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

2201 Newnan Crossing Blvd • Suite 200 • Newnan, GA 30265
1233 HWY 54 West • Suite 210 • Fayetteville, GA 30214
2690 HWY 34 • Suite B • Newnan, GA 30265
Phone: 404-524-0095 • 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.

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 ENTITES 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:_____

Established 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: _____