VASCULAR SURGERY ASSOCIATES, L.L.C.

PATIENT AUTHORIZATION

PLEASE HAVE YOUR INSURANCE CARDS AVAILABLE FOR PHOTOCOPYING AT EACH VISIT. ALL COPAYS AND BALANCES ARE DUE AT THE TIME OF THE SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

I, ______________________________________, acknowledge that I am personally responsible for payment of any and all charges associated with my treatment whether or not payment may also be made in part by insurance, Medicare, Medicaid, or any other health care service plan, financial assistance fund or welfare fund. By signing below, I assign any and all insurance benefits due and payable for the treatment provided.

I also understand and agree that any balance due and not received within 60 days of becoming patient responsibility shall be considered past due and my account shall be in default. Should it become necessary to engage a firm to collect any past due balance, I agree I am responsible for all costs associated with those collection efforts including but not limited to actual Attorney Fees incurred, court costs, collection agency fees up to 35% and all other costs associated with the collection process.

Signature: ________________________________(SEAL) Date: _________________

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

ACKNOWLEDGEMENT

I have received a copy of the Vascular Surgery Associates LLC HIPAA Notice of Privacy Practices

Signature: ________________________________ (SEAL) Date: ____________________

Please select YES or NO to the following questions:

- May we leave a detailed message on your answering machine regarding personal health information, verifying appointments or to change appointments?
  YES NO
- May we leave a detailed message with another family member regarding personal health information, verifying appointments or to change appointments?
  YES NO
  If yes, please list who we may speak with:

  ____

- May we leave a detailed message on your voicemail either at work or on a cell phone regarding personal health information, verifying appointments or to change an appointment?
  YES NO

I authorize the release of medical information necessary in the coordination of my medical treatment/care.

Signature: ____________________________________ (SEAL) Date: ___________________

PLEASE ALSO COMPLETE BACK SIDE

PRIMARY CARE PROVIDER:

Name: ___________________________________ Phone: ___________________________

Address: ____

PHARMACY:

Name: ___________________________________ Phone: ___________________________

Address: ____

DIALYSIS CENTER & LOCATION: ____

DIALYSIS TREATMENT DAYS: Mon, Wed, Fri or Tue, Thurs, Sat / 1st, 2nd, or 3rd shift

NEPHROLOGIST: ____

PODIATRIST NAME: ____

VSA is required by federal regulations to aid health agencies in understanding healthcare disparities, improve quality of care and strengthen research and outreach. We appreciate your assistance in meeting these standards by answering the following questions. VSA is dedicated as your partner in improving patient care.

Preferred Language (please check one)

___ English _____ Spanish _____ Other (Please specify) _______________________________

Race (please check one)

_____ Black/African American _____ Alaskan Native _____ Native American Indian

_____ Multiracial _____ Caucasian/White _____ Native Hawaiian _____ Hispanic

_____ Asian _____ Other (Please specify) ______________________________________

_____ Refuse or Decline to Specify

Ethnicity (please check one)

_____ Hispanic or Latino _____Not Hispanic or Latino _____ Unknown

_____ Refuse or Decline to Specify