North Country Thoracic & Vascular, P.C.

45 Smithfield Blvd., Plattsburgh, NY 12901
518-314-1520

Today's Date: _____/_____/_____ **DOB:** _____/_____/_____

Patient's Name: _____

Marital Status: single married divorced/separated widowed

Street Address: _____

Mailing Address: _____

Telephone: home: (___) ___-_____ work: (___) ___-_____ cell: (___) ___-_____

Email: _____

Employer: _____

Occupation: _____

Primary Care Physician: _____

Pharmacy: _____

Primary Health Insurance: _____

Policy #: _____ Group #: _____ Seq. #: _____

Subscriber's Name:_____Subscriber's DOB:____/_____/_____

Patient's Relationship to Subscriber:_____

Secondary Health Insurance: _____

Policy #: _____ Group #: _____ Seq. #: _____

Subscriber's Name:_____Subscriber's DOB:____/_____/_____

Patient's Relationship to Subscriber:_____

IN CASE OF EMERGENCY: *please list someone with a **different** phone number than yours!*

Name: _____ Telephone: (___) ___-_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Dr. Craig Nachbauer. I understand that I am responsible for any balance. I also authorize NCTV to release any information regarding my condition to my insurance company to process my claims.

_____ _____

patient signature *date*

v. 6/12/2020

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History Form

Patient Name:_____ Date:_____ DOB:_____

How did you hear about us?_____

Allergies: _____

What is the reason for your visit?

_____

List Surgeries/Serious Injuries/Illnesses not listed below:

_____ _____
_____ _____
_____ _____

Past Medical History

Have you ever had the following?

Diabetes	yes	no
Hypertension	yes	no
Cancer	yes	no
Stroke	yes	no
Heart Disease	yes	no
High Cholesterol	yes	no
Blocked Arteries	yes	no
Easy Bleeding	yes	no
Blood Clots	yes	no
Emphysema/COPD	yes	no
Asthma	yes	no
Hepatitis	yes	no
Kidney Disease	yes	no
Varicose Veins	yes	no
Leg Ulcers	yes	no
Bronchitis	yes	no

Family History

Have any family members had the following?

			Who?
Diabetes	yes	no	_____
Hypertension	yes	no	_____
Cancer	yes	no	_____
Stroke	yes	no	_____
Heart Disease	yes	no	_____
High Cholesterol	yes	no	_____
Blocked Arteries	yes	no	_____
Easy Bleeding	yes	no	_____
Blood Clots	yes	no	_____
Emphysema/COPD	yes	no	_____
Asthma	yes	no	_____
Hepatitis	yes	no	_____
Kidney Disease	yes	no	_____
Varicose Veins	yes	no	_____
Leg Ulcers	yes	no	_____
Bronchitis	yes	no	_____

List medications, dose and reason for taking.

1)_____
2)_____
3)_____
4)_____
5)_____
6)_____
7)_____
8)_____
9)_____
10)_____

Occupational Exposure

Any occupational exposure to: fumes solvents chemicals other
Explain:_____

Social History

Marital status Single Married Separated Divorced Widowed

Tobacco

Do you smoke now? yes no
Have you ever? yes no
If yes, what? _____
Number cigarettes per/day _____
For how long? _____
If no, when did you quit? _____
Do you chew tobacco? yes no

Alcohol/Drugs

Do you drink alcohol? yes no
How many drinks/week _____

Diet

Any special diet? yes no _____

Exercise

Do you exercise regularly? yes no
If yes, what kind?_____

Review of Symptoms:

Difficulty breathing	yes	no	Easy Bruising/Bleeding	yes	no
Cough	yes	no	Weakness of arm or leg	yes	no
Chest pain/pressure	yes	no	Numbness or tingling	yes	no
Rapid heart rate	yes	no	Pain in legs when walking	yes	no
Irregular heart rate	yes	no	Varicose Veins	yes	no
Swelling in ankles	yes	no	Weight loss	yes	no

Comments:_____
_____

Vein Patients Complete the Following

Have you had any vein procedures? yes no R leg L leg Both
If yes, what procedure? _____ When?_____

Do you have any of the following?

Aching/pain	yes	no	Leg	R	L
Tired legs	yes	no	Leg	R	L
Heaviness	yes	no	Leg	R	L
Itching/burning	yes	no	Leg	R	L
Swelling	yes	no	Leg	R	L
Cramping	yes	no	Leg	R	L
Throbbing	yes	no	Leg	R	L
Ulcers	yes	no	Leg	R	L
Discoloration	yes	no	Leg	R	L
Restless Leg	yes	no	Leg	R	L

Conservative Measures

Have you used any of the following?
Medication? yes no What?_____
Elevation? yes no
Compression hose? yes no
If so, what compression?_____
Length of time worn _____wks/mos/yrs.

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for NORTH COUNTRY THORACIC & VASCULAR, P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations. (The NOTICE of Privacy Practices provided by NORTH COUNTRY THORACIC & VASCULAR, P.C. describes such uses and disclosures more completely and can be requested at any time.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. PRACTICE reserves the right to revise its NOTICE of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Sharalyn Nachbauer at NORTH COUNTRY THORACIC & VASCULAR, P.C.

With this consent, NORTH COUNTRY THORACIC & VASCULAR, P.C. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TREATMENT, PAYMENT, and HEALTH CARE OPERATIONS, such as appointment reminder, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, NORTH COUNTRY THORACIC & VASCULAR, P.C. may e-mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, and HEALTHCARE OPERATIONS, such as appointment reminder cards and patient statements. I have the right to request that NORTH COUNTRY THORACIC & VASCULAR, P.C. restrict how it uses or discloses my PHI to carry out TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow NORTH COUNTRY THORACIC & VASCULAR, P.C. to use and disclose my PHI to carry out treatment, payment, and health care operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, NORTH COUNTRY THORACIC & VASCULAR, P.C. may decline to provide treatment to me.

_____ _____
Signature Date

_____ _____
Printed Name Name of Legal Guardian if Applicable

WE ARE REQUIRED TO PROVIDE A COPY OF THIS FORM UPON REQUEST

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Patient Financial Policy

Patients are responsible for payment in full for all portions of services due at the time services are provided by our office. A valid insurance card must be presented at every visit and as needed throughout your care.

If you do not show up for an appointment, or you cancel an appointment with the doctor or PA within 24 hours of the scheduled appointment, a missed appointment fee of $50 may be charged.

If you do not show up for an ULTRASOUND appointment, or you cancel the appointment within 48 hours, a missed appointment fee of $100 may be charged.

If you do not show up for a scheduled In-Office procedure, or you cancel the appointment within seven business days, a missed appointment fee of $500 may be charged.

Commercial Insurance Carriers: We will bill most insurances for you. It is the patient's responsibility, ALWAYS, to verify service coverage. Any outstanding balances, co-payments, and deductibles are due prior to checking in for your appointment.

Medicare: Our office is a Medicare participating provider and we will bill Medicare for you. We will bill your secondary insurances that automatically crossover through the Medicare system. Any outstanding balances and deductibles are due prior to your appointments. Any co-insurance and non-covered services will be due as services are rendered.

Medicaid and Fidelis: Our office is a participating Medicaid and Fidelis provider and we will bill Medicaid and Fidelis for you. Any outstanding balance, co-payments, and non-covered services are due prior to your appointments. It is YOUR responsibility to verify coverage for each and every appointment.

Methods of Payments: *Occasionally,* arrangements can be made with our office to make payments if you are in a situation that prevents you from paying in full at the time of the visit. These situations are evaluated on a case-by-case basis, and the decision is at the sole discretion of North Country Thoracic &Vascular. **If payments are not received as scheduled, a late fee may be applied.** If bills become overdue, you may be discharged from our care until they are current.

Our office accepts the following methods of payment for in office payment: Cash, Personal Check, Major Credit Cards, and Money Order. *A $50 charge will be applied if your check is returned for any reason.*

****

X_____ _____

Patient or Responsible Party Signature *Date*

_____

Printed Name

v.6/12/2020