



Today's Date: _____

MRN: _____

Last Name: _____ First Name: _____ Middle Initial: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Date of Birth: ____/____/____ Social Security Number: _____
Sex: _____ Marital Status: _____ Phone #: (____) _____
Email: _____ Ethnicity: _____ Preferred Language: _____

Emergency Contact Information
Name: _____ Phone Number: _____ Relationship: _____

Primary Insurance Responsible Party's Relation to Patient: Self Spouse Parent Guardian
Carrier: _____ Subscriber Name: _____ Subscriber DOB: _____
Policy ID#: _____ Group #: _____ Phone #: _____

Secondary Insurance Responsible Party's Relation to Patient: Self Spouse Parent Guardian
Carrier: _____ Subscriber Name: _____ Subscriber DOB: _____
Policy ID#: _____ Group #: _____ Phone #: _____

Preferred Pharmacy Information
Name: _____ Phone #: _____ Fax #: _____
Address: _____

Assignment and Release of Benefits
I hereby authorize my insurance benefits to be paid directly to the physician. I will assume full financial responsibility for non-covered services. I understand that payment is due on the date of service unless other arrangements have been made and agreed upon in advance. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

Signature: _____ Name: _____ Date: _____
Relationship to Patient if Signed by Legal Representative: _____

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Release of Information

I understand that:

once the Center for Vascular Intervention discloses my health information by my request, it cannot guarantee that the Recipient(s) will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and stat laws governing the use and disclosure of my health information.

I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).

my records are protected and cannot be disclosed without written permission.

this Authorization will remain in effect for one year or if I provide a written notice of revocation to the Medical Records Department.

Signature: _____ Name: _____ Date: _____

Relationship to Patient if Signed by Legal Representative: _____

Physician Care Team Information - Please list information for any other doctors you see.

Specialty	Name	Phone Number	Name of practice
Primary Care			
Cardiologist (Heart)			
Nephrologist (Kidneys)			
Endocrinologist (Diabetes)			
Podiatry (Feet)			
Other:			
Other:			
Other:			

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Medications - include prescription and over the counter			
Medication Name	Strength	Frequency	Comments

Surgical History	
Type of surgery	Date

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Allergies

Name	Reaction

Social History

Do you drink? <input type="checkbox"/> No <input type="checkbox"/> Socially <input type="checkbox"/> Moderately <input type="checkbox"/> Heavily
Do you smoke? <input type="checkbox"/> No <input type="checkbox"/> Yes How much? _____
Did you previously smoke? <input type="checkbox"/> No <input type="checkbox"/> Yes
How long ago did you quit? _____
Do or did you chew tobacco or nicotine gum or use a nicotine vaporizer? <input type="checkbox"/> No <input type="checkbox"/> Yes
Do you use illicit drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes

Past Medical History

<input type="checkbox"/> NONE OF THESE <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Cancer <input type="checkbox"/> Cardiac Arrest <input type="checkbox"/> Chest Pain <input type="checkbox"/> CHF <input type="checkbox"/> COPD <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Diabetes (Type __)	<input type="checkbox"/> DVT (Acute/Chronic) <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> GI Bleeding <input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Migraines <input type="checkbox"/> Neuropathy	<input type="checkbox"/> Osteoporosis <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Pulmonary Embolism <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Stroke <input type="checkbox"/> Other: _____ _____ _____ _____
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Review of Systems

<p><u>General</u></p> <p><input type="checkbox"/> Chills/Fever</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Trouble Sleeping</p> <p><input type="checkbox"/> Weight Gain/Loss</p> <p>Date of last physical:</p> <p><u>Vascular</u></p> <p><input type="checkbox"/> Amputation(s)</p> <p><input type="checkbox"/> Discoloration of Legs/Feet</p> <p><input type="checkbox"/> Gangrene</p> <p><input type="checkbox"/> Leg Pain</p> <p style="padding-left: 20px;"><input type="checkbox"/> At Night</p> <p style="padding-left: 20px;"><input type="checkbox"/> At Rest</p> <p style="padding-left: 20px;"><input type="checkbox"/> When Walking</p> <p><input type="checkbox"/> Leg Swelling</p> <p><input type="checkbox"/> Poor Circulation</p> <p><input type="checkbox"/> Spider Veins</p> <p><input type="checkbox"/> Varicose Veins</p> <p><u>Skin</u></p> <p><input type="checkbox"/> Bleeding</p> <p><input type="checkbox"/> Bruising</p> <p><input type="checkbox"/> Color Changes</p> <p><input type="checkbox"/> Itching</p> <p><input type="checkbox"/> Lesion(s)</p> <p><input type="checkbox"/> Lump(s)</p> <p><input type="checkbox"/> Rash(es)</p> <p><input type="checkbox"/> Shiny Skin/Hair Loss</p> <p><input type="checkbox"/> Ulcer(s)</p> <p><input type="checkbox"/> Wound(s)</p>	<p><u>Eyes</u></p> <p><input type="checkbox"/> Blurry Vision</p> <p><input type="checkbox"/> Pain</p> <p><input type="checkbox"/> Vision Loss</p> <p><u>Ears/Nose/Mouth/Throat</u></p> <p><input type="checkbox"/> Hearing Loss</p> <p><input type="checkbox"/> Ringing in Ears</p> <p><input type="checkbox"/> Nosebleeds</p> <p><input type="checkbox"/> Sore Throat</p> <p><input type="checkbox"/> Stuffiness</p> <p><input type="checkbox"/> Swollen Glands</p> <p><u>Respiratory</u></p> <p><input type="checkbox"/> Cough</p> <p><input type="checkbox"/> Coughing Up Blood</p> <p><input type="checkbox"/> Home Oxygen</p> <p><input type="checkbox"/> Shortness of Breath</p> <p><input type="checkbox"/> Smoking</p> <p><input type="checkbox"/> Wheezing</p> <p><u>Cardiovascular</u></p> <p><input type="checkbox"/> Chest Pain</p> <p><input type="checkbox"/> Palpitations</p> <p><u>Gastrointestinal</u></p> <p><input type="checkbox"/> Abdominal Pain</p> <p><input type="checkbox"/> Changes in Appetite</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Nausea/Vomiting</p> <p><input type="checkbox"/> Rectal Bleeding</p>	<p><u>Urinary</u></p> <p><input type="checkbox"/> Blood in Urine</p> <p><input type="checkbox"/> Burning/Frequent</p> <p><input type="checkbox"/> Incontinence</p> <p><input type="checkbox"/> Reduced Urine Stream</p> <p><u>Musculoskeletal</u></p> <p><input type="checkbox"/> Back Pain</p> <p><input type="checkbox"/> Joint Pain/Stiffness/Swelling</p> <p><input type="checkbox"/> Muscle Cramps/Weakness</p> <p><input type="checkbox"/> Muscle Pain</p> <p><u>Neurological</u></p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Numbness/Tingling</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Tremors</p> <p><input type="checkbox"/> Weakness</p> <p><u>Psychiatric</u></p> <p><input type="checkbox"/> Changes in Mood or Behavior</p> <p><input type="checkbox"/> Memory Loss</p> <p><u>Other Symptoms:</u></p> <hr/> <hr/> <hr/> <hr/>
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HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization

I authorize _____ (healthcare provider) to use and disclose the protected health information described below to the Center for Vascular Intervention and Dr. Douglas Redd/Dr. Belinda Marcus/Dr. Rizción Dagani.

2. Effective Period

This authorization for release of information covers the period of healthcare from:

- a. _____ to _____ **OR** b. all past, present, and future periods.

3. Extent of Authorization

- a. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

****OR****

- b. I authorize the release of my complete health record with the exception of the following information:

- Mental health records
- Communicable diseases (including HIV and AIDS)
- Alcohol/drug abuse treatment
- Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

Patient Birthdate

Printed name

Date

Affix Patient Label



IMPORTANT: DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENT

In consideration of services provided by Center for Vascular Intervention (CVI), the Patient or undersigned representative acting on behalf of the Patient agree and consents to the following:

1. Consent to Routine Medical Treatment/Services

Patient consents to the rendering of Medical Treatment/Services as considered necessary and appropriate by the attending physician or other practitioner, or member of the CVI medical staff who has requested care and treatment of Patient. Medical Treatment/Services may be performed by "Healthcare Professionals" (physicians, nurses, technologists, technicians, physician assistants, or other healthcare professionals). Patient authorized the attending or other practitioner, the medical staff of CVI, and CVI to provide Medical Treatment/Services ordered or requested by attending or other practitioner and those acting in his or her place. **The consent to receive "Medical Treatment/Services" includes, but is not limited to: outpatient care; examinations; laboratory procedures; medications; access to pharmacy information through SureScripts; supplies; sedation; surgical procedures and medical treatments; recording/filming for internal purposes (i.e. identification, diagnosis, treatment, performance improvement, education, safety, security) and other services which Patient may receive.** In the event CVI determines that Patient should provide blood specimens for testing purposes for the diagnosis of disease (i.e. HIV, HBV, etc.), Patient consents to the withdrawing and testing of Patient's blood and to the release of any positive test results as required of CVI by the State of Georgia.

2. Healthcare Practitioners in Training and Approved Industry Vendors

Patient recognizes that among those who may attend Patient at CVI are medical, nursing, and other healthcare personnel who are in training and who, unless specifically requested otherwise, may be present and participate in patient care activities as part of their medical education. There also may be present from time to time a medical product or medical device representative. Consent is hereby given for the presence and participation of such persons as deemed appropriate by the attending physician.

3. Personal Valuables

CVI shall not be liable for the loss or damage of any personal belongings, including, but not limited to, money, cell phones, laptops, electronic devices, jewelry, hearing aids, dentures, or clothing.

4. Consent Timeframe and Applicability

The above consents will be valid for a term of one (1) year or until the end of the calendar year, whichever occurs first, from the date of signature below.

By signing below, I acknowledge that I have read and understood and accepted the terms of this document and the undersigned is the Patient, the Patient's legal representative, or is duly authorized by the Patient's general agent to execute the above and accept its terms.

Signature of Patient or personal representative

Printed name of Patient or personal representative

Date

Relationship to Patient

Reason Patient is unable to sign

Center for Vascular Intervention Representative Signature

Center for Vascular Intervention Representative Name

Date

Affix Patient Label



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of the Center for Vascular Intervention’s Notice of Privacy Practices, which has an effective date of 05/01/2017, and which describes how my health information may be used and disclosed.

I understand that the Center for Vascular Intervention has the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact CVI at any time to request a current version of the Notice of Privacy Practices.

Signature of patient or personal representative

Printed name/Relationship

Date

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT RIGHTS AND RESPONSIBILITIES NOTICE

I acknowledge that I have been provided a copy of the Center for Vascular Intervention’s Patient Rights and Responsibilities Notice, which has an effective date of 05/01/2017.

I understand that the Center for Vascular Intervention has the right to change the Patient Rights and Responsibilities Notice at any time, that I will be provided a copy of any updated version, and that I may contact CVI at any time to request a current version of the Patient Rights and Responsibilities Notice.

Signature of patient or personal representative

Printed name/Relationship

Date

ACKNOWLEDGEMENT OF RECEIPT OF LATE ARRIVAL/CANCELLATION/MISSED APPOINTMENT POLICY

I acknowledge that I have been provided a copy of the Center for Vascular Intervention’s Late Arrival/Cancellation/Missed Appointment Policy, which has an effective date of 09/29/2019.

I understand that the Center for Vascular Intervention has the right to change the Late Arrival/Cancellation/Missed Appointment Policy at any time, that I will be provided a copy of any updated version, and that I may contact CVI at any time to request a current version of the Late Arrival/Cancellation/Missed Appointment Policy.

Signature of patient or personal representative

Printed name/Relationship

Date

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of the above notices/policies, but it could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented obtaining the acknowledgement
- Other (please specify): _____

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