Thomas C. Lackey II, D.O.
Board Certified General Surgeon
Vein Specialist

FLORIDA LAKES
VEIN CENTER

Adam N. Phillips, D.O.
Board Certified General Surgeon
Vein Specialist

Patient Name: _____Date of Birth: : _____

Address: _____

Out-of-State Address:_____

Home telephone: _____Cell phone: _____Email:_____

Circle one: **Employed** **Retired** **Disabled** **Unemployed**

Employer: _____

Primary Insurance: _____ Secondary Insurance: _____

Emergency Contact- Name/Phone: _____

Primary Physician: _____Telephone:_____

Cardiologist:_____Telephone:_____

How did you hear about Florida Lakes Vein Center? _____

Referring Physician: _____Telephone: _____

Preferred Pharmacy: _____Location: _____

Patient Signature: _____ ***Date:*** _____

Patient Name:_____ Date:_____

MEDICATIONS

Please print medications below or give a copy of medication list to the office staff.

Medication, Dosage, and Reason for taking the medication.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.
16.
17.
18.

Please list ALL Allergies:

Blood-thinning medication: _____ ***Dosage:*** _____

FLORIDA LAKES
VEIN CENTER

Financial Agreement, Patient Statement, and Assignment of Benefits

I, the patient, authorize Florida Lakes Surgical, PLLC (dba Florida Lakes Vein Center), and/or Thomas C. Lackey II, D.O. and/or Adam N. Phillips, D.O., to release any and all information necessary to secure reimbursement from any insurance company to which I have subscribed. The insurance policy is a contract between me and the insurance company, and I understand that I am responsible for all charges incurred whether or not paid by the insurance company. Our office will file your claim with insurance company as a courtesy. I also authorize and direct payment to be made directly to Florida Lakes Surgical, PLLC (and its dba) and/or Thomas C. Lackey II, D.O. for service rendered either medically or surgically. However, it is the patient's responsibility to have all the insurance information at the time service is rendered. All co-payments, deductibles, percentages, co-insurances, etc. are the patient responsibility and will be collected **prior** to services rendered. All payments are to be paid in full upon receipt of a bill. Furthermore, the patient will assist in billing appropriate insurance companies. If for any reason there is an outstanding balance or delinquent account, it is the patient's responsibility to pay in full or appropriate actions will be taken to collect the payment. I agree and understand that I am responsible for any costs incurred in collection of said balance should that become necessary. Depending on circumstances, payment arrangements or payment plans can be made with the billing manager.

Patient Signature: _____ *Date:* _____

Consent for Treatment

I, undersigned patient, parent, or legal guardian, present myself (or the patient) for care/treatment at the office of Florida Lakes Vein Center and/or Thomas C. Lackey II,D.O and/or Adam N. Phillips, D.O., and voluntarily consent to the rendering of such care or treatment, including but not limited to consultation, performance of diagnostic testing, and/or surgical procedures that may be rendered in the office or other facility needed for appropriate care. I understand that the physician may rely on other services to help facilitate my care (i.e. radiology, laboratory, pathology, physicians).

Patient Signature: _____ *Date:* _____

FLORIDA LAKES
VEIN CENTER

Authorization to Release and/or Obtain Medical Records

Patient Name: _____

Date of Birth: _____Telephone:_____

Address: _____

Release of Information

Thomas C. Lackey II, D.O. - Adam N. Phillips, D.O.

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken. Those receiving the information without my further written consent, may not disclose my medical information. By signing below, I authorize Florida Lakes Vein Center to release and/or obtain copies of my medical records.

Patient Signature: _____*Date:*_____

9114 Town Center Parkway, Suite 101, Lakewood Ranch, FL 34202 O: 941-866-8989 F: 941-866-8988
1225 Jacaranda Blvd Venice, FL 34292 O: 941-257-0765 F: 941-257-0766
www.floridalakesveincenter.com

FLORIDA LAKES
VEIN CENTER

HIPAA

Our Notice of Privacy provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to a copy our Notice before signing the Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations as it pertains to the law. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent in writing and signed by you. However, such a revocation shall not affect any disclosures we have already made on reliance of your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that: 1) Protected health information may be disclosed or used for treatment, payment or health care operations; 2) The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice and receive a copy; 3) The Practice reserves the right to change the Notice of Privacy policies; 4) The patient has the right to restrict the use of their information as it pertains to the law; 5) The patient may revoke this Consent in writing at any time and all future disclosures will cease; and 6) The Practice may condition treatment upon the execution of this Consent.

I authorize Thomas C. Lackey II, D.O. and the medical staff of Florida Lakes Vein Center and/or Adam N. Phillips, D.O., to release my health care information to the following person(s):

Spouse: _____

Other/Relationship: _____

The information may be released to those listed above by phone, voicemail, fax, mail, email, text, in person, or by other means.

Patient Signature:_____Date:_____

FLORIDA LAKES
VEIN CENTER

Date: _____

MEDICAL HISTORY

Patient Name: _____Date of Birth: _____

Chief Complaint: _____

How long have symptoms been present? _____

Past History

GERD
COPD
Cardiac Disease
Obesity
Hypertension/ High blood pressure

Varicose Veins
Osteoarthritis / Arthritis Diabetes
DVT/ Blood Clot
Cancer: (type) _____

HIV
High Cholesterol IBS
Hepatitis
PFO (Patent Foramen Ovale)
Atrial Septal Defect

Other: _____

Past Surgical History: (please check mark if applicable)

Gallbladder
Breast
Hemorrhoids
Coronary Artery Bypass Graft

Colon
Appendectomy
Total Abdominal Hysterectomy
Vein Stripping

Hernia (type): _____
Cancer (type): _____
Stents: _____

Other: _____

Social History:

Tobacco: **YES/ NO** (packs per day) _____
Alcohol: **YES/ NO** (drinks per day) _____

Married **Divorced** **Widowed** **Single**

RACE/ETHNICITY: CAUCASIAN BLACK HISPANIC ASIAN NATIVE AMERICAN OTHER

Family History: (please check mark, if applicable)

Hypertension
Pulmonary
Diabetes Mellitus
Cardiac
Varicose Veins
Cancer (type):_____

Please indicate on the medication sheet if you are taking any blood thinning medication!