ProActive Heart And Vascular PLLC
7751 Wolf River Blvd
Germantown, TN 38138-1706
(901) 297-4000

PATIENT INFORMATION

NAME (Last, First Middle)		MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS	CITY, STATE ZIP	REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS		ETHNICITY	
HOME PHONE	DAY PHONE / EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP		RACE	
MARITAL STATUS	STUDENT STATUS ☐ Full-Time ☐ Part-Time / SMOKER (Y/N)? / VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE	HOME PHONE		

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)		SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS	CITY, STATE ZIP		SECONDARY/BILLING ADDRESS (if Applicable)		
HOME PHONE	DAY PHONE / EMAIL ADDRESS		CITY, STATE ZIP		
MARITAL STATUS	STUDENT STATUS ☐ Full-time ☐ Part-time / SMOKER (Y/N)? / VETERAN (Y/N)? / PRIMARY CARE PROVIDER		HOME PHONE		
RELATIONSHIP TO PATIENT					

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#
NAME OF INSURED		GROUP#
ADDRESS OF INSURANCE COMPANY		COPAY AMT $
CITY, STATE ZIP	PHONE	DEDUCTIBLE $
RELATIONSHIP TO PATIENT		EFFECTIVE DATE / EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#
NAME OF INSURED	SSN#	BIRTHDATE	GROUP#
ADDRESS OF INSURANCE COMPANY			COPAY AMT $
CITY, STATE ZIP	PHONE		DEDUCTIBLE $
RELATIONSHIP TO PATIENT			EFFECTIVE DATE / EXPIRATION DATE

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

Patient Name _____ Date _____

Dear Patient:

It is very important that you are familiar with the medications that you are taking, the dosage and what the medications are for. You may have more than one doctor prescribing medications for you. Sometimes the medicatins you are taking are not the same we have in our file. Aslo, we do not want to prescribe medications that are going to interfere with others you are taking. Therefore, it is very important that you list ALL the medications you are currently taking including "over the counter" medications.

MEDICATION NAME	DOSAGE	HOW MANY TIMES / DAY

I AM ALLERGIC TO THE FOLLOWING MEDICATIONS

ProActive HEART & VASCULAR

Michael A. Nelson, MD
7751 Wolf River Blvd
Germantown TN 38138
Phone (901) 297-4000
Fax (901) 531-8344

Name _____ Date _____

Please fill out this brief questionnaire to assist us in providing you with the best care possible.

Check all that apply:

- ☐ Do you have pain, cramping, aching, numbness, tiredness, weakness, or burning in your buttock, thigh, calf or foot?
- ☐ Do you have restless legs?
- ☐ Do you have numbness in your legs or feet?
- ☐ Does your skin appear pale and feel cool to the touch?
- ☐ Do you have foot or toe pain or tingling that does not go away with rest?
- ☐ Do you have a feeling that the hip or leg is "giving out" while walking?
- ☐ Do you have skin wounds, sores, infections or ulcers on your legs or feet that heals slowly or don't heal at all?
- ☐ Do you have swelling of ankles or lower legs?
- ☐ Do you have heavy, tight, or achy legs?
- ☐ Do you have varicose veins or spider veins?
- ☐ Do you have skin that becomes discolored, feels leathery, flaky and/or itchy?
- ☐ Do you have chest pain?
- ☐ Do you have shortness of breath?

ProActive HEART & VASCULAR

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Medical Records Release

Date: _____

I _____ Date of Birth _____

Hereby authorize the release of my medical records to:

Proactive Heart & Vascular

7751 Wolf River Blvd

Germantown, TN 38138

Any information including diagnosis, records of treatment, prescribed medications, examination, and test results rendered to me.

_____ A. Complete medical records

_____ B. Services during the time period of _____ to _____. Description of records to be released: _____

_____ C. Medication History from all prescribers.

_____ _____

Signature of patient or Patient Representative Date

ProActive
HEART & VASCULAR

Medical Records and Forms Fee Policy

Forms: A $25.00 fee will be charged to complete any forms. This includes all medical leave forms. We ask that this fee be paid at the time of request to ensure the the availability to fax or mail the requested forms upon completion. FMLA forms that are faxed to us will not be completed until after the fee is paid. To better serve you these fees can be paid over the phone (901-297-4000 option 1) with a credit card.

Medical Records: A fee of $25 will be charged for a copy of your medical record for the first 25 pages. Any additional pages will be charged $.25/page. If medical records are mailed an additional fee to cover the cost of shipping will apply.

Federal Aviation Administration (FAA) patients: All patients associated with the FAA will be charged $100 for copies of all requested studies and additional required paperwork.

In order to comply with your requests in a professional and efficient manner, we ask that you allow 7-10 working days for the forms/medical records request to be completed. If you are going to pick up the forms/records from our office please call ahead to ensure forms/medical records are ready.

I acknowledge that I have been notified of these fees and understand this policy.

_____ _____

Patient Signature Date

_____

Patient Printed Name

ProActive HEART & VASCULAR

Michael A. Nelson, MD
7751 Wolf River Blvd
Germantown TN 38138
Phone (901) 297-4000
Fax (901) 531-8344

Patient Name: _____ Date _____

_____ I give Proactive Heart & Vascular permission to leave results of test and labs as well as instructions and appointment times on my

_____ Answering Machine

_____ Voice Mail

_____ With the following people listed below:

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

_____ I do not give Proactive Heart & Vascular permission to leave results with any person other than myself nor on an answering machine or voice mail.

Patient Signature _____

ProActive Heart and Vascular

FINANCIAL POLICY

Thank you for choosing Proactive Heart and Vascular as your Cardiology healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we provide as pertinent information prior to any treatment.

Appointments

It is very important that you make every effort to keep your appointment. We try our best to allocate the proper amount of time for each patient. If you are unable to keep your scheduled appointment, please call 24 hours in advance to cancel so that we may open that slot for another heart patient. **Please be aware that there is a $35 no-show fee for missing any scheduled appointments.** We truly appreciate your effort to call the practice in advance if you cannot keep your scheduled appointment.

Cancellation/rescheduling of nuclear stress testing and echocardiograms: ProActive Heart & Vascular requires three (3) business day notice for cancellation or rescheduling of nuclear stress tests and echocardiograms. **A cancellation fee of $125 will be applied for cancellations of less than three (3) business days.**

Cancellation/rescheduling peripheral procedures: ProActive Heart & Vascular requires five (5) business day notice for cancellation or rescheduling of peripheral or vein procedures. **A cancellation/rescheduling fee of $500 will be applied for cancellations of less than five (5) business days of your scheduled peripheral or vein procedure.**

Cancellation of a vein procedure (EVLT) fee of $250 will be applied for cancellations of less than five (5) business days.

Cancellation of a sclerotherapy session of $50 will be applied for cancellation of less than three (3) business days.

Insurances

We have made arrangements with many insurance carriers and other health plans to accept assignment of benefits, because of this it is crucial to provide us with the correct insurance information. Proactive Heart and Vascular will bill those plans whom we have an agreement. Co-payments and deductibles are due at the time services are rendered.

We gladly file your primary and secondary insurance as a courtesy to you. We extend this courtesy for a period of 45 days. If no payment has been received from them by that time, we ask that you contact your carrier regarding any 45 day outstanding claim. We will continue to assist you in acquiring reimbursement. Please be aware that some or all of the services we provide may not be covered by your carrier and may not be considered reasonable and necessary under the Medicare program and/or other medical insurances; thus reimbursement is fully your responsibility.

Medicare Patients

If you have Medicare, please be aware that we are required by Medicare to collect deductibles and co-pays from you when you do not have secondary insurance coverage. Please furnish your Medicare card and secondary insurance card to our receptionist.

Regarding unpaid bills over any applicable co-payment or deductible – if you finalize a payment plan agreement within 30 days of receiving your first statement, these bills will not be subject to our policy of furnishing adverse information to consumer collection agencies regarding the amounts owed by the patient.

Private Pay Patients

Patients without health insurance suffering financial hardship may, at Proactive Heart and Vascular's discretion, qualify for a discount equivalent to, but not less than, 150% the 2013 Medicare allowed rate.

Proactive Heart and Vascular reserves the right to charge 12% interest on any charges not paid by third party payers which are more than 60 days delinquent, and to turn over to our collection agency any accounts delinquent after 180 days. Should an unpaid balance be transferred to the collection agency a 30% surcharge will be added to the balance owed amount.

Usual and Customary or Not Covered

Our practice is committed to providing you with the best treatment possible, and we charge what is usual and customary for our area. You are responsible for payment in full of any non-covered service regardless of an insurance company's arbitrary determination of usual and customary rates.

Proactive Heart and Vascular

FINANCIAL POLICY

Regarding Referrals

In the event your insurance company requires a referral from your primary care physician (PCP) and you arrive for your appointment without an authorized referral, or an incorrect referral, you will be responsible for the complete charge or you may reschedule your appointment.

Minor Patients

For all services rendered to a minor or dependent patient, Proactive Heart and Vascular will request the parent and/or guardian to be responsible for all payments.

Medical Records requests

A fee not to exceed $30 will be collected prior to researching and copying patient medical records. If more than 2 copies are requested of the medical record, there will be an additional per page fee beyond the $30 initial processing fee.

Flexible Spending Accounts offered through your Employer

Should you need a physicians' prescription for over-the-counter medications to satisfy your Flexible Spending Obligations, please request them at time of service. Call in requests will not be honored.

Billing Inquiries

Any questions regarding charges or insurance balances should be directed to our billing department at 888-608-7999.

FINANCIAL POLICY

Thank you for taking the time to read our Financial Policy. Please let us know if you have any questions or concerns as we want you to fully understand our policy.

Please PRINT name of Patient or Responsible Party (Parent/Guardian) for patient **Relationship to Patient**

Signature of Patient or Responsible Party (Parent/Guardian) **Date**

Notice of Privacy Practices Acknowledgment

ProActive Heart & Vascular, PLLC
7751 Wolf River Blvd, Germatown, TN 38138
(901) 297-4000

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date:_____ Attempt:_____

Staff Name:_____

ProActive
HEART & VASCULAR

Appointment REMINDER preferences

Please let us know the best way for us to remind you of your appointments.

_____ Cell Phone- TEXT - What is your cell phone number? _____

_____ Cell Phone- VOICE- What is your cell phone number? _____

_____ Home Phone- What is your home phone number? _____

_____ Email- What is your email? _____

Assignment of Benefit Form

I, _____, hereby assign my healthcare benefit payments, to which I am entitled through _____ (name of insurance company) to ProActive Heart & Vascular, PLLC ("assignee').

This assignment is pursuant to the Employee Retirement Income Security Act (ERISA) as defined in 29 CFR 2560-503-1, and applicable by State law, and will remain in effect until revoked by me in writing.

I understand that I am financially responsible for all charges not paid by my insurance. I hereby authorize said assignee to release all information necessary to secure payment of said benefits.

ProActive Heart & Vascular, PLLC is hereby authorized to initiate on my behalf any complaints regarding my healthcare benefit payments or adverse benefit determinations as defined in 29 CRF 2560-503-1, with the State Insurance Commissioner for a possible violation of State Insurance Laws or Employee Benefits Security Administration and the Secretary of Labor as it pertains to ERISA, specifically 29 USC 18§§1003(a) and 1144(a).

ProActive Heart & Vascular, PLLC is allowed full disclosure of any and all information, documentation, policies, procedures and resources used by _____ (name of insurance company) to perform an adverse benefit determination, as defined in 29 CFR 2560-503-1 of my covered benefits.

ProActive Heart & Vascular, PLLC is authorized to represent me in any and all Federal Lawsuits against my insurance company _____ pursuant to the ERISA. A copy of this document is as valid as the original.

_____ _____

Signature of Patient/Insured Date

_____

Printed Name of Patient/Insured

_____ _____

Signature of Witness Date

_____

Printed Name of Witness

Sources

USC 18§§1003(a) Available at http://law.onecle.com/uscode/29/1003.html

USC 18§§1144(a) Available at http://codes.lp.findlaw.com/uscode/29/18/I/B/5/1144

29 CFR 2560-503-1 Available at http://www.dol.gov/ebsa/regs/fedreg/final/2001017145.htm