you must be late, please contact us as soon as possible so we can determine if we need to reschedule your appointment. Cancellations or rescheduling requests with less than 24 hours' notice may result in a cancellation fee of \$25 charged to your account. If a patient does not notify the clinic that they cannot make an appointment, they will be considered a no-show, and a no-show fee of \$50 may be charged to your account. This fee is not covered by insurance and must be paid in full prior to your next appointment. We also reserve the right to terminate our relationship with you after three (3) or more occurrences and/or if you continually cancel or reschedule your appointments. We appreciate your understanding and cooperation in ensuring we can provide timely and efficient care to our patients. Please note we consider exceptions for unavoidable emergencies on a case-by-case basis.

Termination of provider/patient relationship

I understand that Kansas City Vascular Institute has the right to discharge any patient from the practice at any time due to repeated non-compliance, failure to meet financial obligations, or threatening/violent/repetitive rude or offensive behavior. If this occurs, records will be released to a physician of my choice after a signed release of information is received by this office. I understand that this policy is to keep the provider/patient relationship trustworthy and respectful.

Patient/Responsible Party Signature

Date



INITIAL PATIENT QUESTIONNAIRE

Patient Name: _____

Responsible Party: _____

I, the patient (and/or responsible party) identified above, hereby agree as follows:

Consent to Treatment and Procedures. You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment.

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 treatment recommended. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

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.

Patient's Bill of Rights and Non-Discrimination Policy. I have been given a copy of both the Patient Bill of Rights and the Non-Discrimination Policies and have been given the opportunity to ask questions.

Advance Directives. Kansas City Vascular Institute's 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's advance directive policy and I have an advance directive, which I am submitting, have submitted to the facility, or will submit to the facility.

OR

I acknowledge Kansas City Vascular Institute's advance directive policy and I do not have advance directive; I have been given the opportunity to ask 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.)

OR

I acknowledge Kansas City Vascular Institute's advance directive policy and I do not have an advance directive form and am not interested in receiving one from the facility.

The Notice of Privacy Practices, Patient Bill of Rights, Financial Policy and Missed Appointments Policy are available on our website and copies are available upon request.

Patient/Responsible Party Signature

Date