

## Atlanta Vascular In Office Visit During COVID Patient Authorization and Consent Form

During the COVID-19 pandemic, there is some increased risk for patients who visit a healthcare provider. Health problems can happen from being exposed to:

- other patients,
- healthcare staff, or
- healthcare facilities.

Some patients have a higher risk of complications from COVID-19, including those with:

- asthma,
- chronic lung disease,
- serious heart disease or problems,
- chronic kidney disease,
- extreme obesity,
- a compromised or suppressed immune system,
- liver disease,
- pregnant,
- age 65 or older, or
- nursing home or long-term care facility residents.

If these high-risk patients get COVID-19, they may have a greater chance for having more health problems. These may be serious. Patients may need to be in the hospital. They could even die.

### Other Evaluation and Treatment Choices

There may be other ways to meet with your doctor and be treated. You could have:

- a phone evaluation

These other options may or may not be right for you. This depends on your health problem and overall health. If remote assessment and treatment are not appropriate, your doctor will explain why you need an in-person visit.

### More Facts

Medical and office staff may help your doctor when you arrive and while you are evaluated and treated. They will follow state laws and recommendations from local, state, and national health officials related to caring for patients during the COVID-19 pandemic. However, they cannot eliminate risks, especially for high-risk patients.

**Consent to Treatment**

\_\_\_\_\_ The first page of this consent form told you about COVID-related risks. If, after reviewing this form, you do not believe that you really understand the risks and choices, **do not sign the form until all questions have been answered.**

\_\_\_\_\_ I understand the facts provided to me on the first page of this consent form. I give my consent for in-office evaluation and treatment. By signing below, I agree that staff/doctor has discussed the facts in this form with me, that no one has given me any guarantee, that I have had a chance to ask questions, and that all of my questions have been answered.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date and Time

\_\_\_\_\_  
Relationship to Patient (if Responsible Party is not Patient)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date and Time

# AVS

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Phone: 404-524-0095 • [www.vascularspecialistofga.com](http://www.vascularspecialistofga.com)

**General Consent To Treat**

**Date:** \_\_\_\_\_

**Patient's Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

- **Consent:** I request and authorize medical or surgical treatment as may be deemed necessary and appropriate by the physician and his/her assistants participating in my care. This care may include; diagnostic, laboratory or radiology procedures; anesthesia, therapeutic procedures, nursing, hospital or blood transfusions. I understand I will sign an informed consent IF surgery or surgical procedure is recommended.
- **Release of Information:** I authorize Atlanta Vascular Specialists to release pertinent information and/or copies of medical records for treatment, payment, or health care operation purposes. I understand such information may include Human Immunodeficiency Virus (HIV), AIDES Related Complex (ARC) and Acquired Immunodeficiency Syndrome (AIDS), Hepatitis, substance abuse, psychiatric/psychological services records and social work records, if any. See Notice of Privacy Practices for further information.
- **Payment:** I assign and authorize payment from my insurance company directly to Atlanta Vascular Specialists for any and all services rendered. I agree to pay, at the time of competed services all charges not covered by my insurance company. I understand that it is my primary responsibility to pay all charges for services rendered irrespective of any disputes or disagreements between myself and the insurance company.
- **No Guarantees:** I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me as to the results of the care and treatment which I have hereby authorized. I release Atlanta Vascular Specialists of all responsibility for personal articles which I have with me during the time I am a patient. I understand the office is not responsible for personal articles of value kept in my possession while a patient at the office.

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I have read this form or it has been read to me and I am satisfied that I understand its contents. I further understand that this content will be deemed continuing and I am free to withdraw my consent at any time.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

# Atlanta Vascular Specialists \* Vein Specialists of Georgia

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Phone: 404-524-0095 Fax: 404-658-9558

**Eric Wellons, M.D., F.A.C.S. James Combs, M.D., F.A.C.S.**

**John Dooley, M.D. Courtney Grant, M.D**

## Acknowledgement of Receipt of Notice of Privacy Practices

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. As provided in our notice, the terms of our notice may change. If so, you may obtain a revised copy by contacting Carol Daigle, RN or Connie Dillard, Practice Administrator. By signing below, you acknowledge that you have received a copy of our Notice of Privacy Practices on the date indicated below.

Patient Name (please print): \_\_\_\_\_ DOB: \_\_\_\_\_

Phone- Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

**Messages**-please call my:  home  cell  work  other \_\_\_\_\_

If unable to reach me (choose one):

you may leave a detailed message  please leave a message asking me to return your call

other: \_\_\_\_\_

The best time to reach me is: Day(s): \_\_\_\_\_ Time Range: \_\_\_\_\_

## Release of Information

**PATIENT ACKNOWLEDGES AND AGREES THAT PATIENT'S RECORDS WILL BE AVAILABLE TO ALL PIEDMONT HEALTHCARE HOSPITALS, PHYSICIAN GROUPS, PIEDMONT HEALTHCARE AFFILIATED ENTITIES AND PROVIDERS AND NON-PIEDMONT HEALTHCARE AFFILIATED ENTITIES AND PROVIDERS.**

I authorize the release of information including diagnostic, records, examination rendered to me and claims information. This information may be released to:

Spouse: \_\_\_\_\_

Child/Children: \_\_\_\_\_

Other: \_\_\_\_\_

\*The release of information will remain in effect until terminated by me in writing.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

## Atlanta Vascular Specialists – Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Social Security No.: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Marital Status:  M  S  D  W Race:  Asian  Black  White  Other Gender:  M  F  
Primary Language: \_\_\_\_\_ Ethnic Group:  Hispanic/Latino  Not Hispanic/Latino  
Address: \_\_\_\_\_ Apt # \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Ph. \_\_\_\_\_ Cell Ph. \_\_\_\_\_  
Office Ph. \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Preferred Method of Contact:  Home Phone  Cell Phone  Office Phone  E-Mail

### EMERGENCY CONTACT: please provide the nearest relative NOT living with you

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### INSURANCE INFORMATION:

Medicare #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_  
Primary Insurance Co. Name: \_\_\_\_\_  
Policy/ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Policy Holder: \_\_\_\_\_ S.S.# \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Policy Holder-Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Secondary Insurance Co. Name: \_\_\_\_\_  
Policy/ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Policy Holder: \_\_\_\_\_ S.S.#: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Policy Holder-Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to patient: \_\_\_\_\_

### PHYSICIANS:

Referring Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Cardiologist: \_\_\_\_\_ Phone #: \_\_\_\_\_

**AUTHORIZATION and ASSIGNMENT:** I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf, I assign the benefits payable to which I am entitled including private insurance and other health plans to Atlanta Vascular Specialists (AVS). This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize the practice to appeal any incorrect insurance payment.

Signature/Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

**New Patient**

Wellons    Combs    Dooley    Grant    FVL Office    NWN Office    Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

PCP: \_\_\_\_\_ Referring Provider: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_  
\_\_\_\_\_

Do you smoke? Yes No      Have you ever used tobacco? Yes No

\*\*Pharmacy: \_\_\_\_\_ Pharmacy phone #: \_\_\_\_\_

Pharmacy address: \_\_\_\_\_

**Location of pain:** \_\_\_\_\_

Describe your type of pain: aching burning cramping itching stabbing tingling

What helps? Hose rest/elevation walking lying down OTC medications

other \_\_\_\_\_ none

What causes your pain? walking prolonged sitting standing other \_\_\_\_\_

none

Severity of pain: \_\_\_\_\_ (rate pain level from 1-10)

How long has there been pain? \_\_\_\_\_ How often do you have pain? \_\_\_\_\_

**Location of swelling:** \_\_\_\_\_

What helps? Hose rest/elevation walking lying down OTC medications other \_\_\_\_\_

none

What causes your swelling? walking prolonged sitting standing other \_\_\_\_\_

none

Severity of swelling: \_\_\_\_\_ (rate swelling from mild to severe)

How long has there been swelling? \_\_\_\_\_ How often do you have swelling? \_\_\_\_\_

Do currently have any of these symptoms? dizziness slurred speech headaches loss of vision/vision changes facial drooping loss of balance weakness on one side or the other

**Dialysis/Renal Patients**

Kidney Doctor/Nephrologist: \_\_\_\_\_

Are you on dialysis? Yes No    When did you last dialyze? \_\_\_\_\_

Do you have a Fistula or Graft? Yes No    if so, Right or Left

Do you have a Perma Cath? Yes No    Any pain?(1-10) \_\_\_\_\_ swelling? \_\_\_\_\_ (mild-severe)

Dialysis days: M/W/F T/TH/SAT    Dialysis Center: \_\_\_\_\_



**Surgical History**

- No surgical history
- Previous anesthesia problems
- Previous blood transfusion

\*\*\*Please mark the year next to the surgical procedure\*\*\*

<u>Surgery</u>	<u>Year</u>	<u>Surgery</u>	<u>Year</u>	<u>Surgery</u>	<u>Year</u>
Breast Surgery		Amputation		Fistulogram	
Bleeding Problems		Heart Cath		Angioplasty	
C-Section		Heart Bypass Surgery		Arteriogram	
Cataract Removal		Heart Stent		Bypass Graft (Extremity)	
Appendectomy		Pacemaker		Carotid Surgery	
Cosmetic Surgery		Defibrillator Placed		ABD Aneurysm Repair	
Hysterectomy		Orthoscopic Surgery		IVC Filter Placed	
Injury Related		Dialysis Graft or Fistula		Perma-cath Placement	
Hemorrhoidectomy		Spider Vein Treatment		Embolectomy	
Tonsils Removed		Varicose Vein Surgery		Stent Placement (renal)	
Tubal Ligation		De-clotting Procedure		Stent Placement (legs)	
Gall Bladder Surgery		Hernia Repair			

**Family History**

Mother (M) Father (F) Brother (B) Sister (S) Aunt (A) Uncle (U) Maternal Grandmother (Mat-M) Paternal Grandmother (Pat-M)  
 Maternal Grandfather (Mat-F) Paternal Grandfather (Pat-F)

Please mark in the appropriate block which family member has/had the following medical conditions:

<u>Condition</u>	<u>Family Member</u>	<u>Comments</u>	<u>Condition</u>	<u>Family Member</u>	<u>Comments</u>
Carotid Stenosis			Aneurysm		
Stroke/ TIA			Diabetes		
Cancer			PVD		
Varicose/ Spider Veins			Renal Failure		
Venous Disease			Blood Clot		
High Blood Pressure			High Cholesterol		
Heart Disease			Bleeding Disorder		
Lung Problems			COPD		
Hepatitis B/C			Parkinson's Disease		
Multiple Sclerosis			Alzheimer's		
Hyperthyroidism			Hypothyroidism		

**Social History**

Information obtained from:  patient  spouse  parent  significant other  sibling  child  caretaker  other

Marital Status:  married  divorced  single  widowed Number of children: \_\_\_\_\_

Other living arrangements:  assisted living  nursing home  other: \_\_\_\_\_

Do you exercise?  Yes  No

Alcohol Use:  denies use  yes-social  yes-daily

Tobacco Use:  never  previously stopped packs/day \_\_\_\_\_ # of years \_\_\_\_\_

currently smoking packs/day \_\_\_\_\_ # of years \_\_\_\_\_

Substance Use:  never  yes type: \_\_\_\_\_ frequency: \_\_\_\_\_

Have you ever worn support hose?  yes  no if so, how long? \_\_\_\_\_