Western Vascular Institute, PLLC

7165 E University Drive #183, Mesa, AZ 85207-6415
Phone (480) 668-5000 Fax (480) 668-5065

PATIENT WELCOME LETTER

Welcome to Western Vascular Institute. This organization is owned by Mitar Vranic, D.O. and Henry Tarlian, M.D.

We would like you to know that all physicians are board certified by the American Board of Surgery and are licensed in the State of Arizona. We have extensive training in the field of Vascular Surgery. Should you choose to have surgery at this organization, we will be the only ones performing your surgery and anesthesia services.

This organization also uses credentialed and licensed in the State of Arizona, mid-level providers, i.e. Nurse Practitioner. They provide care according to their scope of service.

We also have a certified Aesthetician on staff that performs cosmetic services.

Please be advised that if you have a grievance please ask for a grievance form from the receptionist.

If you have a suggestion, please place this is writing. This can be done anonymous and hand to the receptionist or mail it to the office.

We encourage all patients to participate in their care, ask questions about anything; surgery, medications, treatments, diet; etc.

This organization educates staff upon hire and annually thereafter in hand hygiene and we follow the CDC guidelines for hand hygiene. We encourage staff to stay home when they are sick. We provide tissues and garbage cans throughout the facility and encourage everyone to cover their mouth when coughing or sneezing and then wash their hands.

Should you have a procedure or surgery in this organization we want you to know that we value patient safety. Therefore you may hear us performing certain tasks or asking certain questions that may surprise you. Even though we may know you we will ask you identifying information such as your date of birth or your address besides asking you to tell us your name. We take a pause or a "time out" before we actually start your procedure to assure once again that we have everything that we need and the entire team is in agreement. Only the physician performing your procedure will mark your surgical site. This organization adheres to strict infection control measures before, during, and after your procedure including but not limited to: procedural technique, the environment of care, care of equipment and instruments, and education of all staff in the most up to date infection control measures.

If anyone has concerns about patient care and safety in the organization, that the organization has not addressed, you are encouraged to contact a member of the organization's management team. If you feel the concerns were not resolved through the organization, you are encouraged to contact the Joint Commission by calling 800-994-6610 or emailing complaint@jointcommission.org.

WESTERN VASCULAR INSTITUTE, PLLC.

PATIENT BILL OF RIGHTS AND RESPONSIBILITES

Rights

The observance of the following guidelines will provide more effective patient care and greater satisfaction for the patient, the physician and the individuals that make up the office organization. It is in recognition of these factors that these rights are affirmed.

The patient has the right to considerate and respectful care; cultural, psychosocial, spiritual, personal values, beliefs, and preferences will be respected and care will be given in a safe setting. Patients with vision, speech, hearing, language and cognitive impairments have the right to effective communication.

The patient has the right to receive from his/her physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternative, the patient has the right to know the name of the person(s) responsible for the procedures and/or treatment as well as the person(s) responsible for their sedation and anesthesia.

The patient has the right to every consideration of his/her privacy concerning his/her medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. The patient has the right to expect that all communications and records pertaining to his/her care should be treated as confidential. Those not directly involved in his/her care must have permission of the patient to be present.

The patient has the right to obtain from the physician complete current information concerning his/her diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. The patient has the right to be involved in decisions about their care, treatment and services and the patient has the right to have their pain assessed, managed, and treated as effectively as possible.

The patient has the right, and when appropriate, the patient's family to be informed of unanticipated outcomes of care, treatment, and services that relate to sentinel or adverse reviewable events.

The patient has the right to expect that within its capacity, this ambulatory facility must provide evaluation, service and/or referral as indicated by the urgency of the case. When medically permissible, a patient may be transferred to another facility only after he/she has received complete information and explanation concerning the needs for and alternatives to such a transfer.

The patient has the right to obtain information as to any relationship of this facility to other health care and educational institutions insofar as his/her care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, which is treating him/her.

The patient has the right to expect reasonable continuity of care. The patient has the right to expect that this facility will provide a mechanism whereby he/she is informed by his physician of the patient's continuing health care requirements following discharge.

The patient with cognitive disabilities has the right to be treated with the consent of either, a family member or surrogate. Such family member or surrogate must prove legal authority to represent the patient via legal guardianship, proof of health care proxy, or power of attorney. Proof of legal authority must be presented before treatment is rendered.

The patient has the right to know the mechanisms for grievance as well as suggestions.

The patient has the right to change their choice of physician.

The patient has the right to refuse care, treatment, and services in accordance with law and regulation.

The patient has the right to dispute information in their medical record.

The patient has the right to examine and receive an explanation of his/her bill and to expect ethical billing practices.

The patient has the right to exercise all rights without discrimination or reprisal, abuse or harassment.

Responsibilities

The patient has the responsibility to provide the physician with the most accurate and complete information regarding present complaints, past illnesses, hospitalizations, medications, allergies and unexpected changes in the patient's condition.

The patient is responsible for asking questions when they do not understand what they are told or what they are expected to do.

If the plan of care is agreed upon, the patient has the responsibility to follow the plan of care or express concerns with compliance. The patient and family are responsible for following the preoperative and post discharge care plan. The patient and family are responsible for the outcomes if they do not follow the care plan.

The patient is responsible to provide an adult to transport him/her home from the facility and remain with him/her for 24 hours, if required by his/her physician.

The patient is responsible to inform his/her physician about any living will medical power of attorney, or other directive that could affect his/her care.

The patient and family are responsible for following the practice's rules and regulations concerning patient care and conduct.

Patients and families are responsible for being considerate of the practice's staff and property.

The patient and family are responsible for promptly meeting any financial obligation agreed to with the practice.

PATIENT INFORMATION

Name: _____

Address: _____

_____

City,State, Zip: _____

Phone: _____ **[ ] Home [ ] Work [ ] Other**

Phone: _____ **[ ] Home [ ] Work [ ] Other**

Phone: _____ **[ ] Home [ ] Work [ ] Other**

Ethnicity: **[ ]Hispanic or Latino [ ] Non Hispanic or Latino [ ]Other**

Race: **[ ]American Indian or Alaska Native [ ]Asian [ ]Black or African American [ ] Native Hawaian or Other Pacific Islander [ ]White or Caucasian [ ]Other or Undetermined**

Patient ID #: _____ **Sex:** **[ ] M [ ] F**

Date of Birth: _____ **Age:**

Social Security #: _____

Preferred Language: _____

Marital Status: **[ ] Married [ ] Single [ ] Divorced**

Email Address: _____

Referring Physician: _____

Primary Physician: _____

PATIENT EMPLOYMENT INFORMATION

[ ]Employed [ ]Retired [ ]Unemployed [ ]Other

Employer's Name: _____

Employer's Phone: _____

Occupation: _____

EMERGENCY CONTACTS

Name	Relationship	Phone

RESPONSIBLE PARTY *(If patient is under 18 years of age)*

Name: _____

Address: _____

_____

City,State, Zip: _____

Employer: _____

Home Phone: _____

Work Phone: _____

SSN: _____

Date of Birth: _____

PRIMARY INSURANCE

Insurance Company Name: _____

ID #: _____

Group/Policy #: _____

Subscriber's Name: _____

Subscriber's Phone #: _____

Relationship to Patient: _____

Subscriber's Employer: _____

Subscriber's SS #: _____

Subscriber's Date of Birth: _____

SECONDARY INSURANCE

Insurance Company Name: _____

ID #: _____

Group/Policy #: _____

Subscriber's Name: _____

Subscriber's Phone #: _____

Relationship to Patient: _____

Subscriber's Employer: _____

Subscriber's SS #: _____

Subscriber's Date of Birth: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor, and authorize him/her to furnish information regarding my illness to my insurance carrier. ***I understand that I am responsible for any amount not paid for by my insurance.*** I authorize the clinic to obtain medication history electronically from my pharmacy benefit administrator.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

Western Vascular Institute, PLLC

Please Print Your Name: _____

Payment Policy

Payment of Insurance and/or Medicare Benefits to Western Vascular Institute:
7165 E University Drive Suite 183, Mesa, AZ 85207-6415
Mitar Vranic, D.O., Henry Tarlian, M.D., and Cynthia Peters, CRNFA, FNP-C

I request payments be made directly to me or the provider listed on the claim for services furnished to me during the effective period of this authorization. I authorize the above listed provider(s) to release to the Social Security Administration, its intermediaries or carriers any information required for any claim to be paid and processed. I authorize the release of any information necessary to determine these benefits or the benefits payable for related services.

Patient Bill of Rights and Disclosure of Information

Your signature below indicates that you've received a "Patient Welcome Letter" that provides you with information about our organization and your rights as a patient with us.

Cancellation Policy

If you are unable to keep your appointment, you are obligated to inform our office within 24 business hours of your scheduled office visit or ultrasound appointment and 48 business hours for an in-office surgery or hospital surgery. If you do not cancel your appointment within that time frame, you will be subject to a non-cancellation fee as follows: Office visits $35.00, Ultrasounds $50.00, In-office surgery $150.00 and Hospital surgery $200.00. Your signature below acknowledges that you have read and understand our non-cancellation policy.

Consent for Electronic Chart Identification Policy

Western Vascular Institute uses an Electronic Medical Record (EMR) system to maintain your health care information. We use a digital photo to visually identify our patients. We will only use your picture for identification purposes. Your picture will never be disclosed or released outside this facility and will only be used that complies with our Notice of Privacy Practices and HIPAA law. Your signature below acknowledges that you have read and understood this policy.

Consent for Treatment & Insurance Authorization/Assignment

1. The patient or authorized representative recognizes the need for care and consents to ANY and ALL medically necessary services as ordered by the physician and at the discretion of the patient. These services may include lab procedures, medical treatment, minor or emergency surgical treatment, exam or other services rendered under the specific instructions of the physician.
2. I hereby authorize WESTERN VASCULAR INSTITUTE, PLLC to furnish information to insurance carriers concerning myself or my illness and treatment. I hereby assign to the providers of this practice ALL payments for medical services rendered to myself or my dependents. I understand that I am responsible for ANY amount NOT covered by insurance, including any attorney's fees.

By signing below you read, acknowledge and agree with the above mentioned policies, patient rights & consents.

_____ _____

Signature of Patient or Patient Representative Date

Acknowledgement of Receipt Notice of Privacy Practices

By signing below, I acknowledge that I have received the Notice of Privacy Practices of Western Vascular Institute, which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this acknowledgement.

_____ _____

Signature of Patient or Patient Representative Date

Western Vascular Institute, PLLC
Patient History Form

Patient Name: _____ Date of Birth: _____

Primary Care Physician: _____ Referring Physician: _____

Person Recording Information: _____ Relationship to Patient: _____

Current Medications and Allergies

Drug	Dosage (mg)	How many times daily?

Are you currently taking Aspirin? Yes or No

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Pharmacy:_____ Cross Roads:_____ Phone:_____

MEDICATION ALLERGIES:

_____

_____

OTHER ALLERGIES:

_____

_____

IMMUNIZATIONS:

When was your last flu shot:_____ When was your last pneumonia shot:_____

Please indicate if you have had any of the following by marking the corresponding check box.

Past Medical History

Cancer

☐ Cancer (specify type below)

_____

_____

☐ Cancer Treatment (specify below)

_____

Heart Disease

☐ Heart Disease
☐ Stroke
☐ Heart Attack
☐ High Blood Pressure
☐ High Cholesterol

Ear, Nose, Throat

☐ Ear, nose, throat problems
☐ Eye Disease
☐ Hearing Impaired

Skin

☐ Skin Disease

Musculoskeletal

☐ Arthritis
☐ Osteoporosis
☐ Chronic Back Pain
☐ Growth/Development Disorder

Endocrine

☐ Diabetes
☐ Thyroid Disease
☐ Autoimmune Disorder
☐ Kidney Disease

Respiratory

☐ Asthma
☐ Chronic Lung Disease
☐ TB

Neurological

☐ Neurological Disease
☐ Epilepsy
☐ Chronic Headaches

Psychiatric

☐ Psychiatric Illness
☐ Depression

Other

☐ Anemia
☐ Bleeding Disease
☐ Blood Transfusion
☐ Thoracic/Abdominal Aneurysm

Past Surgical History

Cardiac Surgery

☐ Heart Bypass
☐ Heart Stents
☐ Pacemaker
☐ Cardioversion
☐ Mitral Valve Replacement
☐ Other Cardiac Surgery:

_____

Lung Surgery

☐ Lung Surgery

Musculoskeletal Surgery

☐ Orthopedic Surgery
☐ Back Surgery
☐ Shoulder Surgery
☐ Foot Surgery
☐ Knee Surgery

Genitourinary Surgery

☐ Genitourinary Surgery
☐ Renal Surgery
☐ Prostate Surgery
☐ Vasectomy

Gastrointestinal Surgery

☐ Gasterointestinal Surgery
☐ Ulcer Surgery
☐ Appendectomy
☐ Colectomy
☐ Cholecystectomy
☐ Hernia Surgery
☐ Hemorrhiodectomy

***Woman Only**

☐ **GYN Surgery**
☐ **Hysterectomy**
☐ **Uterine Surgery**
☐ **Lumpectomy**
☐ **Mastectomy**
☐ **Breast Reduction**
☐ **Ovary Removal**
☐ **Tubal Ligation**

<u>Vascular</u>

☐ Carotid Surgery
☐ Aneurysm Surgery
☐ Angioplasty/Stents
☐ Amputation

Other Vascular Surgery:

_____

_____

_____

DIFFICULTY WITH ANESTHESIA OR SURGERY? NO YES (please explain)

_____

_____

Family Medical History

If you have a family history of any of the following, please indicate which family member in the space provided.

Cancer-

- ☐ Colon Cancer: Who? _____
- ☐ Lung Cancer: Who? _____
- ☐ Ovarian Cancer: Who?_____
- ☐ Breast Cancer: Who? _____
- ☐ Skin Cancer: Who? _____
- ☐ Prostate Cancer: Who? _____

Heart Disease-

- ☐ Heart Disease: Who? _____
- ☐ Stroke: Who? _____
- ☐ CAD: Who? _____
- ☐ Hypertension: Who? _____
- ☐ Hyperlipidemia: Who? _____

Diabetes/Renal-

- ☐ Diabetes: Who? _____
- ☐ Renal Disease: Who? _____

Vascular

- ☐ Abdominal Aneurysm: Who?_____
- ☐ Thoracic Aneurysm: Who?_____

Respiratory-

- ☐ Asthma : Who? _____
- ☐ Allergies: Who? _____
- ☐ COPD: Who? _____

Psych/Social-

- ☐ Psychiatric Problems: Who? _____
- ☐ Depression: Who? _____
- ☐ Substance Abuse: Who? _____

Other-

- ☐ Osteoporosis: Who? _____
- ☐ Anemia: Who? _____
- ☐ Arthritis: Who? _____
- ☐ Thyroid Disease: Who? _____
- ☐ Eye Problems: Who? _____

Other:

_____

_____

Social History

Occupation:

_____

Marital Status:

_____

History of Smoking

- ☐ Current every day smoker
- ☐ Current some days smoker
- ☐ Former smoker
- ☐ Never a smoker

Year quit:_____
Packs per day:_____

History of Drinking-

☐Yes ☐No

Alcohol frequency-

☐Frequently

☐Occasionally

☐On a Social Basis

Other Social History Comments:

_____

_____

_____

General
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Anorexia
- ☐ Fatigue
- ☐ Weight loss

ENT
- ☐ Blurred or double vision
- ☐ Vision loss
- ☐ Cataracts
- ☐ Ear ringing
- ☐ Diminished hearing

Cardiovascular
- ☐ Chest discomfort
- ☐ Skipped heartbeats
- ☐ Swelling in ankles or feet
- ☐ Fluttering feeling in chest

Respiratory
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Asthma
- ☐ Wheezing

Gastrointestinal
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Ulcers

Genitourinary
- ☐ Loss of bladder
- ☐ Blood in urine

Musculoskeletal
- ☐ Arthritis
- ☐ Back pain
- ☐ Joint pain
- ☐ Muscle weakness

Skin
- ☐ Skin rash
- ☐ Itching
- ☐ Dryness
- ☐ Lesion
- ☐ Suspicious lesions
- ☐ Ulcer

Neurological
- ☐ Memory loss
- ☐ Seizures
- ☐ Vertigo
- ☐ Weakness
- ☐ Stroke

Extremities
- ☐ Edema
- ☐ Open ulcers
- ☐ Gangrene
- ☐ Discoloration

Psychological
- ☐ Depression
- ☐ Anxiety
- ☐ Memory loss
- ☐ Unusual stress

Endocrine
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive thirst

Hematology/Lymphatic
- ☐ Breast mass/lump
- ☐ Enlarged lymph nodes
- ☐ Unexplained bruising

Allergy/Immunologic
- ☐ Hay fever
- ☐ Dust/pollen allergies
- ☐ Persistent infections

Infectious Disease

Exposed to or been recently diagnosed with
- ☐ C-diff (Clostridium difficile)
- ☐ Hepatitis
- ☐ HIV
- ☐ MRSA

Other

_____
_____
_____
_____

I have filled this form out to the best of my ability and accuracy. I understand that this form will be used to establish my past medical history in my chart.

Patients Signature: _____ Date: _____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I authorize	Western Vascular Institute, PLLC	Phone #	480-668-5000
Address:	7165 E University Drive #183	Fax #	480-668-5065
City, State , Zip:	Mesa, AZ 85207		

To release health/medical information of:

Patient's Full Name: _____ Date of Birth: _____

This information is to be released to:

Recipient: Patient Relationship to patient: Self

Recipient: _____ Relationship to patient: _____

Recipient: _____ Relationship to patient: _____

Recipient: _____ Relationship to patient: _____

I understand that the information I have agreed to release to the aforementioned party may include sensitive clinical information obtained during the dates listed below. These may or may not include treatment of substance or other abuse, HIV, psychiatric disorders, sexually-transmitted diseases, etc., unless herein except:

_____

This release includes all documents created by Western Vascular Institute, PLLC., such as but not limited to;

- Office, Chart & Progress Notes
- Ultrasound Reports
- All documents that Western Vascular Institute, PLLC that has ordered on your behalf

Covering records from:

- The date of its creation by Western Vascular Institute, PLLC, whether in the past or future.

I UNDERSTAND THIS AUTHORIZATION MAY BE REVOKED IN WRITING AT ANY TIME. THIS AUTHORIZATION SHALL REMAIN IN EFFECT UNLESS OTHERWISE REVOKED.

SIGNATURE (person authorizing release): _____

Date of Signature: _____ **Relationship to Patient:** _____