LONGSTREETCLINIC Vascular & Vein

Patient Registration Form

Date:____________________________ How did you hear about TLC? ___________________________

INFORMATION ON THE PERSON BEING SEEN TODAY

Patient's Name

___________________________________ ___________ ___________________________________

(First Name) (Middle Initial) (Last Name)

Address: ____

City: ___________________________ State: ___________ Zip: ____________________________

Home Phone: _____________________________ Mobile Phone: ________________________________

Emergency Phone: ___________________ Emergency Contact (Relationship): ___________________

Date of Birth: _____ / _____ / _____ Gender: ❑ Male ❑ Female

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Unknown

Social Security Number: ________ - _____ - ________ Email: _________________________________

Employer Name: ___________________________ Employer Phone: ______________________________

Race:	**Ethnicity:**
____White/Caucasian	____Non-Hispanic/Non-Latino
____Black/African American	____Hispanic/Latino
____Asian	____Unknown
____Other (explain)______________________________	____Declined
____Declined	

Preferred Language:______English ____Spanish ____Other_______________________

Preferred Method of Communication

❑ Letter Phone Number: _________________ Email Address: ______________________________

INFORMATION ON THE PERSON RESPONSIBLE FOR PATIENT

Responsible Person's Name

___________________________________ ___________ ___________________________________

(First Name) (Middle Initial) (Last Name)

Address: ____

City: ___________________________ State: ___________ Zip: ____________________________

Home Phone: _____________________________ Mobile Phone: ________________________________

Emergency Phone: ___________________ Emergency Contact (Relationship): ___________________

Date of Birth: _____ / _____ / _____ Gender: ❑ Male ❑ Female

Social Security Number: ________ - _____ - ________ Email: _________________________________

Patient Registration Form

INSURANCE INFORMATION:

******** Please allow the receptionist to make copies of your insurance cards********

PLEASE NOTE: It is the policy of ***Longstreet Clinic*** that we collect full payment at the time of your visit. If you have a policy with a company with which we have a contract, we will gladly file your claim for you. Please understand that if you are not with a ***contracted*** carrier, you must pay for your visit at time of service. If you have a concern about your ability to pay for the services in full, please speak with the receptionist at time of service.

PRIMARY INSURANCE CARRIER: ______________________________

Name of Policyholder:______________________________ Policyholder's DOB: ____/____/____

Policyholder's Employer: ______________________ Policyholder's SS#: ______________

Policyholder's Relationship to patient: ____

SECONDARY INSURANCE CARRIER: ______________

Name of Policyholder:______________________________ Policyholder's DOB: ____/____/____

Policyholder's Employer: ______________________ Policyholder's SS#: ______________

Policyholder's Relationship to patient: ____

I authorize *Longstreet Clinic* to release to my insurance company any information required for services provided. I authorize payment of Medical Benefits to *Longstreet Clinic.*

Signature: ____

I understand that I remain responsible to *Longstreet Clinic* for any and all charges.

Signature: ____

Revised: 02/27/18

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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

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, **[Name of patient]**______________________________, acknowledge and agree that I have received a copy of **Longstreet Clinic's** Notice of Privacy Practices.

Patient Signature	Date
Patient Legal Representative (if applicable)	Date
Print Name of Legal Representative	Relationship to patient

FOR CLINIC USE ONLY:

Longstreet Clinic made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices:

> **[Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.]**

____

____

____

____

____

Signature of Longstreet Clinic staff member	Date

LONGSTREET CLINIC
Vascular & Vein

Authorization for the Release of Medical Information

Patient's Name: ________________________________ Date of Birth: ___________

Date: _________________ Physician you are seeing today: __________________

I give my consent and authorize Vascular and Vein Specialists at 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, EKG's, 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 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 ______________________

LONGSTREET CLINIC
Vascular & Vein

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: ____

Primary Care Physician's Phone Number: ____

Reason for today's visit: ____

Allergies and reactions: ____

____

Current medications and dosages including over the counter medication:

Medication	Dosage	Medication	Dosage	Medication	Dosage
______________	________	______________	________	______________	________
______________	________	______________	________	______________	________
______________	________	______________	________	______________	________
______________	________	______________	________	______________	________
______________	________	______________	________	______________	________
______________	________	______________	________	______________	________

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

Heme / Oncology:

❑ DVT ❑ Cancer ❑ Anemia ❑ Blood Disorder ❑ Pulmonary Embolism

Name: ____ DOB: ________________________

MEDICAL HISTORY continued:

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
Respiratory: ❑ 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
Vascular Surgery: ❑ Carotid Endarterectomy (Left/Right) ❑ Carotid Stent (Left/Right)
❑ Angiogram ❑ Angioplasty ❑ Endovascular repair of AAA ❑ Open repair of AAA
❑ Permcath ❑ Repair of Thoracic Aneurysm ❑ Carotid Bypass ❑ Bypass Aorto-Iliac
❑ Carotid Subclavian Bypass ❑ Bypass Aorto-Bifemoral-Iliac
❑ Bypass Femoral-Popliteal ❑ Bypass Aorto-Femoral or Bifemoral ❑ 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: ❑ Home Alone ❑ 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 ____