Vascular & Vein Specialists

at The Longstreet Clinic, P.C.

Authorization For The Release Of Medical Information

Patient's Name: ________________________________ **DOB:** ________________________

Date:________________________ **Doctor you are seeing today:**_____________________

I give my consent and authorize Vascular and Vein Specialists at The Longstreet Clinic to release any medical records including but not limited to records, reports, notes, chart notes, letters, photographs, test reports or results (including physical test results, pathology test results, laboratory test results, x-rays, MRI & CAT scans, EKGs, etc), financial information (including insurance information and/or billing statements), and referral letters. I also consent and authorize the discussion of medical records and information pertaining to me or my treatment. I understand I am authorizing the release of this information to the following individuals:

________________________	________________________	________________________
Name	**Relationship To Patient**	**Phone Number**
________________________	________________________	________________________
Name	**Relationship To Patient**	**Phone Number**
________________________	________________________	________________________
Name	**Relationship To Patient**	**Phone Number**

This release of information is intended to include records maintained in my maiden or other names as follows:____

I understand Vascular and Vein Specialists at The Longstreet Clinic may not make my completing and signing this authorization a condition of my treatment.

I understand that I am authorizing the use or disclosure of my protected health information as described above. I understand that information released may no longer be protected under the HIPAA rules and regulations. I understand that I may be charged for any copies provided. I may revoke this authorization at any time in writing.

I have read, understand and agree to the above stated policy.

____ ________________________________

Patient Signature **Date**

Vascular & Vein Specialists

at TLC The Longstreet Clinic, P.C.

Today's Date: ___________________________

Name: _________________________ **DOB:** ___________________ **Sex:** _______Male_____Female

What doctor are you seeing today? ____

Referring Physician's name and phone number____

Primary Care Physician's name and phone number____

Reason for today's visit____

Allergies and reactions____

____

Current medications and dosages including over the counter medication:

____

____

____

____

____

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____

____

PAST MEDICAL HISTORY:

Cardiovascular: ___Chest pain ___Heart Attack ___Atrial Fib ___CHF ___Heart disease(CAD)

___Hypertension ___High Cholesterol ___TIA ___Stroke ___Heart Murmur ___Heart Valve

Respiratory: ___Shortness of breath ___Asthma ___COPD ___TB

Gi: __GERD ___Gallbladder Disease ___Hepatitis ___Constipation ___Diarrhea

____Diverticular Disease ___GI bleeding

Endo: ___Type 1 Diabetes ___Type 2 Diabetes ___Hypothyroidism ___Hyperthyroidism

Name________________________________ DOB____________________________

MEDICAL HISTORY continued:

Heme/Oncology: ___DVT ___Cancer ___Anemia ___Blood Disorder ___Pulmonary Embolism

Msk: ___Arthritis ___Rheumatoid Arthritis ___Osteoarthritis ___Backache ___Obesity

Skin: ___Skin Disorder ___Eczema ___Psoriasis ___Rashes

Gyn: ___Infertility ___Recent Pregnancy

Gu: ___UTI ___Acute Renal Failure ___Chronic Renal Failure ___Incontinence ___BPH

Psych: ___Depression ___Anxiety ___Bipolar Disorder ___Schizophrenia

Neuro: ___Seizures ___Alzheimer's ___Migraines ___Dementia ___Parkinson's Disease

Sleep: ___Insomnia ___Sleep Apnea

Other medical history not listed:

____

SURGICAL HISTORY:

Cardiovascular: ___CABG ___Valve Surgery ___Stent Placement ___Cardiac Cath ____Pacemaker

Resp: ____Lung Surgery

GI: ___Appendectomy ___Cholecystectomy ___Hernia Repair ___Weight Loss Surgery

Gyn: ___C-Section ___Tubal Ligation ___Hysterectomy ___D&C

Endo : ___Thyroidectomy ___Parathyroidectomy

Gu: ___TURP ___Prostatectomy ___Bladder Surgery ___Lithotripsy ___Nephroectomy (Left/Right)

Breast: ___Breast Biopsy ___Mastectomy ___Breast Reduction ___Breast Augmentation

___ Breast Reconstruction

Neuro: __Spine Surgery ___Laminectomy ___Craniotomy

Heent: ___Sinus Surgery ___T&A ___Cataracts ___Oral Surgery

Msk: ___Knee Replacement ___Hip Replacement ___Shoulder Surgery ___Arthroscopy

Name_________________________________ DOB_____________________________

SURGICAL HISTORY cont:

Vascular Surgery: ___Carotid Endarterectomy (Left/Right) ___Carotid Stent (Left/Right)

___Angiogram ___Angioplasty ___Endovascular repair of AAA ___Open repair of AAA

___Repair of Thoracic Aneurysm ___Carotid Bypass

___Carotid Subclavian Bypass ___Bypass Aorto-Iliac ___Bypass Aorto-Bifemoral-Iliac

___Bypass Aorto-Femoral or Bifemoral ___Bypass Femoral-Popliteal

___Permcath ___AV Fistula (Left/Right) ___AV Graft (Left/Right)

Dialysis patients ONLY: Dialysis center **and** location: Davita __________________________________
Fresenius Medical Care_______________________
Other ___________________________________

Dialysis days: _______Monday, Wednesday, Friday
_______ Tuesday, Thursday, Saturday

Nephrologists: Who is your kidney doctor? ____

___Unspecified Vascular Surgery (____)

Social History:

Tobacco use: Do you smoke? _____ No (*non-smoker*) ______yes _______quit

If yes, do you smoke: _____ cigarettes ______cigars ______pipe ______vapor/electric
If quit, when did you last smoke: __________ (year)

Alcohol use: ___None ___Rarely ___Occasionally ___Frequently ___Daily (___Number of drinks)

Exercise: ____Type and Frequency

Occupation: ____

Marital Status: ___Married ___Single ___Widowed ___Significant other

Living Situation: ___At Home Alone ___At Home with Family ___Assisted Living ___Nursing Home

Family History (LIST Mother, Father, Sibling, etc.):

Heart disease/Heart attack_____________________________________
Hypertension____
Stroke____
Diabetes____
Aneurysm____
DVT/Blood Clot____
Cancer____

The Longstreet Clinic, P.C.
A Multi-Specialty Practice

FINANCIAL POLICY

- **We participate in most insurance plans, including Medicare and Medicaid.**
    - We do not file to general liability or homeowner's insurance.
- **You and your insurance company are responsible for your bill.**
    - Knowing your insurance benefits is your responsibility.
    - Any questions concerning your coverage should be directed to your insurance company.
- **If your primary insurance company requires a co-payment, you must make the co-payment at time of service.**
    - Failure to pay your copay at time of service will result in a billing fee of $25.00. *Please remember that we are contractually obligated by your insurance company to collect your copay at time of service.*
    - The balance of your charges will be billed. Payment in full of patient portion will be expected with receipt of your statement.
- **Proof of current, valid insurance must be provided at time of service.**
    - If you do not provide this information, you will be considered a self-pay patient.
    - Self-pay patients are required to make an advance payment on their office visit charge. The advance payment amount will be based on the services provided. *Please ask about your advance payment responsibility when making your appointment*
    - Failure to pay your advance payment at time of service will result in a billing fee of $25.00.
    - You will be billed for the balance of your charges. Payment in full will be expected with receipt of your statement.
- **Failure to receive your statement does not relieve you of your financial obligation. It is your responsibility to notify us of any changes in your billing information.**
- **We accept cash, checks, money orders and major credit cards.**
    - Returned checks are subject to a $25.00 return check fee.
- **Past due accounts are subject to our collections process.**

Patient Name (or responsible party) ____________________ Date ____________