Alessi Vascular Surgery, PC

www.alessivascularsurgery.com

Christopher Alessi, M.D.

Today's date:	**Primary Care Physician**:	**Referred to clinic by:** Dr.

PATIENT INFORMATION

Patient's Legal Name: (Last) (First) (Middle)	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	**Marital status** (circle one)
Preferred Name:		Single / Mar / Div / Sep / Wid

Ethnicity (circle one) Hispanic/Latino : Caucasian : Asian : Other : Unknown	**Race** (circle one) White : Asian : African American : Pacific Islander : American Indian : Other : Unknown

Language (circle one) Arabic : Bulgarian : Central Khmer : Chinese : English : French : German : Haitian : Hebrew : Hindi : Italian : Japanese : Korean : Polish : Portuguese : Russian : Spanish	**Birth date**: / /	**Age**:	**Sex**: ❑ M ❑ F

Mailing address:	**Social Security Number**:	**Home Phone** : ( ) **Cell Phone** : ( )

City:	**State**:	**ZIP Code**: (+4) -	**E-Mail Address:**

Occupation:	**Employer**:	**Employer phone** : ( )

Employer Address:	**City:**	**State:**

If patient is a minor, Responsible party:

Pharmacy:	**Pharmacy Location:**

SPOUSE INFORMATION

Spouse's Legal Name: (Last) (First) (Middle)	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	**Birth date:** / /	**Sex** ❑ M ❑ F

Spouse's Cell Phone: ( )

PERSONAL INSURANCE INFORMATION

PRIMARY INSURANCE NAME		**SECONDARY INSURANCE NAME**	
SUBSCRIBER'S NAME	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S NAME	SUBSCRIBER'S DATE OF BIRTH
POLICY ID NUMBER	GROUP NUMBER	POLICY ID NUMBER	GROUP NUMBER
RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER:		RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER:	

PATIENT HEALTH HISTORY

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Patient Height _____ Patient Weight _____

Chief Complaint

Reason for today's visit: _____

Past Medical History

Please list any medical conditions (i.e hypertension, diabetes, etc) or major injuries: _____

_____

_____

_____

Surgical History

Surgeries/Hospitalizations	Year	Complications

Have you ever had an antibiotic resistant infection? ☐ Yes ☐ No
If Yes, was it MRSA (Methicillin Resistant Staphylococcus Aureus) or VRF (Vancomycin Resistant Enterococcus)? (Please circle)

Have you ever had problems with anesthesia? ☐ Yes ☐ No
Do you take Aspirin? ☐ Yes ☐ No If Yes, how often : _____

Medications

Including Over the Counter	Dose	Frequency

Patient Name: _____

ALLERGIES/TYPES OF REACTIONS Please circle: **Latex** Yes No **Iodine** Yes No **Shellfish** Yes No **Asthma** Yes No

Family Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

SOCIAL HISTORY

Do you have children? □ Yes □ No How many? _____

Do you live alone? □ Yes □ No Who lives with you? _____

Do you smoke? □ Yes, I've smoked _____ packs of cigarettes per day for _____ years.
□ Yes, I smoke cigars or a pipe.
□ No, I have never smoked.
□ No, I quit _____ years ago. At that time I was smoking _____ packs per day for _____ years.

Do you use street drugs? □ No □ Yes Type _____

Do you drink alcohol? □ No, never (or rarely) □ No, but I used to
□ Yes □ Daily □ 1 or more times a week □1 or more times a month

Are you at risk for AIDS (e.g., sexual orientation, drug abuse, previous blood transfusion)?
□ No □ Yes, please explain _____

□ Deferred by patient: Signature _____

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Patient Name:_____ Date:_____

REVIEW OF SYSTEMS

Check if you currently have any of the following problems:

CONSTITUTIONAL

___Chills

___Fatigue

___Fever

___Weight loss/Gain

___Other_____

HEENT

___Dental Problems

___Hearing Loss

___Nasal drainage/Sinus

___Burred/Double vision

___Glaucoma

___Other_____

RESPIRATORY

___Chronic cough

___Shortness of Breath

___Wheezing

___Asthma

___Other_____

HEMATOLOGIC/ LYMPH

___Easy bleeding

___Easy bruising

___Other_____

CARDIOVASCULAR

___Artificial heart valves

___Chest pains

___History of blood transfer

___Irregular/rapid heartbeat

___Poor circulation

___Swelling of ankles or feet

___Varicose veins

___Other_____

Date of last EKG:_____

GASTROINTESTIONAL

___Incontinence

___Change in stool

___Constipation

___Nausea

___Vomiting

___Other_____

GENITOURINARY

___Urinary frequency

___Urinary incontinence

___Urinary retention

___Painful urination

___Other_____

IMMUNOLOGIC

___Seasonal allergies

___Food allergies

___Other_____

REPRODUCTIVE

___Vaginal discharge

___Irregular menses

___Erectile dysfunction

___Penile discharge

___Other_____

INTEGUMENTARY

___Redness

___Rash

___Hives

___Skin lesion

___Hair loss

___Other_____

___Seizures

___Other_____

PSYCHIATRIC

___Anxiety

___Depression

___Insomnia

___Paranoia

___Other_____

NEUROLOGICAL

___Dizziness

___Numbness

___Weakness

___Tingling

___Gait disturbance

___Headache

___Memory loss/confusion

___Tremor

___Seizures

___Other_____

METABOLIC/ENDO

___Nipple discharge

___Heat/Cold intolerance

___Diabetes

___Excessive thirst

___Excessive hunger

___Other_____

MUSCULOSKELETAL

___Back pain

___Neck pain

___Joint pain

___Joint swelling

___Muscle weakness

___Other_____

The above information is accurate to the best of my knowledge.

_____ _____

Patient/Guardian Signature Date

Alessi Vascular Surgery, PC

Christopher Alessi, M.D.

Initial

_____ **Medication Refill Policy:**

- Refills must be received between 9:00am and 3:00pm Monday through Friday.
- Refill requests must be received by fax from your pharmacy. Allow 72 hours for refills to be processed, excluding weekends and holidays.
- It is illegal to drive under the influence of drugs or alcohol. **Do not** drive after you take a narcotic prescribed by this office and while you are under the influence of narcotics. Please consult with the provider who wrote the prescription, for each narcotic, to assess when you are legal to drive.

I authorize access to my medication history from any prescriber within SureScripts to assist in preventing adverse drug reactions.

_____ **Medicare Payment Authorization:** I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Alessi. I also further authorize and direct any holder of medical information about me to release such information to the Centers of Medicare and Medicaid Services; formerly the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. This authorization shall remain in full force and effect until revoked in writing by myself. A copy of this authorization shall be as valid as the original.

_____ **Acknowledgement**: I acknowledge that I have reviewed the Notice of Privacy Practices on our website at www.alessivascularsurgery.com. If a paper copy of the Notice of Privacy Practices is preferred, I will request a copy from the receptionist at the time of my appointment and review it before I sign below.

Signature: _____ Date: _____

Print patient / representative name: _____ Relationship: _____

Alessi Vascular Surgery, PC

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FMLA, DISABILITY, MISC. Form Completion Agreement

We are happy to complete forms for you; however, due to the volume of patients who require paperwork to be completed and signed by the provider, we have adopted to the following guidelines to assist in rapid processing of these important forms:

1. All forms are completed in the order they are received. Due to the volume of forms, it may not be possible to complete your form immediately.

2. All patient information must be completed before we can accept the forms, and all pages of of the form need to be provided.

3. Please allow 7 **business days** for completion and plan accordingly.

4. Some forms cannot be completed until your most recent office note has been dictated and transcribed. This may increase the time it takes to complete the form.

5. There is a fee **per form** which must be paid before the forms will be completed.
   - No charge for 1 page (except Activity Restriction form; $25.00 fee)
   - $25.00 for 2-5 pages
   - $50.00 for 6+ pages

6. Payment is the patient's responsibility and will not be submitted to insurance.

7. When forms are completed they will be mailed to the patient's home address unless other arrangements have been made.

8. The authorization for disclosure of protected health information must be signed if forms are to be mailed or faxed to anyone other than the patient.

9. Urgent forms may be completed in 48 business hours at the rate of $50.00 for 2-5 pages and $75 for 6+ pages.

10. **NO FORMS MAY BE GIVEN TO THE PHYSICIAN AT ANY TIME.**

I have read and understand the form Completion Policy.

_____
Print Name

_____ _____
Signature Date

Thank you for your cooperation

6140 Curtisian Ave., Suite 400 ▪ Boise, ID 83704 ▪ Ph (208)378-9977 ▪ Fax (208)327-5602

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How the Payment Process Works at Alessi Vascular Surgery

We agree to submit your medical bill for payment to the insurance carrier who is primarily responsible for payment and agree to receive payment directly from the responsible insurance carrier. Responsible insurance carriers may be your personal medical plan or health insurance, your auto or homeowner's liability insurance, your employer's workers' compensation insurance plan, or a third party liability insurance carrier. If your medical plan or health insurance includes a deductible and co-insurance provision, we will bill the patient or guarantor as directed by your plan or policy. Responsibility for payment begins the date services are provided. A billing statement will be sent to advise you of any amounts due.

In cases where a third party liability insurance carrier is involved, such as in an auto accident, a lien may be placed, in accordance with Idaho Code § 45-701, *et seq*., with the third party liability insurance carrier.

Provisions in our participating provider contracts with health insurance company's request, permit, and, in many instances, direct us to send your bill to the third party liability insurance carrier for full payment before we send it to your medical plan or health insurance for payment. For example, if your treatment was for injuries caused by someone else, we will submit your bill to the other person's insurance company (third party liability insurance carrier) for payment in full, **before** we send your bill to your health insurance to pay. If the total unadjusted amount of your bill is $10,000, for example, we will ask the other person's insurance company to pay the entire $10,000. No health insurance contractual adjustments will be made to your bill prior to submitting it to the other person's insurance company – we will submit the full, unadjusted amount for payment.

Co-pays, deductibles, limits, and contractual adjustments only apply to bills sent directly to your medical plan or health insurance for payment. They do not apply to bills sent to third party liability carriers for payment. If you do not have health insurance, we ask that you pay $275.00 as a deposit for your first visit.

If you are injured in a work-related accident, we will submit your bill directly to the workers' compensation insurance carrier. If your worker's compensation claim has been properly filed with and accepted by the Idaho Industrial Commission, there will be no charges incurred by you. If your claim is denied or is not paid in accordance with IDAPA 17.02.09, any remaining balance will be your responsibility.

If you have a balance due after all possible insurance carriers have paid, or if you do not have insurance, the following options are offered:

- Payments by cash, check or credit card;
- Short term internal payment plans not to exceed three (3) months; or
- Long term payment plans through DL Evans Bank for plans beyond three (3) months. These payment plans are administered by DL Evans Bank on behalf of your physician.
- We reserve the right to charge interest on balances over 120 days old from date of service. The fee is assessed annually at 12% or a monthly interest rate of 1%.

Patients with financial constraints should speak to a financial counselor for assistance. We will not deny critical care to anyone due to inability to pay or lack of insurance. If surgery is indicated and a financial hardship is determined, we will assist in obtaining available coverage, such as county assistance or Medicaid.

If you have the ability to pay your bill but refuse to pay under the terms defined above, your account may be turned over to a collection agency.

I have read the information about how the payment process works at Alessi Vascular Surgery, PC. I understand and agree that I am financially responsible for the payment of medical charges incurred on my behalf as outlined above.

Signature:_____ Date:_____

Alessi Vascular Surgery, PC

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Medical Record Release

Patient Name: _____ Date of Birth: _____
(Please print)

Social Security No: _____

Authorization for medical information regarding the above patient to be released.

From: _____
Name

_____
Street Address

_____
City State Zip Phone#

To: _____
Name

_____
Street Address

_____
City State Zip Phone #

Purpose for release: _____

Information Requested to be released:

Chart Notes: _____ Hospital Records: _____
Radiology Results: _____ Lab Results: _____
Itemized Billing: _____ All Records: _____

I hereby consent to release the above stated information.

Signature: _____ Date: _____

Relationship to Patient: _____

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDs virus), other sexually transmitted diseases, drug or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released.

Signature: _____Date: _____

Relationship to Patient: _____

This authorization is valid for 1 year from date of signature and may be revoked at any time by written request.

Date Mailed or Faxed: _____ Date Hand Carried: _____

6140 W Curtisian Ave. Suite 400, Boise, ID 83704 Phone (208) 378-9977 Fax (208) 327-5602

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6/2017

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SPANISH
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al 1-888-808-9008.

CHINESE
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-808-9008。

SERBO-CROATIA
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno.
Nazovite 1-xxx-xxx-xxxx (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-888-808-9008.

KOREAN
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-888-808-9008 번으로 전화해 주십시오.

NEPALI
ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस्
1-888-808-9008 ।

VIETNAMESE
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Gọi số 1-888-808-9008.

ARABIC
لحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-808-9008 (رقم هاتف الصم والبكم:

GERMAN
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: 1-888-808-9008.

TAGALOG
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa 1-888-808-9008.

RUSSIAN
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
Звоните 1-888-808-9008.

FRENCH
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.
Appelez le 1-888-808-9008.

JAPANESE
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-888-808-9008 まで、お電話にてご連絡ください。

ROMANIAN
ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit.
Sunați la 1-888-808-9008.

BANTU
ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu.
Woterefona 1-888-808-9008.

PERSIAN_FARSI
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-808-9008 تماس بگیرید.