1836 Florida Avenue
Panama City, Florida 32405

10800 PCB Parkway, Unit #300
Panama City Beach, Florida 32407

Ph: (850) 872-8510 • www.ArteryandVeins.com • Fax: (850) 872-7412

"Committed to making a difference in the quality of life in those we serve and those with whom we work"

Patient Information

Today's Date:__________

Social Security Number:_____-____-_____

First Name: ___________________________ M.I. ______ Last Name: __________________________ Suffix:_____

Gender: Male or Female Date of Birth: ____/____/____

Marital Status: Single Married Divorced Widowed Legally Separated

Race: _______________ Ethnicity: Not Hispanic/Latino or Latino/Hispanic Primary Language: ____________

Mailing Address:______________________________________ Apt./Unit#: _____________

City: ____________________________________ State: ________ Zip: ________

Check if Physical Address is the same as the mailing address, if not please complete:

Physical Address:______________________________________ Apt./Unit#: _____________

City: ____________________________________ State: ________ Zip: ________

Email Address: ____

***Please list phone number in the order in which you would like to be contacted. Thank you!**

1st: (________) ____________________ Home Cell Work (**this number will be used for confirmation calls)**

2nd: (________) ____________________ Home Cell Work

3rd: (________) ____________________ Home Cell Work

Emergency Contact: _______________________ ____________________ (_____) ____________________
Name **Relationship** **Phone**

Pharmacy: ______________________ ___________________________ (_____) ____________________
Name **Address** **Phone**

Primary Care Physician: ______________________

Please continue on reverse side

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Insurance Information

Patient Name:____

Primary Insurance:___________________________________ **ID #**____

Insured's Name:___________________________**DOB:**_________________**SSN:**______________________

Secondary Insurance: _________________________________ **ID #**___________________________________

Insured's Name:___________________________**DOB:**_________________**SSN:**______________________

Acknowledgement of Privacy Practices

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Vascular Associates, LLC to use and disclose my protected health information to carry out:

-Treatment (including direct or indirect treatment by other healthcare providers involved in my care)

-Obtaining payment from third party payers (e.g. my insurance company)

-Healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of Vascular Associates' Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that Vascular Associates reserves the right to change the terms of this notice from time to time and that I may request the most current copy of the notice at any time.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, obtain payment and maintain health care operations, but that Vascular Associates is not required to agree to these requested restrictions. However, if Vascular Associates does agree, it is bound to comply with those restrictions.

I understand that I may revoke this authorization, in writing, at any time. However, any disclosure that occurred prior to the date I revoke the consent is not affected.

I authorize the release of any healthcare information necessary to submit claims to my insurance company, and request payment of benefits to Vascular Associates, LLC.

Printed Name___________________________________

Signature of Patient/ Legal Representative:_______________________________________ Date:________________

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Release of Information

Patient Name:____**DOB:**____________________

I authorize the following individuals to retrieve/discuss any and all of my medical information and make/cancel appointments as directed below. I can refuse to sign this form, or revoke it at any time by completing a revocation form. I understand that if information is shared with the below individuals it may be subject to exposure by the individual.

Name: ____________________ Phone: (____)________________ Relationship:________________

Name: ____________________ Phone: (____)________________ Relationship:________________

Name: ____________________ Phone: (____)________________ Relationship:________________

I do not authorize anyone other than myself to retrieve/discuss my information to include making/canceling appointments on my behalf.

Printed Name____________________________

Signature of Patient/ Legal Representative:______________________________ Date:____________

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Practice Financial Policy

Vascular Associates has a financial policy that clearly outlines patient and practice financial responsibilities. We are committed to making a positive difference in lives of our patients by providing the best possible, and most cost effective, medical care. This financial policy has been established with these objectives in mind to avoid any misunderstanding or disagreement concerning payment for professional services. Please carefully read the outlined policy below and sign at the bottom:

1. If a patient has insurance with which we do not participate, our office will be happy to file the claim on behalf of the patient. However, payment in full is expected from the patient at time of service. Please note, that while our office will perform verification of benefits, this does not guarantee insurance payment.

2. Our practice participates with numerous insurance companies. For patients who are beneficiaries of one of these insurance companies, our billing office will submit a claim for services rendered. All necessary insurance information, including special forms, must be completed prior to being evaluated by our providers.

3. By law, it is the patient's responsibility to pay any deductible, copayment, or any portion of the charges as specified by their insurance plan. The patient's financial responsibility is due upon check in. Any old account balances will need to be paid prior to being seen. Payments can be made with cash, check, credit card, or debit card. Additionally, we now offer Care Credit for patients who qualify. If patients do not qualify for Care Credit, they will meet with our billing department to discuss payment options.

4. Financial assistance is available for qualified patients. If a patient feels that he or she may qualify for assistance, the billing department will be notified. Patients who do not have insurance are expected to pay for professional services at the time of service, unless prior arrangements have been made with us.

5. It is the patient's responsibility to ensure that any required referrals or authorizations for treatment are provided to the practice prior to the visit.

6. It is the patient's responsibility to provide us with all current insurance information and to bring his/her insurance card with a form of photo identification to each visit.

7. Our staff is happy to help with insurance questions in relation to how a claim was filed, or regarding any additional information the payer might need to process the claim. Specific coverage issues, however, can only be addressed by the insurance company member services department. (Telephone number is printed on the insurance card)

8. We charge a Missed Appointment fee of $25 if a patient misses a scheduled appointment. We require notification 24 hours prior to the scheduled appointment time to avoid that fee.

9. We do fill out payment protection, FMLA, and disability forms. However, there is a $25 fee due prior to completion of the forms. We reserve the right to refuse completion of forms, if deemed not applicable to our specialty.

I have reviewed and understand the financial policy of Vascular Associates.

Printed Name________________________________

Signature of Patient/ Legal Representative:___________________________________ Date:__________________

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Health History:

Patient Name: ______________________________________ **DOB:**__________ **Today's Date:**_________

Referring MD: ______________________ **Primary Care Physician:** _______________________
Cardiologist: _________________________________ **Neurologist:** _______________________________
Nephrologist: ________________________________ **Other Physicians:** ___________________________
Reason for visit: ____

Allergies: Yes (Please list below with reaction)**/No** (No Known Drug Allergies)

1)____________________ 2) __________________ 3) __________________ 4) ___________________

Are you allergic to IV Contrast, Iodine or Shellfish? **YES / NO**
Are you allergic to Latex? **YES / NO**

Social History (Please check/circle all that apply)

Marital Status: Single Married Divorced Widowed Separated
Children: Yes / No
Currently Living: Alone With Family With Friends With Significant Other
Profession: Working _________________________________ Retired
Smoker: Yes / No Past or Present Quit Date: ___________________
Type: Cigars/Pipe/Cigarettes How many? #_____Pack/Day How Long? ________(Years)
Alcohol: Y / N Daily Weekends Socially

Family History (Please check all that apply and include family member)
Aortic Aneurysm (AAA)__________ Heart Disease/Attack__________ Diabetes__________
Cancer___________ Stroke___________ DVT (blood clots)___________
Arterial Disease of Legs___________ Varicose Veins___________ Bleeding Disorder___________

Patient Surgical History (Please check all that apply and include year)
Angioplasty/Stenting of the leg _____ (year)
Arterial Bypass of the Leg _____ (year)
Aortic Aneurysm Repair _____ (year)
Thrombolysis/Thrombectomy (clot busting) _____ (year)
Sclerotherapy _____ (year)
Vein Stripping _____ (year)
Heart Surgery/Stenting/Bypass _____(year)
Carotid Artery Surgery/Stent _____ (year)
IVC Filter Placement _____ (year)
Saphenous Vein Harvesting _____ (year)
Phlebectomy _____ (year)
EVLT/Thermal Ablation of Veins _____ (year)

Any other surgeries (including year)____
____

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Medical History (Check all that apply)

Raynaud's Disease	Diabetes	High blood pressure
Varicose Veins	High Cholesterol	Bleeding Disorder
Chronic Renal Failure	Kidney problems	Peripheral vascular disease
Carotid Stenosis	TIA	Clot in lung/legs (DVT/PE)
Heart Attack/CAD/Angina	HIV/AIDS	Cancer
Abdominal Aneurysm (stomach)	Heart Valve Disease	

Are you Currently on Dialysis? **YES or NO** Hemodialysis **or** Peritoneal Dialysis?

If Yes, Where**:** ______________________________ What days? Mon, Wed, Fri (or) Tues, Thurs, Sat

REVIEW OF SYSTEM (Check all that apply)

Constitutional

Fatigue Unexplained weight loss

Eyes, Ears, Nose & Throat

Blurry vision Loss of vision in one eye Hearing loss Nose-bleeds

Psychological symptoms

Depression Anxiety Insomnia

Neurological

Seizures Fainting (syncope) Difficulty in balance

Respiration

Shortness of Breath Wheezing Cough

Cardiovascular

Chest Pain Heart Palpitation Irregular Heartbeat

Gastrointestinal

Abdominal Pain Change in Appetite Heartburn

Musculoskeletal

Leg pain Leg swelling

Endocrine

Excessive sweating Excessive Thirst

Hematological

Blood Clotting Easy bruising

Printed Name_________________________________

Signature of Patient/ Legal Representative:____________________________________ Date:__________________

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Medication List

Patient Name: ______________________________________ **DOB:**__________
Today's Date:_________

Please check if you are on any of the following medications and fill in the dosage you are taking:

Medication containing Metformin/Glucophage _________mg

Plavix_____mg Aspirin _____mg Warfarin/Coumadin _____mg Xarelto _____mg

Arixtra/Lovenox_____mg Pradaxa _____mg Any other blood thinner __________-___mg

Please list any other medications you are currently taking, the dosage and how often (you may attach printed or typed sheet):

Medication Name	**mg/mcg & times per day**
1)	
2)	
3)	
4)	
5)	
6)	
7)	
8)	
9)	
10)	
11)	
12)	
13)	
14)	
15)	

Please continue on reverse side

Patient Self-Assessment

Patient Name (print):____DOB:_________________

This form is to assess your symptoms and whether conservative treatment has provided any relief. Medicare and other insurance companies require documentation of a significant decline in your quality of life in order to authorize coverage for more aggressive treatment. In order for us to be able to treat unresolved symptoms, it is important for this form to be as accurate as possible. We may ask you to reassess your symptoms as you move forward in our care.

My Leg Symptoms (check all that apply):

□ **Tiredness** □ **Heaviness** □ **Cramping** □ **Pain/achiness** □ **Itching**

□ **Restless Legs** □ **Swelling** □ **Burning** □ **Bulging, ropey veins**

□ **Bleeding from Visible Veins** □ **Skin Discoloration or texture changes**

Do you have pain when walking: Yes / No
If yes how far can you walk before the pain starts______________

Symptoms are felt in the: □ **Left leg** □ **Right leg** □ **Both legs**

Which leg is worse: □ **Left** □ **Right**

Pain intensity: None 1 2 3 4 5 6 7 8 9 10 (worst)

How long have you had these issues_____________________________ Years/Months/Days

My symptoms affect my quality of life in the following areas: (check all that apply)

□ **Work** □ **Socializing** □ **Exercise** □ **Hobbies**

□ **Caring for family** □ **Housework** □ **Sleep** □ **Other ___________**

The following things worsen my symptoms: (check all that apply)

□ **Prolonged Sitting** □ **Prolonged Standing** □ **Walking**

□ **Driving** □ **Elevation** □ **Compression hose**

I have tried the following to relieve my symptoms: (check all that apply)

□ **Wound Care** □**Weight Loss (____lbs)** □ **Frequent Elevation** □ **Compression hose**

□ **Exercise** □ **Prescription Medication** □ **Non-prescription Pain Medication**

I have worn graduated compression stockings/socks for:

□ **More than 3 months** □ **Less than 3 months** □ **Other_________________**

Patient Signature_____________________________________ Todays Date _________________________