Vascular Center
of Northern Michigan

PATIENT REGISTRATION INFORMATION

PATIENT FULL NAME_____ DATE_____

ADDRESS_____SS #_____

CITY_____STATE_____ZIP_____HOME #_____

DATE OF BIRTH_____AGE_____ MALE ___ FEMALE___ CELL #_____

EMAIL_____ LANGUAGE_____WORK #_____

- ✓ Your Email is for the patient portal – your online connection to your records.

REFERRING PROVIDER:_____MD / DO / PA / NP

PRIMARY CARE PROVIDER:_____MD / DO / PA / NP

CIRCLE ETHNICITY*:*

HISPANIC
NON HISPANIC
UNKNOWN

CIRCLE RACE*:*

WHITE AMERICAN INDIAN / ALASKAN NATIVE
ASIAN / PACIFIC ISLANDER BLACK / AFRICAN AMERICAN
HISPANIC UNKNOWN

ALTERNATE ADDRESS AND PHONE #_____

EMPLOYER_____

INSURANCE INFORMATION:

PLEASE PRESENT YOUR INSURANCE CARD (S) TO THE RECEPTIONIST SO THAT WE CAN MAKE A COPY FOR A BILLING REFERENCE.
PLEASE PRESENT YOUR DRIVERS LICENSE OR A PICTURE ID TO THE RECEPTIONIST.

NOTE: The subscriber's date of birth is needed in order to bill the insurance company. This is due to the Health Insurance Portability and Accountability Act (HIPAA) changes. In addition, we need to know which insurance company to bill first; otherwise, you may be denied benefit payment if the claim is billed in the improper sequence.
Thank you

IS THIS WORK RELATED? YES___NO___ IS THIS AN AUTO ACCIDENT? YES___NO___ IF YES, PLEASE BRING YOUR CLAIM #

PRIMARY INSURANCE_____

ID #_____GROUP #_____

SUBSCRIBER NAME_____SUBSCRIBER DATE OF BIRTH_____

SECONDARY INSURANCE_____

ID #_____GROUP #_____

SUBSCRIBER NAME_____SUBSCRIBER DATE OF BIRTH_____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I am aware that the Vascular Center of Northern Michigan (VCNM) has a copy of the notice of privacy practices for me to review, if I choose.

I hereby give consent for VCNM's notice to use, disclose and receive protected health information (PHI) about me to carry out treatment, payment, and health care operations. VCNM's notice of privacy provides a more complete description of uses and disclosures.

I have the right to review the notice of privacy practices prior to signing this consent. VCNM 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 VCNM office at 3930 Cedar Run Road, Traverse City, MI 49684

With this consent, VCNM may mail or call my home or other alternative location (that I name) and leave a message in reference to any items that assist the practice in carrying out treatment, payment, and health care operations, such as appointment reminders, test or pathology results, insurance items, recommended procedures, diagnostic testing, reminder cards and patient statements pertaining to my clinical care.

With this consent, VCNM has my permission to release any and all medical information to the following person (only one) other than your doctors. (Re: information such as: surgical, diagnostic testing, billing, etc.)

Name of representative _____ Phone #_____
Relationship_____

SPOUSE NAME IF APPLICABLE_____PARENT (IF MINOR)_____

EMERGENCY CONTACT (OTHER THAN SPOUSE) _____ RELATIONSHIP_____PH#_____

I have the right to request that VCNM 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 request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to VCNM use and disclosure of 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, VCNM may decline to provide treatment to me. By signing this consent, I am acknowledging receipt of this practice's notice of privacy practices for review.

Signature_____ Date_____
Legal guardian's name_____

FINANCIAL RESPONSIBILITY

- The Vascular Center of Northern Michigan participates with Medicare, Blue Cross and Blues Shield, Blue Care Network, Priority Health, Cofinity, Tricare, Medicare Advantage, BCN Advantage, Cigna, Aetna, Humana, Medicaid, Meridian, and McLaren. We accept the approved amount for services rendered as designated by the insurance company, excluding any co-pays, co-insurances and or deductibles, at which time this becomes the patient's responsibility.
- Vascular Center of Northern Michigan will bill your insurance carrier. Any co-pays will be collected at the time of service.
- After billing your insurance or insurances any remaining balance will be forwarded to you and becomes your financial responsibility.
- **NO INSURANCE** – If you have no insurance coverage you are responsible for all services rendered at the time of your visit – VCNM and yourself should have discussed the approximate amount of your visit and it will be noted in your chart. We do offer **financial arrangements, but they must be made prior to your appointment.** We do accept Visa and Master Card for your convenience.
- I hereby authorize my insurance carrier to make payment for service rendered directly to VCNM. The remaining balance will become my responsibility.
- I hereby authorize the VCNM to release any information acquired in the course of my examination or treatment to my insurance carrier, attending physician or Attorney in order to obtain payment.
- I understand I am fully responsible for all charges incurred whether or not paid by my Insurance carrier. I have read and agree to the terms and financial policies stated above.

- **Signature_____Date_____**
- **Legal guardian's name_____**

MEDICAL HISTORY

NAME_____ DATE OF BIRTH _____ HEIGHT_____

ARE YOU IN PAIN AT THIS TIME? YES / NO HOW MUCH PAIN 1 – 10 _____

PRESCRIPTIONS (BRING LIST IF YOU HAVE ONE)

NAME	DOSE (MG) FREQUENCY	NAME	DOSE (MG)FREQUENCY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PAST MEDICAL HISTORY (CHECK ALL THAT APPLY)

__GLAUCOMA	__DIABETES	__VARICOSE VEINS	__TUBERCULOSIS
__EMPHYSEMA/COPD	__HYPOTHYROIDISM	__STROKE	__ASTHMA
__BLOOD DISORDER	__MIGRAINES	__ULCER / GASTRITIS	__SCARLET FEVER
__HYPERTENSION	__HEART MURMUR	__SKIN CONDITION	__HEPATITIS
__IRREGULAR HEART BEAT	__ARTHRITIS	__HIGH CHOLESTEROL	__KIDNEY STONES
__HEART VALVE DISEASE	__PERIPHERAL VASCULAR DISEASE (PVD)		__RHEUMATIC FEVER

CANCER (TYPE)_____WHEN_____
OTHER_____

MEDICATION ALLERGIES

NO MEDICATION ALLERGIES ☐

NAME _____REACTION _____
NAME _____REACTION _____
NAME _____REACTION _____

PREVIOUS SURGICAL HISTORY

PROCEDURE	DATE	PROCEDURE	DATE
CAROTID ENDARTERECTOMY RT / LT	_____	CORONARY ARTERY BYPASS	_____
ANEURYSM	_____	JOINT REPLACEMENT	_____
CATARACT REMOVAL RT / LT	_____	APPENDECTOMY	_____
HYSTERECTOMY	_____	TUBAL LIGATION/VASECTOMY	_____
MASTECTOMY RT / LT	_____	PROSTATE SURGERY	_____
THYROID SURGERY	_____	CHOLECYSTECTOMY (GALLBLADDER)	_____
VEIN STRIPPING RT / LT	_____	VEIN SCLERO RT / LT	_____

OTHER_____

_____

FAMILY HISTORY - PLEASE IDENTIFY ***PARENTAL MEMBER(S)*** FOR ALL THAT APPLY

HYPERTENSION_____ DIABETES_____
HEART DISEASE_____ HEPATITIS_____
THYROID DISEASE_____ HIGH CHOLESTEROL_____
SKIN CANCER_____ BREAST CANCER_____
LUNG CANCER_____ COLON CANCER_____
OSTEOPOROSIS_____ MENTAL ILLNESS_____
ALCOHOLISM_____ OTHER_____
OTHER_____

PARENTS

FATHER: AGE_____ LIVING / DECEASED – CAUSE _____
MOTHER: AGE_____ LIVING / DECEASED – CAUSE _____

SOCIAL HISTORY

OCCUPATION_____FULL TIME_____PART TIME_____
EVER SMOKE? YES / NO PIPE_____ CIGARETTES_____PACK PER DAY_____
YEARS SMOKING_____ DATE QUIT_____
MARITAL STATUS _____ NUMBER OF CHILDREN_____
ALCOHOL HISTORY NONE_____ OCCASIONAL_____ DRINKS PER WEEK_____
HEAVY – DRINKS PER DAY_____ TYPE_____

NONPRESCRIPTION DRUG USE

__ANTACIDS __ASPRIN __TYLENOL __DIET __OTHER (NARCOTICS, MARIJUANA, ETC.)

IV DRUG USE EVER? YES / NO WHEN_____HERBAL SUPPLEMENTS_____

REGULAR EXERCISE YES / NO (TYPE) _____
FOREIGN TRAVEL IN THE LAST YEAR? YES / NO WHERE / WHEN_____

Vascular Center of Northern Michigan

Name:_____ Date of Birth:_____

Please mark **ALL** of the bubbles – do not leave any unmarked

Constitutional

fever	O Yes O No
chills	O Yes O No
night sweats	O Yes O No
sleeping problems	O Yes O No

Ophthalmology

diminished vision	O Yes O No
drainage from eyes	O Yes O No
blurring of vision	O Yes O No

ENT/Respiratory

cold	O Yes O No
cough	O Yes O No
hearing loss	O Yes O No
frequent sinus infections	O Yes O No

Cardiology

shortness of breath	O Yes O No
palpitations	O Yes O No
chest pain	O Yes O No

Gastroenterology

abdominal pain	O Yes O No
gas	O Yes O No
heartburn	O Yes O No
nausea	O Yes O No

Turn Page Over

Vascular Center of Northern Michigan

Name:_____ Date of Birth:_____

Gastroenterology

vomiting O Yes O No

constipation O Yes O No

Genitourinary

difficulty urinating O Yes O No

increased urinary frequency O Yes O No

Constitutional

blood in Urine O Yes O No

burning with urination O Yes O No

Neurology

headache O Yes O No

seizures O Yes O No

Musculoskeletal

leg cramps O Yes O No

back pain O Yes O No

joint pain O Yes O No

Endocrinology

fatigue O Yes O No

cold intolerance O Yes O No

heat intolerance O Yes O No

Psychology

anxiety O Yes O No

depression O Yes O No

Vascular Center
of Northern Michigan

Michael Colburn, MD, F.A.C.S.
Vascular and Endovascular Surgery

Michael Boros, MD, F.A.C.S.
Vascular and Endovascular Surgery

Matthew Roos, MD
Vascular and Endovascular Surgery

Date:_____

Dr. Colburn, Dr. Boros, Dr. Roos and the staff at the Vascular Center would like to thank you for choosing our office for your vascular care. Please take a moment to let us know how you heard about us. We appreciate your feedback and thank you for your time.

Physician_____

Friend or Family_____

TV 7 & 4_____

TV 9 & 10_____

Record Eagle_____

Community Sponsorship_____

Internet_____

Yellowbook_____

AT & T_____

GT Women or Traverse Magazine_____

Other_____

May we thank someone for your referral? (Your name will remain confidential)

_____

WHY WE ASK FOR YOUR EMAIL ADDRESS

What Is the "Patient Portal"?

The patient Portal allows our patients to communicate with their physicians easily, securely, and reliably over the internet.
The interface is user –friendly and presents all of the information needed for our patients to connect with our physicians and pro-actively participate in the management of their healthcare.

What are the benefits?
You can:

- View the date and time of upcoming appointments.
- Request prescription refills from your specific, pre-populated list of currently refillable prescriptions.
- Review your account statement.
- Send secure messages to our staff.
- Update your demographic information.
- Complete medical questionnaires and history forms online, saving you time in our office.

Is it secure?
Yes! The Patient Portal is hosted on a secure data center using Hypertext Transfer Protocol with SLL technology (HTTPS) to provide encrypted communication between our patients and our office.
Each patient is given a password at the practice upon enrollment. Upon the first log-in at home, you are prompted to create your own password, and your own security question and answer. Password strength rules are enforced.

"But I don't want my personal information in my email…"
Vascular Center of Northern MI will never send your Protected Health Information (PHI) over regular email. You will receive a notification in your email inbox whenever new information is available for you to view. You will ALWAYS need to enter your username and password in order to access PHI.

How do I get to the Patient Portal?
You can access the Patient Portal two ways:
When you register with our practice to enable your access, an email is automatically sent to the email address you provide which contains the link to the Patient Portal.
You can always access the Patient Portal by going to our website, **vascularcentermi.com**, and clicking on the "Patient Portal" button.

What if I have questions when I get logged in?
Call us! We are here in the office Monday-Thursday 7:30am-5:00pm, Friday 7:30am-3:00pm to assist you with any questions you have when working with Patient Portal. If you forget your password, there is a link under the login that will allow you to reset your password without having to call for support.

Patient Information	
Name:_____ Address:_____ _____	Phone Number:_____ E-mail Address:_____ Date of Birth:_____

Vascular Center of Northern Michigan, Dr. Colburn, Dr. Boros, and Dr. Roos, participates in a Community Health Information Exchange (Community HIE) operated by Northern Physicians Organization, Inc. (NPO). The Community HIE is also connected to the Michigan Health Information Network (MiHIN), which is the statewide health information exchange. This Community HIE and MiHIN are tools that we and others involved in your care can use to carry out your treatment and engage in health care operations activities to help manage your care such as coordinating your care, conducting quality assessment and improvement activities, patient safety activities and related planning and management activities that do not include treatment. The Community HIE also allows us to see a longitudinal view of your care.

☐ I opt-out of the NPO Community HIE.

- OR -

☐ I understand that by signing this form, I agree to participate in the NPO Community HIE and agree to allow the providers involved in my health care to talk to each other about my care, electronically share my health information with each other to give me better care, and to use my information in health care operations.

WHAT MAY BE DISCLOSED: I authorize my Provider to disclose all of my health information, including demographic information, allergies, medications, immunizations, lab reports, problems and diagnosis, mental health conditions, birth control and abortion, alcohol or drug use problems, my care plan, health care providers, sexually transmitted diseases (STDs), HIV/AIDS, and genetic diseases or test results. This includes information created before and after the date of this Authorization.

WHO MAY RECEIVE THE INFORMATION:

(1) I authorize my Provider to disclose my health information to NPO, its participating physicians, physician groups, care plan manages, labs, pharmacies, and others involved in my care that have entered into a written agreement with NPO, before or after the date of this Authorization; and

(2) I authorize NPO to disclose my health information to

(a) NPO's participating physicians and physician groups that have entered into a written agreement with NPO, before or after the date of this Authorization;

(b) other health care service providers (*e.g.*, labs and hospitals) that have entered into a written agreement with NPO, before or after the date of this Authorization, where they have agreed to comply with HIPAA and Michigan privacy laws; and

(c) MiHIN and its network of physicians, physician groups, and other health care service providers, who have agreed to comply with HIPAA and Michigan privacy laws.

PURPOSES: I allow disclosure of my health care information for medical treatment, to coordinate care among my providers, for patient safety and population health management activities, and to improve my provider's health care operations.

EXPIRATION: If not previously revoked, this Authorization will expire on the *earliest of* the following: **(i)** upon my death, **(ii)** when my Provider ceases its relationship with NPO, **(iii)** NPO ceases operation of the Community HIE, or **(iv)** if I am under eighteen, when I turn eighteen.

REVOCATION: I can revoke this Authorization at any time by giving written notice to my Provider. I understand that my revocation does not apply to any information already released as a result of this Authorization.

ADDITIONAL RIGHTS: I understand that I have additional rights under HIPAA, including the right to request restrictions on certain uses and disclosures of my health information, the right to inspect and copy my health information, and the right to request amendments to my health information, and that these rights are further explained in my Provider's Notice of Privacy Practices. I am entitled to a copy of this Authorization. I also understand that I may refuse to sign this Authorization, and that the Provider cannot deny or refuse to provide treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

POTENTIAL FOR RE-DISCLOSURE: I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient, in which case it may no longer be protected under the HIPAA Privacy Rule.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian or Personal Representative Date

Michael D. Colburn, MD, FACS
Michael J. Boros, MD, FACS
Matthew G. Roos, MD

E-Prescribing Consent Form

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribe program. These include:

- **Formulary and benefit transactions –** Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions –** Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification –** Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescriptions has been picked up, not picked up or partially filled.

By signing this consent form, you are agreeing that Michael Colburn, MD, Michael Boros, MD or Matthew Roos MD can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Michael Colburn, MD, FACS, Michael Boros, MD, or Matthew Roos, MD to enroll me in the E-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____
Print Patient Name Patient's Date of Birth

_____ _____
Signature of Patient **or** Relationship to Patient if the Guardian
Signature of Guardian if Patient is unable to sign

_____ _____ _____
Local Pharmacy of Choice City Date