Vascular & Endovascular Center
of Western New York

Thank you for choosing Vascular & Endovascular Center of WNY. We look forward to providing you with quality vascular care.

Your appointment is scheduled for:

Date: ______________________________ Time: ___________________ am/pm

□ **2121 Main Street, Suite 316, Buffalo, NY 14214 (Seton Professional Building)**

□ **4949 Harlem Road, Suite 302, Amherst, NY 14226 (University Orthopedics Building)**

□ **One Colomba Dr., Suite 3, Niagara Falls, NY 14304 (Witmer Park Medical Center)**

In order to prepare for your upcoming visit, please fill out (use blue/black ink) the enclosed **Patient Registration** and **Patient History Forms** and bring with you to your initial visit. Please read, sign and bring in the **Financial Policy** sheet and the **HIPAA Privacy Waiver.**

Additionally, we ask that you also bring:

- Insurance Card(s); insurance referrals; co-pay or co-insurance (please note that we will gladly accept your personal check and/or all major credit cards)
- Photo ID
- **Films of any MRI, MRA, CT or CTA you may have had done previously (disc or printed films are accepted)**

Once again, thank you for choosing Vascular & Endovascular Center of WNY. If you have any questions, please feel free to call our Buffalo/Amherst Office at 716-837-2400 or our Niagara Falls Office at 716-371-2456.

Sincerely,

Joseph M. Anain Sr., MD, FACS
Paul M. Anain, MD, FACS, RPVI
Roger Walcott, MD, FACS, RPVI
Aimee Swartz, MD, RPVI
Gregory T. Clabeaux, DO
Sara Clouden, MS, PA-C
Leah M. Gorski, MS, PA-C

The physicians and staff at Vascular & Endovascular Center of WNY feel that we can better serve your health care needs if you are familiar with following policies and procedures:

1. Our staff is available to take your phone calls:
    - Monday; 10 am – 5:30 pm
    - Tuesday; 8 am – 4:30 pm
    - Wednesday; 8 am – 4 pm
    - Thursday; 8 am – 4:30 pm
    - Friday; 8 am – 3 pm

    The answering service will assist you after these hours.

2. Office visits are by appointment.

3. In an attempt to minimize everyone's time in the waiting room, we must advise that if patients are more than 20 minutes late for an appointment, they may need to reschedule their visit.

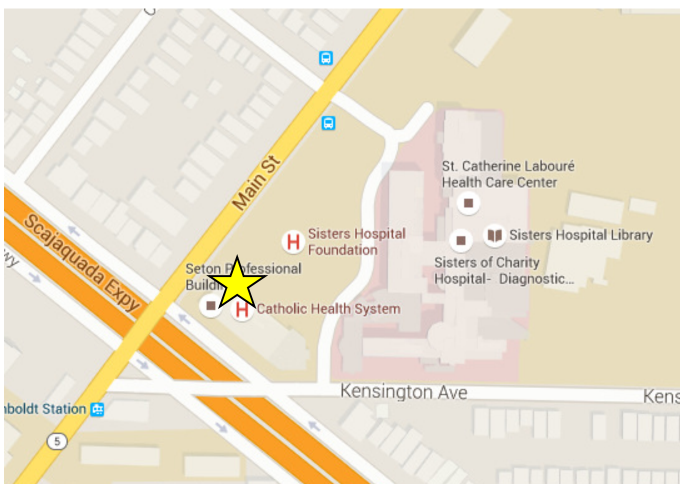
4. In order to provide you with the highest quality of care possible, we ask that you bring a current medication list to each visit.

5. All medication refill requests are handled electronically, please allow 48 business hours for completion of your request.

6. Disability paperwork and FMLA paperwork will be completed within 5 business days of a qualifying event (discharge from hospital, receipt of paperwork (non-inpatient hospitalization).

7. Your insurance policy may require a referral to see a specialist. As a courtesy, we will make one call to your primary care physician to obtain this referral. However, your health care coverage is a contract between you and the insurance company and it is ultimately your responsibility to make sure the referral is in place.

Locations & Directions



Buffalo Office

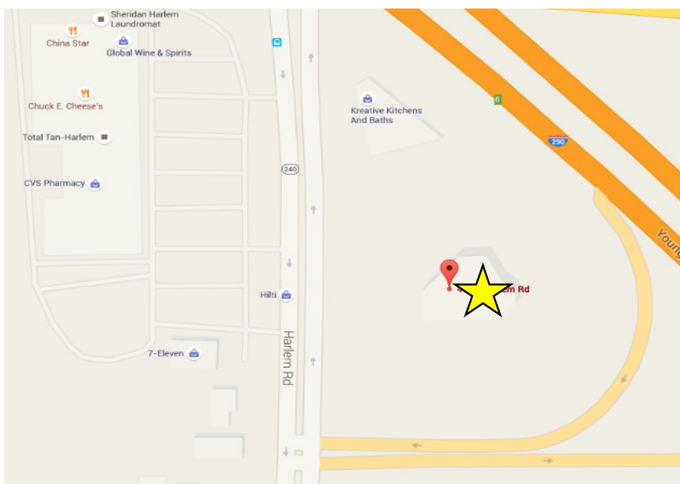
Located in the Seton Professional Building, next to Sisters of Charity Hospital.
Please park in the visitor's parking lot & bring in your parking ticket for validation

From the 190 North or South:

- 190 South
- Scajaquada Expy (NY-198)
- Main Street exit
- Left onto Main Street (NY-5)
- Right into Sisters of Charity Hospital Campus

From the Kensington Expressway (NY-33)

- Scajaquada Expy (NY-198)
- Main Street exit (NY-5)
- Merge onto Humboldt Prkwy
- Right onto Kensington
- Left into Sisters of Charity Hospital Campus



Amherst Office

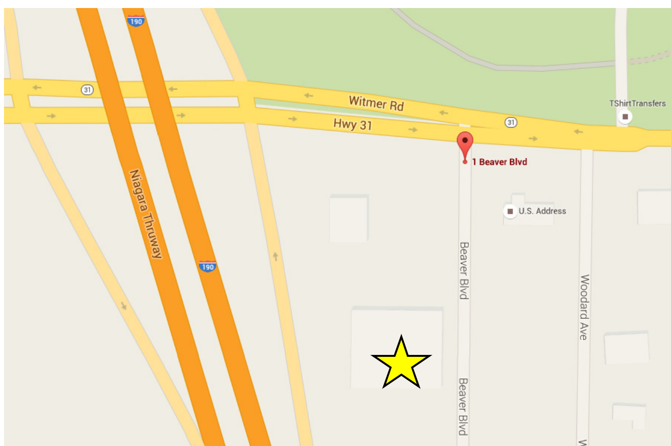
Located in the University Orthopedics Building

From Niagara Falls/Northtowns

- Robert Moses Parkway South
- I-190 South
- I-290 East
- Exit Harlem Road
- Right onto Harlem Road

From Southtowns:

- I-90 East
- Merge into I-290
- Exit Sheridan Drive
- Left onto Sheridan Drive
- Left onto Harlem Road



Niagara Falls Office

Located in the Witmer Park Medical Center

From Northtowns:

- I-190 North
- Exit Witmer Road
- Right on Witmer Road
- Right onto Colomba Drive (formerly Beaver Blvd.)

From Lewiston:

- I-190 South
- Exit Witmer Road
- Left onto Witmer Road
- Right onto Colomba Driver (formerly Beaver Blvd.)

Vascular & Endovascular Center
of Western New York

Financial Policies

We are dedicated to providing the best possible care for you and we want you to completely understand our financial policies:

Insurance Information/Assignment of Benefits

Patients are required to provide VEC of WNY with current and accurate insurance information at every visit. Your failure to provide us with accurate information will result in a patient bill that you may be held responsible for. By signing below, you authorized VEC of WNY to furnish information to insurance carriers concerning your illnesses and treatments and hereby assigning all payments for medical services rendered to you to Vascular & Endovascular Center of WNY. Furthermore, you will be held responsible for any amount not covered by your insurance plan.

Co-payments, Co-insurance

As part of your agreement with your insurance provider, you co-pay is due at the time of service. VEC of WNY accepts cash, check or credit card.

Deductibles

If you have a deductible with your insurance plan, or a Point of Service Plan, you are required to pay for a portion or all of your medical services. Because electronic health insurance verification systems are not always current, VEC will fill your claim and you will be billed for any deductible payments due.

Private Payments

Private payment for services rendered are due at the time of treatment. If you will be paying privately for services, please call the office for a current fee schedule.

In accordance with HIPAA regulations, you have the right to private pay for services rendered that are not reported to any insurance carrier. If you wish to restrict access to your medical records that fall into this category, please ask to speak with the office manager for more information and additional paperwork.

Returned Check Fees

VEC of WNY will assess a $25 fee for all checks returned for insufficient funds.

Unpaid Balances

If for any reason, you maintain an unpaid balance on your account and fail to work out a payment arrangement with us, after 120 days, your account will be turned over to a collection agency and proceedings will begin. Accounts sent to collections will have a collection fee added to the balance.

I have read and agree to all of the above policies. I understand and agree that such terms may be amended by the practice from time to time, and that I will be notified of any changes.

PLEASE KEEP THIS COPY FOR YOUR RECORDS, YOU WILL BE ASKED TO SIGN AN ACKNOWLEDGEMENT OF RECEIPT UPON ARRIVAL FOR YOUR APPOINTMENT.

Vascular & Endovascular Center of WNY

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Registration Form

Today's Date:						
PATIENT INFORMATION						
Last Name:		First Name:			Middle Initial:	
Date of Birth:	Gender: ☐ F ☐ M	Social Security No:	Pharmacy Name & Phone Number:			
Mailing Address:		City:		State:	Zip Code:	
Home Phone:		Cell Phone:		Other Phone:		
Occupation:		Employer:		Employer Phone:		
Who referred you to our practice?						
Who is your primary care physician?						
Why were you referred to our practice?						
INSURANCE INFORMATION						
(PLEASE BRING YOUR INSURANCE CARDS TO EVERY APPOINTMENT)						
Primary Insurance Carrier:						
Policy Number:				Group Number:		
Secondary Insurance Carrier (if applicable):						
Policy Number:				Group Number		
Worker's Compensation Information (if applicable)						
Carrier:		Claim Number:		Address of Carrier:		
Date of Injury:		Are You Presently Working?: ☐ Yes ☐ No		Contact Person for Insurance Carrier:		
IN CASE OF EMERGENCY						
Name of local friend or relative (not living at same address):		Contact Number:		Alternative Number:		Relationship:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorized VASCULAR & ENDOVASCULAR CENTER OF WNY to release any information required to process my claims.

____ __________________

Patient/Guardian Signature Date

Vascular & Endovascular Center
of Western New York

HIPPA Compliant Patient Consent Form

New York State law prohibits our medical office staff from speaking with any individual other than you regarding any of your medical health information. This include information regarding your condition, medications, appointments, or test results. Patients have the right to privacy and confidential records. You have the right to give consent so that protected health information (PHI) may be disclosed so that our office can carry out our treatment, obtain payment, and conduct healthcare operations. Vascular & Endovascular Center of WNY Notice of Privacy Practices & Policy provides a more complete description of the law and health information disclosures. Patients have the right to view this notice and copies are available at our office.

Vascular & Endovascular Center of WNY will need your consent to be able to call your home with messages regarding health information and appointments. We will also need your consent to allow us to discuss your health information with anyone else. Your consent will be noted as you complete the form below. We will witness your signature. Please note, copies of your records will automatically be sent to your referring physician and primary care physician, unless otherwise specified by you.

____ ____________________

Patient Printed Name Date of Birth

I give my consent for Vascular & Endovascular Center of WNY to use and disclose my PHI to carry out healthcare operations. With this consent, VEC of WNY may mail items or call my home (or other alternate locations) to facilitate treatment, payment and healthcare operations. They may leave messages concerning health information (such as appointment reminders, payment questions and clinical care) on voicemail, or message machines.

I ALSO GIVE MY CONSENT TO VEC OF WNY TO SPECIFICALLY SPEAK WITH (PRINT NAMES AND RELATIONSHIPS):

VEC of WNY may speak with the above named individual(s) regarding any of my health information including, but not limited to clinical information, physician advice and treatment, appointments and payment information.

I have read and understood all of the above information.

____ __________________

Signature of Patient or Representative Date

Vascular & Endovascular Center
of Western New York

ORIGINAL DATE: ____________

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.) ____________________________________ M F DOB ________/________/________

PERSONAL MEDICAL HISTORY Indicate any medical problems that other doctors have diagnosed

	ASTHMA		HEART ATTACK (MYOCARDIAL INFARCTION)
	AAA (ABDOMINAL AORTIC ANEURYSM)		HEART DISEASE (CORONARY ARTERY DISEASE)
	ATRIAL FIBRILATION		HEART MURMUR PE (PULMONARY EMBOLISM)
	ARTHRITIS		HIGH BLOOD PRESSURE (HYPERTENSION)
	BACK PAIN		HIGH CHOLESTEROL (HYPERCHOLESTEROLEMIA)
	BLEEDING DISORDER (PLEASE SPECIFY): ____		HYPERTHYROID HYPOTHYROID
	COPD		LYMPHEDEMA
	CANCER (TYPE):_______________________________		MITRAL VALVE PROLAPSE
	CAROTID ARTERY STENOSIS		PERIPHERAL ARTERIAL/VASCULAR DISEASE (PAD/PVD)
	CONGESTIVE HEART FAILURE		RAYNAUD'S DISEASE
	DVT (DEEP VEIN THROMBUS)		SEIZURE DISORDER
	DIABETES TYPE I TYPE II		SLEEP APNEA
			STROKE

OTHER MEDICAL PROBLEMS:
____
____
____
____

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Name: ____ Date of Birth: ___________________

SURGICAL HISTORY Please list any prior surgical procedures you've had

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FAMILY HISTORY

	Indicate family member
AAA (ABDOMINAL AORTIC ANEURYSM)	
HIGH BLOOD PRESSURE (HYPERTENSION)	
DVT (DEEP VEIN THROMBUS)	
PE (PULMONARY EMBOLISM)	
HEART DISEASE (CORONARY ARTERY DISEASE)	
CAROTID ARTERY STENOSIS	
HIGH CHOLESTEROL (HYPERCHOLESTEROLEMIA)	

ARE YOU A SMOKER? _____ YES ______ NEVER ________ FORMER

If yes: _______________ packs per day ___________ number of years smoking

Former: _______________year you quit

Name: ____ Date of Birth: __________________

LIST your prescribed drugs and over-the-counter drugs (including vitamins, supplements and inhalers):

Name Strength Frequency taken

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Allergies:

Name of drug Reaction

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