2202 State St. Suite 102
Panama City, Florida
32405

Southern Vascular

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

Ashish K Gupta MD, FACS, RVT
850-532-6303

Patient Information

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:** _____

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**

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Insurance Information

Patient Name:_____

Primary Insurance:_____ **Secondary Insurance:** _____

***If you are not the primary card holder (including Tricare) we will need the following information in order to process your insurance.**

_____ _____ _____

Policy Holder Name **D.O.B.** **SSN**

Patient HIPPA Consent Form

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 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

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

-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 your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

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

I authorize the release of any healthcare information necessary to process this bill to my insurance company, and request payment of benefits to Southern Vascular.

Signature of Patient/ Legal Guardian:_____ **Date:**_____

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Privacy Information

Patient Name:_____

☐ **I authorize the following individuals to retrieve/discuss all of my medical information. Without their names on this list, Southern Vascular WILL NOT be allowed to release ANY information. I can refuse to sign this form, or revoke it at any time by completing a new form. I understand that if information is shared with the below individuals it may be subject to exposure by the individual.**

☐ **I do not authorize anyone other than myself to retrieve/discuss my information.**

Name: _____ **Phone:** (_____)_____ **Relationship:** _____

Name: _____ **Phone:** (_____)_____ **Relationship:** _____

Name: _____ **Phone:** (_____)_____ **Relationship:** _____

Signature of Patient/ Legal Guardian:_____ **Date:**_____

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Practice Financial Policy

Southern Vascular 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 in which we do not participate, our office is happy to file the claim upon request; however, payment in full is expected 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 patients financial portion is due upon check in. Prior 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 financing 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. Visits may be rescheduled, or the patient may be financially responsible due to lack of a required referral.

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 have an Appointment No-Show fee of $25 if patients do not cancel or reschedule appointments 24 hours prior to appointment.

9. We do fill out payment protection, FMLA, and disability forms, however please note that there is a $25 fee prior to receipt of the completed form. We do reserve the right to refuse completion of forms if deemed not applicable to our specialty.

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

_____ _____ _____

Signature Printed Name Date

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PATIENT HISTORY INFORMATION

Name: _____ **DOB**:_____ **Date**:_____
Referring MD: _____ **Primary Care Physician**: _____
Cardiologist: _____ **Neurologist**: _____
Nephrologist: _____ **Other Physicians:** _____

Briefly describe your reason for visit today: _____

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 circle all that apply**)
Marital Status: Single Married Divorced Widowed Separated **Children:** Y / N
Currently Living: Alone With Family With Friends with significant other
Profession: Working (job)_____ Retired
Smoker: Y / N 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**)
Aortic Aneurysm (AAA) Heart Disease/Attack Diabetes Cancer Stroke
DVT(blood clots) Arterial Disease of Legs Varicose Veins Bleeding Disorder

Your Surgical History (**Please check all that apply**)
☐ Peripheral Angioplasty/Stenting (Non-Heart) ☐ Coronary Artery Stenting/Bypass ☐ Arterial Bypass of the Leg
☐ Carotid Artery Surgery/Stent ☐ Aortic Aneurysm Repair
☐ IVC Filter Placement ☐ Thrombolysis/Thrombectomy (clot busting)
☐ Saphenous Vein Harvesting ☐ Vein Stripping ☐ EVLT/Thermal Ablation of Veins
☐ Sclerotherapy ☐ Phlebectomy
☐Any other surgeries_____
_____

Continued on next page…

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Your Medical History(Please 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/Stroke	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? M W F or T TH S

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 Nosebleeds

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

PrintName_____Signature_____DOB_____

Date:_____

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MEDICATION LIST

Name: _____ **DOB**:_____ **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 □ Aspirin ____mg □ Warfarin/Coumadin ____mg □ Xarelto

□ Arixtra/Lovenox □ Pradaxa □ 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):
