Ozark Regional
VEIN & ARTERY CENTER

OVA Patient Registration

Patient Name: _____

- Male
- Female

Date of Birth: _____

Social Security # _____

Address: _____

City: _____

State: _____

Zip: _____

Home Phone: _____

Cell Phone: _____

Employer: _____

Work Phone: _____

Please check one:

- Married
- Single
- Partner
- Divorced
- Widowed
- Separated

Race:

- White
- African American
- Asian
- Native Hawaiian/Other Pacific Islander
- Native American Indian/Alaskan
- Other Race

Ethnicity (Origin):

- Not Hispanic or Latino
- Hispanic or Latino

Ozark Regional
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Preferred Language: _____

Primary Physician: _____

Preferred Pharmacy: _____

Pharmacy Address: _____

Email Authorization

Email Address: _____

By providing my email address above, I hereby agree to allow ORVAC to contact me by email with newsletters, wellness reminders, health news and updates regarding health-related services and appointments by ORVAC. I understand that ORVAC will not share the information provided above with outside marketing companies.

Spouse or Parent (if minor) Information

Name: _____

Date of Birth: _____

Social Security: _____

Employer: _____

Phone: _____

Emergency Contact Information

Emergency Contact: _____

Relationship: _____

Phone: _____

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REFERRAL

If you are a new patient, how did you hear about the clinic or physician?

- o Recommended by a friend or family member
- o Referred by a physician
- o Insurance Plan Directory
- o Newspaper or Magazine
- o Employer
- o Clinic Website
- o Facebook or other Social Media
- o TV
- o REALSELF
- o Other
- o Returning Patient/Not applicable

PERSON RESPONSIBLE FOR PAYMENT

- o My self/ My spouse (skip to next section)
- o Father, Mother, Guardian or other

HEALTH INSURANCE INFORMATION

Please provide a copy of your insurance card to the receptionist or send a photo of the front and back of your card.

- o MEDICARE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Ozark Regional Vein and Artery Center for any services furnished to me by the provider. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid and it's agents any information to determine these benefits payable for related services.

PRIMARY INSURANCE: _____

Relationship to Policy Holder

- o Self
- o Spouse
- o Child
- o Step-Child
- o Other

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SECONDARY INSURANCE: _____

Relationship to Policy Holder:

- Self
- Spouse
- Child
- Step-Child
- Other

PATIENT NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received a copy of the Patient Notice of Privacy Practices from Ozark Regional Vein and Artery Center (ORVAC).

SIGNATURE: _____

In the event this Acknowledgement form is being executed by a personal representative, guardian or parent, please print your name, date of birth, social security number and relationship to the patient here:

If you would like to authorize ORVAC to release information to a family member, spouse or personal representative, please complete an Individual Authorization Form provided by the receptionist.

You have the option to sign this Agreement electronically or sign a paper copy of this Agreement. By signing electronically using any device, means or action, you consent to the legally binding terms and conditions of this Agreement. You further agree that your signature on this Agreement (hereafter referred to as your 'E-Signature') is as valid as if you signed this Agreement in writing. You also agree that no certification authority or other third party verification is necessary to validate your E-Signature, and that the lack of such certification or third party verification will not in any way affect the enforceability of your E-Signature or any resulting agreement between you and Ozark Regional Vein Center. You are also confirming that you are authorized to enter into this Agreement in your behalf. You understand that by selecting the 'Decline' button you have the option to have this Agreement made available to you in paper form for hand signing.

You acknowledge that you have access to an account with an internet service provider, and you are able to view or download a copy of the this Agreement by accessing your secure TouchMD account at https://patient.touchmd.com/ (requires the latest web browser), or by using the myTouchMD app (requires the latest iOS or Android version). You understand that a paper copy of this Agreement can also be obtained by contacting Ozark Regional Vein Center at ftownsley@ozarkvein.com or by calling 4794648346.

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VEIN & ARTERY CENTER

OVA Patient Responsibility for Payment of Charges

Patient Name: _____

All patients are responsible for their insurance deductible and co-pay amounts.

DEDUCTIBLES, COINSURANCE AND COPAYS MAY BE REQUIRED BY YOUR INSURANCE, YOU WILL RECEIVE A BILL FOR ANY BALANCE AFTER INSURANCE HAS PAID. ALL BLUE CROSS BLUE SHIELD PATIENTS WILL BE REQUIRED TO READ AND SIGN A WAIVER FOR CERTAIN PROCEDURES. THIS WILL ALSO APPLY FOR THOSE PATIENTS THAT ARE PAYING OUT OF POCKET FOR CERTAIN PROCEDURES WITH INSURANCE.

Payment is due at the time of service via cash, check or charge (All major credit cards accepted. CareCredit or Compassionate Financing are options available.).

I hereby authorize the Ozark Regional Vein and Artery Center (ORVAC) to release any medical information to process a medical claim. I understand that the ORVAC has the right to charge for a consultation and any necessary studies once I am an established patient. I understand that I am financially responsible for any and all charges rendered at the time of office visit. Not all services are included in my treatment plan, I understand any services outside my treatment plan are my responsibility.

If for any reason it becomes necessary to initiate collections proceedings, I understand I am responsible for the cost of all treatments received, as well as any and all legal or collection fees the ORVAC incurs.

I understand & agree to the terms for payment of my account.

Signature: _____

You have the option to sign this Agreement electronically or sign a paper copy of this Agreement. By signing electronically using any device, means or action, you consent to the legally binding terms and conditions of this Agreement. You further agree that your signature on this Agreement (hereafter referred to as your 'E-Signature') is as valid as if you signed this Agreement in writing. You also agree that no certification authority or other third party verification is necessary to validate your E-Signature, and that the lack of such certification or third party verification will not in any way affect the enforceability of your E-Signature or any resulting agreement between you and Ozark Regional Vein and Artery Center. You are also confirming that you are authorized to enter into this Agreement in your behalf. You understand that by selecting the 'Decline' button you have the option to have this Agreement made available to you in paper form for hand signing.

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OVA Record Request

Authorization for Release of Private Health information

Patient Name: _____

D.O.B.: _____

Last 4# SSN _____

Information to be released to the above referenced entity:

- All records: op/intervention procedure notes, most recent vascular ultrasounds, recent clinic notes, CTA images in report and a CD or
- Other _____

From: _____

Address: _____

Fax Number: _____

To: Ozark Regional Vein and Artery Center

Christopher Stout, MD

5433 W Walsh Lane

Rogers, AR 72758

Phone Number: (479) 464-8346

Fax Number: (479) 464-9046

This Authorization shall be deemed to expire on the earlier of one (1) year from the date set forth next to my signature or within reasonable time following completion of the event which gave rise to the purpose of the Authorization. I understand that I have the right to revoke this Authorization in writing at any time and that I may do so by delivering a revocation in writing to the Clinic. I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the receiving entity and may no longer be protected by the Privacy Standards of this Clinic. The Clinic has informed me that the Clinic will not condition treatment, payment, enrollment, or eligibility for benefits on obtaining this authorization.

I understand that I may refuse to sign this Authorization.

Patient Signature: _____ Date: _____

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OVA Universal Consent

HIPPA Consent

In April of 2003, new federal requirements regarding privacy of information for health care patients took effect. the Health Insurance Portability and Protection Act (HIPPA) requires that all medical providers, insurance companies and others put in place controls to ensure that your personal medical information is safe. The Ozark Regional Vein and Artery Center requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about your for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Authorization to Release Information to Family Member

Many of our patients allow family members such as their spouse, parents or others to call and request the results of tests and procedures. Under the requirements for HIPPA we are not allowed to give this information to anyone without the patient's consent. This consent form will allow ORVAC to release your medical and billing information to family members listed in your chart.

Authorization to Leave Messages with Household Members/Answering Machine

From time to time it is necessary for representatives of ORVAC to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss ultrasound or procedure results, or to ask a patient to call regarding an issue or concern. At no time will a representative discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

Authorization to Release Health Information

As needed, we may request relevant medical records from any of your existing healthcare providers that may assist in your evaluation and treatment.

Photography Consent

I understand that photographs or other digital images may be recorded to document my care. I agree to have photographs taken for my records, medical purposes and insurance purposes. I understand that ORVAC will retain the ownership rights to these photographs or digital images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy. I waive all my rights to any claims for payment or royalites.

- o Please check here if you agree to all of the above consents
- o Please check here if you refuse any of the above consents

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If you refuse, please list here: _____

You have the right to revoke any of these consents, in writing, except where we have already made disclosures in reliance on your prior consent

Signature: _____

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OVA Notice of Privacy Practices
This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to provide treatment, obtain payment, and conduct health care operations and for other purposes permitted or required by law. It also describes your rights concerning your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to follow the practices described in this Notice. We may change the terms of this Notice at any time. The new Notice will be effective for all protected health information we maintain at that time including health information we created or received before we made the changes. You may obtain a copy of our Notice of Privacy Practices at any time by calling our office or requesting one at your next appointment.

Uses and Disclosures of Protected Health Information Treatment: We will use and disclose your protected health information to provide, coordinate, and manage health care and related services for you. For example, we will disclose information to a specialist to whom you have been referred to ensure the provider has enough information to diagnose and/or treat you. We may also disclose information to a laboratory that, at our request, becomes involved in your treatment.

Payment: We may use and disclose your information to obtain payment for services we provided for you. For example, we will send the necessary information to your health insurance company to obtain payment for the treatment provided.

Healthcare Operations: We will use and disclose your health information to conduct the business activities of this office. These activities include, but are not limited to, quality assessment and improvement activities, review of the performance and qualifications of employees, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may use a sing-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when we are ready to begin your treatment.

We will share your protected health information with business associates that perform specific functions for our practice such as billing. When a business arrangement of this type requires the use of your information, we will have a written contract with the third party to protect the privacy of your protected health information.

Others Involved in Your Health Care: We must disclose your health information to you as described in the Patient Rights sections of this Notice. We may disclose your health information to a family member or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree. If we determine it is in your best interest based on our professional judgment or experience with common practices, we may allow another person to pick up filled prescriptions, medical supplies, x-rays or other forms of health information. We may use or disclose protected health information to notify or assist in notifying a family member, a personal representative or any other person responsible for your care of your location, your general condition or death. If you are present prior to the use or disclosure of your protected health information, we will provide you with the opportunity to object to such

uses or disclosures. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family members or others involved in your health care.

Emergencies: In the event of your incapacity or in emergency circumstances, we may use or disclose your protected health information to treat you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization at any time, in writing, except to the extent that an action has already been taken in reliance on the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object: We may use or disclose your protected health information in the following situations without your consent or authorization.

Required by Law: We may use or disclose your protected health information to the extent that law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. We must make disclosures to you and, when required, to the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule, Section 164.500 et. seq.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. Additionally, we may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Questions and Complaints: If you have any questions, concerns or want more information about our privacy practices please contact us using the information below. If you are concerned that we may have violated your privacy rights or you disagree with a decision we have made regarding your access to your health information or any other request you have made in the exercise of your rights, you may send your complaint to us using the information below. You may also submit a written complaint to the Secretary of Health and Human Services. Contact us for the address of the Department of Health and Human Services. We support your right to the privacy of your health information and we will not retaliate against you in any way for filing a complaint.

Signature: _____

Contact our Office:

Ozark Regional
VEIN & ARTERY CENTER

Contact Office or Official: Ozark Regional Vein and Artery Center – Felecia Townsely Phone: 479-464-VEIN(8346) Fax: 479-464-9046 Email: ftownsley@ozarkvein.com Address: 5433 Walsh Lane Rogers, AR 72758

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OVA HEALTH HISTORY

Primary care doctor name/number: _____

Height: _____

Weight: _____

Preferred Pharmacy:

Symptoms, please check all that apply:

- claudication (leg pain/aches w/ walking that resolves w/ rest)
- numbness or weakness in legs
- leg cramps
- burning or aching on feet at rest
- non-healing open sore
- one or both legs feeling cold or changing color (pale, bluish, dark reddish)
- hair loss in legs
- discolored or brittle toenail
- temporarily loss of vision in one or both eyes
- sudden weakness or numbness in the face or limbs
- trouble speaking or understanding speech.
- severe headaches with no known cause

How far can you walk before experiencing leg pain? _____

Are you a current or former smoker?

- Never
- Current
- Former

If so, when did you quit: _____

Patient Medical History (Please check all that apply):

- Hypertension
- Coronary Artery Disease
- Cholesterol
- Diabetes
- Peripheral Artery Disease
- Carotid Artery Disease
- Abdominal Aortic Aneurysm
- May-Thurner Syndrome

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- Prior Arterial Stents/ballooning
- Deep Vein Blood Clot
- HIV/AIDS
- Lung Disease/COPD
- Pulmonary Embolus (clots in the lungs)
- Cancer

Other: _____

Do you have a family history of:

- Diabetes
- Peripheral Arterial disease
- Aneurysms
- Carotid Artery disease

Other: _____

Please list your past surgeries:

_____

_____

Please list all of your current medications:

_____

_____

Please list any and all allergies:

_____

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Authorization for Release of Medication History

Patient Name:_____

I, or my authorized representative, consent to allow Ozark Regional Vein Center to download a list of medications purchased through my insurance in the last two years, as set forth on this form.

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

1.
Ozark Regional Vein Center uses SureScripts, Inc. a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized by Ozark Regional Vein Center.

2.
This Authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to Ozark Regional Vein Center.

3.
I have the right to revoke this authorization at any time by notifying Ozark Regional Vein Center. I understand that I may revoke the authorization except to the extent that action has already been taken based on this authorization.

4.
Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan. or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

This authorization does not authorize Ozark Regional Vein Center to discuss my health information or medical care with anyone other than those permitted under applicable law.

Signature of patient or representative:

_____ Date: _____