1836 Florida Avenue
Panama City, Florida 32405

VASCULAR ASSOCIATES, LLC
The Artery and Vein Experts

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

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_____

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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)	

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Patient Name: _____ **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** □ **Itching**

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

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

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

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

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

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

□ **Caring for family** □ **Housework** □ **Other** _____

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

□ **Wound Care** □**Weight Loss (____lbs)** □ **Frequent Elevation** □ **Wraps**

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

I have worn graduated compression stockings/socks for:

□ **More than 3 months** □ **Less than 3 months** □ **Other**_____

Photograph documentation is an important part of our cycle of care, and is required by many insurance companies in order to authorize treatment. I consent to the taking of photographs of my treatment area(s). Understanding that my identity will not be revealed to the public, I grant Vascular Associates, LLC the right to edit, use and reuse said photographs for advertising purposes, including use in print, internet and all other forms of media. I also release Vascular Associates, LLC from all claims, demands and liabilities, whatsoever, in connection with the above.

Signature_____ **Date**_____