Associates in Vascular Care
Owano Pennycooke, MD
Lori Boyle, APN, WCC, CWS

New Patient Packet

Thank you for choosing Associates in Vascular Care for your healthcare needs.

We ask that you please complete the following packet of new patient paperwork prior to your appointment with us.

Please complete the packet in its entirety as this will help us make your appointment go smoothly. If there is anything in the paperwork that you don't understand, please feel free to contact our office and the office staff will be happy to help you.

At the time of your appointment, please bring this packet completed along with the following:

- *Photo ID & Insurance Cards*
- *Insurance Referrals (If your insurance plan requires referrals. If you are not sure whether your need referrals to see a specialist, please contact your insurance company prior to your visit.)*
- *Any testing you may have had done prior that is related to your visit.*

*** Please remember to bring everything listed above with you on the day of your appointment***

We will not be able to see you if you don't have your Insurance Referral, Photo ID & Insurance Cards present the day of your appointment.

If you have any questions or concerns, please contact our Office Staff.

Main Office:
1000 Rt. 35 South
Suite 300
Middletown NJ, 07748
Phone: (732) 784-6550
Fax: (732) 737-9836

Satellite Office:
479 Rt. 520
Suite A103
Marlboro NJ, 07746
Phone: (732) 784-6550
Fax: (732) 737-9836

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Patient Registration Form

Please complete this form in its entirety to ensure that we have the proper information given on file.

Patient Information:

Last Name: ________________________ First Name: ________________________ DOB: __________

Address(Street):____________________________ City, State, Zip: ______________________________

Home Phone: ______________________ Cell: _______________ Work: ____________________

Are you currently in a Skilled Nursing Facility or Assisted Living? (If yes, please provide below where you currently reside):

____

Sex: □ Male □ Female **Marital Status**: □ Single □ Married □ Widowed □ Separated □ Divorced □ Partner

Ethnicity: □ Caucasian/ Non-Hispanic □ African American □ Latin / Hispanic □ Other ______________

Email Address: ____

Primary Care Physician: ____________________ **Ref Physician** (if different): ____________________

Address (Street):____________________________ Address (Street): ____________________________

City, State, Zip: ____________________________ City, State, Zip: ____________________________

Telephone #: ______________________________ Telephone #: ______________________________

Cardiologist: ______________________________ **Add'l Physician:** ____________________________

Address (Street): ____________________________ Address (Street): ____________________________

City, State, Zip: ____________________________ City, State, Zip: ____________________________

Telephone #: ______________________________ Telephone #: ______________________________

Insurance Information: Please also be prepared to give the front desk a copy of your insurance cards.

Primary Insurance Carrier Name: ____

Address:_________________________________ City, State, Zip: ____________________________

ID/Policy #: ______________________________ Group/Plan #:______________ Effective Date: ___________

Secondary Insurance Carrier Name: ____

Address:_________________________________ City, State, Zip: ____________________________

ID/Policy #: ______________________________ Group/Plan #:______________ Effective Date: ___________

Emergency Contact Information:

Contact: ________________________________ Relationship to You: ______________________________

Home Phone: _____________________________ Alt. Phone: ____________________________________

Contact: ________________________________ Relationship to You: ______________________________

Home Phone: _____________________________ Alt. Phone: ____________________________________

I acknowledge that all the information given above is true to the best of my ability.

Signature: ______________________________________ Date: ______________________________

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HIPAA
Acknowledgement and Authorizations

HIPAA Notice of Privacy Practices

Patient Acknowledgment

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about our patients. We are required by law to maintain the privacy of protected health information, and provide individuals with this Notice of our legal duties and privacy practices with respect to protected health information. You have the right to review our notices before signing this consent. You are also welcome to take a copy of the HIPPA privacy notice with you.

I acknowledge that I have been offered the following HIPPA Notice of Privacy Practices. I also acknowledge and approve the uses and disclosures of my Protected Health Information (PHI) as described in the HIPPA Notice of Privacy Practices packet.

Print Name: ____

Signature: ____ Date Signed: ______________________________

Authorization for use or Disclosure of Health Information

Patient Contact Information

Home #: ___________________________ Cell #: ____________________________ Work #: ___________________________

I authorize Brief messages with medical information to be left on voicemail (check all that apply) □ Home □ Cell □ Work

I authorize Extended messages with medical information to be left on voicemail (check all that apply) □ Home □ Cell □ Work

I authorize secure electronic communications be sent to my email address at: ____

Restrictions/ Instructions: ____

Patient Acknowledgement

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I understand that:

1. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me, or my representative and be delivered to our office address. My revocation will be effective once received by the practice, Associates in Vascular Care.
2. A copy of this authorization may be used with the same effectiveness as the original. This authorization replaces any prior written authorizations I have made regarding the use, release, and disclosure of my medical information.

Print Name: _______________________________ Date: ______________________________

Signature: ________________________________ Relationship: _______________________

Associates in Vascular Care
Owano Pennycooke, MD
Lori Boyle, APN, WCC, CWS

Annual Consent:

Patient Name:_________________________________ Date of Birth: ___________________________

Consent for Treatment:

● I hereby give permission for any medical / surgical procedures, radiology or diagnostic testing, medications or exams as may be deemed necessary by the Physician or Nurse Practitioner.

● I understand I have the right to see the Physician or Nurse Practitioner and address any questions or concerns that may pertain to my care.

● I understand that I also have the right to see the Physician or Nurse Practitioner prior to any medical / surgical procedures that will be scheduled on my behalf to go over and concerns and/or questions I may have.

● Permission is also granted to provide any necessary emergency medical treatments that may be needed while being seen in the office.

Financial Consent for Treatment:

I hereby authorize Associates in Vascular Care, or any of its affiliates, contractors or business associates to contact me (by any telephone numbers, email addresses or other contact points provided by me or on my behalf) by the use of any automatic dialing system, by pre-recorded forms of voice/messaging systems, by electronic mail owned or used by the guarantor/responsible party, by text messages, by telephone or by cell phone for reasons related to the services I received at Associates in Vascular Care or payment for the services I received including but not limited to, debt collection purposes.

Patient Signature: ____

Representative/ Guardian Signature: ______________________________________

Date Signed: ____

Associates in Vascular Care
Dr. Owano Pennycooke
Lori Boyle, APN, WCC, CWS

Patient Financial Responsibility Statement

We are pleased that you have chosen Associates in Vascular Care for your healthcare needs. It is our goal to provide you with the highest quality of healthcare services possible. In exchange for providing these services, we ask that you take the time to understand your financial responsibilities to ensure timely and acceptable payment for our services.

1. **I am responsible for knowing the details of my insurance coverage(s) including my responsibility for co-payments, deductibles, co-insurances, and referrals. It is my responsibility to call my insurance company to obtain this information.**

2. **I authorize payment of my insurance benefits to Associates in Vascular Care for the medical services received.**

3. **I accept responsibility for payment of any amounts (co-payments, deductibles, and co-insurances) that are not covered by my insurance(s).**

4. **I will provide all current insurance information (We require both sides of your insurance cards) at the time of service, including a photo ID.**

5. **I agree to have a current and active insurance referral (if applicable) at the time of service issued by my primary care physician). Otherwise my appointment may be canceled, rescheduled or I will pay for the full fee for my appointment. I understand that I am responsible for obtaining this referral from my PCP. A doctor's prescription is not a valid insurance referral.**

6. **If I am without insurance coverage, Associates in Vascular Care expects to be paid at the time services are rendered.**

7. **I understand that after (3) attempts to collect any patient balance, my account will be turned over to a collection agency. I will also be responsible for any and all fees and service charges incurred as a result of a collection agency's involvement.**

8. **I understand I will be charged a $35.00 fee if my personal check is returned by my bank.**

I have read all the above statements and fully understand and agree to these terms.

______________________________________ Date: ______________________________
Print Patient Name

____
Patient Signature

____
Responsible Party / Guardian

Associates in Vascular Care
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Notice to Medicare Patients:

As a Medicare participating provider it is required that we have all our patients complete this form which is standard authorization that allows us to bill Medicare on your behalf each time you receive services from *Associates in Vascular Care.* When you complete this form, we can bill Medicare directly, receive Medicare's portion of the reimbursement, and then bill you or your secondary insurance for the uncovered services and any balance for which you are directly responsible according to Medicare rules and regulations.

"I request and authorize that payment be made to Medicare benefits on my behalf. I authorize any holder or medical information about me to be released to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. This authorization will remain in effect until revoked by me or my legal representative in writing."

____________________________________ ______________________________

Signature of Patient or Representative *Date Notice Signed (**Must Complete**)*

____

Medicare Number

Secondary Insurance:

"I request that payment be authorized to my secondary insurance benefit. I authorize any holder of Medicare information about me to be released to my secondary insurer (named below) any information needed to determine these benefits payable for related services."

Name of Secondary Insurance: ____

Policy ID Number: ____

____ ____________________________________

Signature of Patient or Representative *Dated Notice Signed (**Must Complete**)*

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Patient Name: ____ Date of Birth: ___________________

Authorization to Release Medical Records:

I, authorize the office of Associates in Vascular Care to release any medical records to the following third party(s) listed below.

Name of Facility(s) and/or Practice(s):

____

Address:

____

Phone Number & Fax Number:

____

Release of Medical History & Treatment Information

I authorize the following individual(s) to receive information pertaining to any medical history and treatment received on my behalf:

Name: _________________________ Relationship: ____________________ Phone #:________________________

Name: _________________________ Relationship: ____________________ Phone #:________________________

Restrictions: ____

Medical records released from our office pertain to the following information:

□ Physician's Office Notes
□ Radiology or Ultrasound reports ordered by one of our physicians
□ Operative Reports

Signature: ____

Relationship to Patient: ____

Date: ____

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PLEASE COMPLETE ALL PAGES

Patient Name: ____ Date of Birth: ________________________________

Primary Physician: ____

Referring Physician (If Not Primary): ____

Chief Complaint: ____

MEDICAL HISTORY: (CHECK/FILL IN ALL THAT APPLY)

Aneurysms:
□ Renal (Kidney) □ Thoracic (Chest) □ Popliteal (Knee) □ Abdominal (Stomach)

Circulation Complications:
□ Head □ Neck □ Upper Extremity □ Lower Extremity

Neurology Complications:
□ Seizure / Epilepsy □ Stroke □ Transient Ischemic Attack (TIA)

Renal Complications:
□ Hepatitis □ Peritoneal Dialysis □ Hemodialysis □ Kidney Disease
Type: _________

Arthritis:
□ Osteoarthritis □ Rheumatoid Arthritis

Cardiac/Vascular Complications:
□ Coronary Artery Disease □ Heart Valve Disease □ Heart Failure □ Heart Attack
□ Pacemaker/Defibrillator □ Carotid Stenosis (Narrowing) □ Carotid Dissection □ Irregular Heart Beat
□ Varicose Veins □ Bulging Veins □ Spider Veins □ High Blood Pressure
□ Bleeding Disorder □ High Cholesterol
□ Deep Vein Thrombosis (DVT)
□ Upper Extremity Rt. / Lt. □ Lower Extremity Rt. / Lt.

Cancer:
□ Chemotherapy □ Radiation
□ Cancer Type: ____

Diabetes Mellitus:
□ Type I □ Type II □ Insulin Dependent

Pulmonary Complications:
□ Asthma □ Emphysema □ Pulmonary Embolism (Clot in Lungs) □ COPD

Other Medical History/Complications: ____

FAMILY HISTORY: (CIRCLE/FILL IN ALL THAT APPLY)

	Mother	Father	Siblings	Grandparents- Paternal	/Maternal	Relatives
Cancer:	______	______	_______	__________ ______	_______	________
If yes, what type:						
High Blood Pressure	______	______	_______	__________ ______	_______	________
High Cholesterol	______	______	_______	__________ ______	_______	________
	Mother	Father	Siblings	Grandparents- Paternal	/Maternal	Relatives

Heart Disease	______	______	______	______	______	______	______
Stroke	______	______	______	______	______	______	______
Diabetes	______	______	______	______	______	______	______
Aneurysm	______	______	______	______	______	______	______
Varicose Veins	______	______	______	______	______	______	______
Bleeding Disorder	______	______	______	______	______	______	______

PREVIOUS SURGERIES/HOSPITALIZATIONS:

Date:	Type of Surgery/Hospitalization:	Name of Hospital:
______________	____	_____________________
______________	____	_____________________
______________	____	_____________________
______________	____	_____________________
______________	____	_____________________

ARE YOU CURRENTLY ON DIALYSIS □ YES □ NO (If yes, please complete information below)

Name of Dialysis Center: ____________________________________ Days of Dialysis: ___________________________

Office Phone: ____ Office Fax: ________________________________

MEDICATION/FOOD ALLERGIES:

Are you allergic or have had a "bad reaction" to any of the following?

Latex □ YES □ NO If yes, what type of reaction:____

Contrast (IV Dye) □ YES □ NO If yes, what type of reaction:____

Shellfish □ YES □ NO If yes, what type of reaction:____

Iodine □ YES □ NO If yes, what type of reaction:____

If any other allergies and reactions, please specify below:

Allergy:	Reaction:
_____________________	____________________________
_____________________	____________________________
_____________________	____________________________
_____________________	____________________________

SOCIAL HISTORY:

Social Status:

□ Single □ Married □ Divorced □ Widowed

Daily Living:

Do you have family members or friends that are able to help you out? □ YES □ NO

Need assistance with daily activities? □ YES □ NO

Do you exercise regularly? □ YES □ NO

If yes, frequency: ________________________

Recreational Status:

Are you currently smoking? □ YES □ NO

If yes, how many years? ____________________

Have you smoked in the past? □ YES □ NO

If yes, Quit; when: _________________________

If current or past; what type?

□ Cigarettes □ Cigars □ Pipe □ Chewing Tobacco

Amount per day:__________________________________

Do you drink alcohol? □ YES □ NO

□ Social □ Moderate □ Heavy

If yes; what type?

□ Wine □ Beer □ Liquor

Amount: _________________________

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Patient Medication List

Please provide us with a list of all your current medications below. If you already have a copied list of your medications, please bring that with you on the day of your appointment.

Name: ______________________________________ Date of Birth: _________________________

Pharmacy Information:

Pharmacy Name:____________________________________ Phone Number: _______________________

Address: ____

Name of Medication	Dosage of Medication	How Medication should be Taken	Times of Day Medication Should be Taken
Example: Lipitor	*10mg*	*1 tablet*	*2x a day*

**If Additional Lines are needed please ask the front desk for another medication list.