NSVS
NORTH SHORE VASCULAR SURGERY

HIPAA Compliant Patient Consent Form

New York State Law prohibits our medical staff from speaking with any individual other than you regarding any of your medical health information. This includes information regarding your condition, medications, appointments, or test results. You have the right to give consent so that protected information may be given to whom you choose in order for your office to carry out treatment, obtain payments, and conduct healthcare operations.

North Shore Vascular Surgery needs your consent in order to call and leave messages regarding your health information and appointments. Please verify the options we may contact you with:

Home Number: Yes / No (*Circle One*) // Phone Number: _____

Cellular Number: Yes / No (*Circle One*) // Phone Number: _____

May we leave detailed messages: Yes / No (*Circle One*)

Provide the name of the person we may speak with regarding your medical information:

Name: _____ Relationship: _____

Phone Number: ( ) -

Please list all physicians you would like medical information sent to:

Name: _____ Specialty: _____
Phone Number: ( ) -

Name: _____ Specialty: _____
Phone Number: ( ) -

Name: _____ Specialty: _____
Phone Number: ( ) -

Name: _____ Specialty: _____
Phone Number: ( ) -

I have read and understood all of the above information.

_____ _____
Signature of Patient or Representative Date

Office: 631.524.5960 | Fax: 631.524.5963
www.nsvascularsurgery.com
620 Belle Terre Road, Suite #2 | Port Jefferson, New York 11777

Vascular & Endovascular Surgery

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CURRENT PATIENT INFORMATION
PLEASE PRINT

Last Name: _____
First Name: _____
Address: _____
City, Zip: _____
Home Phone: _____
Mobile Phone: _____
Sex (*Please Circle*): M or F
Date of Birth: _____

Referred by: _____

Required by the government mandate
***(although you may refuse)* -**

Language: _____
Race: _____
Ethnicity: _____
Martial Status: _____

EMERGENCY CONTACT INFORMATION

Name: _____
Relationship: _____
Mobile Phone: _____
Home Phone: _____

EMPLOYER INFORMATION

Employer: _____
Address: _____
Phone: _____

PHARMACY INFORMATION

Name: _____
Address: _____
Phone: _____

PRIMARY INSURANCE INFORMATION

Insurance Plan Name:

Relationship to policy holder:

SECONDARY INSURANCE INFORMATION

Insurance Plan Name:

Relationship to policy holder:

To the best of my knowledge, the above information is complete and accurate.

Signed: _____ **Date**: _____

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		YES	NO
Medications:	Aspirin	☐	☐
	Plavix (clopidogrel)	☐	☐
	Brilinta (ticagrelor)	☐	☐
	Coumadin (warfarin)	☐	☐
	Xarelto, Eliquis, or Pradaxa	☐	☐
	Glucophage (metformin)	☐	☐
	Insulin	☐	☐
Medical Conditions:	Diabetes	☐	☐
	Abnormal/poor kidney function	☐	☐
	Dialysis dependent	☐	☐
	Atrial fibrillation	☐	☐
	Pacemaker/Defibrillator	☐	☐
	Heart failure	☐	☐
	Clotting/bleeding disorder	☐	☐
	Aneurysm(s)	☐	☐
Personal History:	Problems with arteries/veins	☐	☐
	Blood clots (“DVT”)	☐	☐
	Stroke	☐	☐
	Previous treatment/surgery of arteries/veins	☐	☐
Family History:	Problems with arteries/veins	☐	☐
	Blood clots (“DVT”)	☐	☐
	Aneurysm(s)	☐	☐
	Amputation(s)	☐	☐

Patient Name:_____ Date:_____

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Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our office. Necessary forms will be completed to file for insurance carrier payments. I understand that I am responsible for turning over payments and EOBs from my insurance carrier for medical services rendered by this office.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Dr. Ahmad Bhatti for medical services rendered to myself and/or my dependent regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. I furthermore understand that I am waiving any anti-assignment clauses that are written in to my health care contract. I have requested that the office of Dr. Ahmad Bhatti be my agent in the filing, processing and appealing of claims related specifically to medical treatment rendered by this office. I understand that I have the opportunity to submit my bills directly to my health insurance carrier but have chosen voluntarily to have the claims submitted by and paid directly to the office of Dr. Ahmad Bhatti with accompanying explanation of benefits.

Patient Signature: _____ Date: _____

I agree that all information I have provided is true and I give permission to Dr. Ahmad Bhatti and medical staff of North Shore Vascular Surgery, PC to release medical records to my insurance company for the purpose of receiving payment. Under the circumstances that my insurance company does not pay for my scheduled office visits, I will be responsible for payment directly.

Patient Signature: _____ Date: _____

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