Center for Vascular Intervention

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: _____

Additional Contact Information

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Advanced Directives

Do you have any of the following advanced directives? If yes, please provide the appropriate documentation.

□ Living Will □ Power of Attorney □ DNR □ None

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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Center for Vascular Intervention

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 state 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)			
Pulmonologist (Lungs)			
Other:			
Other:			

Hemodialysis Clinic

Name: _____ Address: _____

Phone number: _____ Fax number: _____

Routine treatment days (circle one)**:** **M – W – F** or **T – Th – S**

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Center for Vascular Intervention

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

Surgical History	
Type of surgery	**Date**

Implanted Devices		
☐ Cardiac Stents	☐ Pain Pump	☐ VP Shunt
☐ IVC Filter	☐ Peripheral Vascular Stents	☐ Watchman Device
☐ Mediport	☐ Permcath	☐ Other: _____
☐ Pacemaker/Defibrillator	☐ Spinal Cord Stimulator	☐ Other: _____

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Center for Vascular Intervention

Allergies

Name	Reaction

Social History

Do you drink? ☐ No ☐ Socially ☐ Moderately ☐ Heavily
Do you smoke? ☐ No ☐ Yes How much? _____
Did you previously smoke? ☐ No ☐ Yes
How long ago did you quit? _____
Do or did you chew tobacco or nicotine gum or use a nicotine vaporizer? ☐ No ☐ Yes
Do you use illicit drugs? ☐ No ☐ Yes

Past Medical History

Cardiovascular

- ☐ Atrial Fibrillation
- ☐ Cardiac Arrest
- ☐ Chest Pain
- ☐ DVT (Acute/Chronic)
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Peripheral Vascular Disease
- ☐ Pulmonary Embolism

Endocrine

- ☐ Diabetes (Type ___)
- ☐ Thyroid Disease

GI/GU

- ☐ Dialysis (HD or PD)
- ☐ GI Bleed
- ☐ Kidney Disease
- ☐ Liver Disease

Infectious Disease

- ☐ Antibiotic Resistant Bacteria (MRSA, VRE, etc)
- ☐ COVID-19
- ☐ Hepatitis B/C
- ☐ HIV/AIDS
- ☐ Tuberculosis

Neurological

- ☐ Alzheimer's/Dementia
- ☐ Neuropathy/Numbness
- ☐ Seizure Disorder
- ☐ Stroke

Pulmonary

- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Sleep Apnea

Other

- ☐ Anemia
- ☐ Blood Clots
- ☐ Cancer: _____
- ☐ Chronic Pain
- ☐ Immunocompromised
- ☐ _____
  _____
  _____
  _____
- ☐ NONE OF THE ABOVE

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Center for Vascular Intervention

Review of Systems

General

- ☐ Chills/Fever
- ☐ Fatigue
- ☐ Headaches
- ☐ Trouble Sleeping
- ☐ Weight Gain/Loss

Date of last physical:

Vascular

- ☐ Amputation(s)
- ☐ Discoloration of Legs/Feet
- ☐ Gangrene
- ☐ Leg Pain
  - ☐ At Night
  - ☐ At Rest
  - ☐ When Walking
- ☐ Leg Swelling
- ☐ Poor Circulation
- ☐ Spider Veins
- ☐ Varicose Veins

Skin

- ☐ Bleeding
- ☐ Bruising
- ☐ Color Changes
- ☐ Itching
- ☐ Lesion(s)
- ☐ Lump(s)
- ☐ Rash(es)
- ☐ Shiny Skin/Hair Loss
- ☐ Ulcer(s)
- ☐ Wound(s)

Eyes

- ☐ Blurry Vision
- ☐ Pain
- ☐ Vision Loss

Ears/Nose/Mouth/Throat

- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Nosebleeds
- ☐ Sore Throat
- ☐ Stuffiness
- ☐ Swollen Glands

Respiratory

- ☐ Cough
- ☐ Coughing Up Blood
- ☐ Home Oxygen
- ☐ Shortness of Breath
- ☐ Smoking
- ☐ Wheezing

Cardiovascular

- ☐ Chest Pain
- ☐ Palpitations

Gastrointestinal

- ☐ Abdominal Pain
- ☐ Changes in Appetite
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea/Vomiting
- ☐ Rectal Bleeding

Urinary

- ☐ Blood in Urine
- ☐ Burning/Frequent
- ☐ Incontinence
- ☐ Reduced Urine Stream

Musculoskeletal

- ☐ Back Pain
- ☐ Joint Pain/Stiffness/Swelling
- ☐ Muscle Cramps/Weakness
- ☐ Muscle Pain

Neurological

- ☐ Dizziness
- ☐ Fainting
- ☐ Numbness/Tingling
- ☐ Seizures
- ☐ Tremors
- ☐ Weakness

Psychiatric

- ☐ Changes in Mood or Behavior
- ☐ Memory Loss

Other Symptoms:

_____

_____

_____

_____

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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.

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

Center for Vascular Intervention

ACKNOWLEDGEMENT OF RECEPIT 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 RECEPIT 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 RECEPIT 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): _____

Affix Patient Label