COASTAL VASCULAR & VEIN CENTER

NEW PATIENT INFORMATION

(please print and complete entire packet)

Patient's Name _____ **Birthdate** _____

(Last) (First) (Middle)

Address _____

(Street) (City) (State) (Zip)

Social Security # _____ **Primary Phone** _____

Secondary Phone _____ **Work Phone** _____

Email_____ **Employer**_____

Primary Care Physician _____ **Referring Physician** _____

Pharmacy_____ **Pharmacy Phone**_____

If you are a minor – Parent/Guardian Name _____ **Phone**_____

In case of Emergency, call: _____

Phone _____ **Relationship** _____

INSURANCE INFORMATION

Primary Insurance Company _____

Policy/Member Number _____

If your insurance is in the name of a spouse/partner/parent:

Name of insured _____

Birthdate of insured _____ Relationship to insured _____

Address of insured if different from yours _____

Secondary Insurance Company _____

Policy/Member Number _____

If your insurance is in the name of a spouse/partner/parent:

Name of insured _____

Birthdate of insured _____ Relationship to insured _____

Address of insured if different from yours _____

COASTAL VASCULAR & VEIN CENTER

HIPAA/Alternate Contact Authorization

I □DO □DO NOT authorize COASTAL VASCULAR & VEIN CENTER to discuss my appointments, medical evaluation, treatment, and results with another person/persons as indicated below:

Name of authorized person: _____ Relationship: _____

Name of authorized person: _____ Relationship: _____

Name of authorized person: _____ Relationship: _____

_____ _____
Initials Date

I □DO □DO NOT authorize COASTAL VASCULAR & VEIN CENTER to leave messages on my home/cell answering machine/voicemail regarding appointments and to inform me that test results are available.

_____ _____
Initials Date

I □DO □DO NOT authorize COASTAL VASCULAR & VEIN CENTER to contact me or leave messages for me at my place of work.

_____ _____
Initials Date

I □DO □DO NOT authorize COASTAL VASCULAR & VEIN CENTER to contact me at my email address.

_____ _____
Initials Date

Email address if authorized:_____

I am able to receive a copy and read the Notice of Privacy Practices for COASTAL VASCULAR & VEIN CENTER at the time of my appointment.

_____ _____
Signature Date

COASTAL VASCULAR & VEIN CENTER

MEDICAL RELEASE AUTHORIZATION

I, the undersigned patient, or my authorized representative hereby authorize my physician and whomever he/she may designate as his/her assistant to render medical treatment to me. I consent to any medical care which encompasses laboratory, diagnostic, or medical treatment which my physician or his/her assistant may deem necessary during my office visit.

I, the undersigned patient or my authorized representative hereby authorize my physician and whomever he/she may designate as his/her assistant to release any medical information accumulated in the course of my examination and treatment to any other doctor, hospital or other parties assisting in my medical care.

I, the undersigned patient, or my authorized representative authorize the release of medical information and request payment of benefits to Coastal Surgical Vascular and Vein when they accept payment. I understand I am responsible for any amount no covered by my insurance. I authorize use of photostatic copy of the assignement in lieu of the original when necessary.

PATIENT'S SIGNATURE _____ DATE _____

SOCIAL SECURITY ADMINISTRATION

If you have health coverage through Medicare, please sign this authorization:

I authorize any holder of medical or other information about me to release, to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I permit a copy of the authorization to be used in place of the original and request payment of the medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B fo the Social Security Act and 31 U.S.C 3801-3812 provides penalties for withwolding this information). Regulations pertaining to Medicare assignment of benefits also apply.

PATIENT'S SIGNATURE _____ DATE _____

COASTAL VASCULAR & VEIN CENTER

FINANCIAL POLICY / INSURANCE POLICY / MISSED APPOINTMENT AND LATE ARRIVAL POLICIES

Your clear understanding of our financial policy, insurance policy, and appointment policies is important to our professional relationship. Payment for services is part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. Address, name, insurance information etc.).

CO-PAYS

Please be prepared to pay any co-payments, deductibles and non-covered services at the time of each visit. We will also collect all previous outstanding patient balance during check out at the end of your visit.
As a convenience to our patients, we accept cash, check (there will be $35.00 fee assessed for all checks returned unpaid by banks), Visa, MasterCard, Discover, and American Express.

SELF PAY

If you do not have medical insurance we offer a self-pay discount. You are required to pay for services **in full** at the time of each visit.

REFERRALS and PREAUTHORIZATIONS

If your insurance company requires a referral form or pre authorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in lower or no payment from your insurance company, and the balance will become your responsibility.

INSURANCE

As a participating provider, we follow all mandatory guidelines as specified in each individual carrier's contract. Upon verification that we participate with your plan, we will file our charges with your carrier. With most participating contracts, we are required to collect the full "allowed" amount. (The "allowed" amount is specified by your carrier.) Therefore, you will be expected to pay your co-payment and/or deductible at the time services are rendered. Many insurance carriers have provisions in their policies resulting in non-payment of certain services. In these cases, the patient will be responsible for the non-covered charges.

In the event a procedure is necessary, we will estimate our charges, insurance company's payment, and your co-payment, and/or deductible. Your estimated co-payment and/or deductible is due prior to your procedure. (In the event of an emergency procedure you will be allowed 30 days to pay estimated portion.) Upon payment from the carrier, you will be billed or refunded for any difference between the estimate and the actual amount due after your carrier's payments.

If we do not receive payment or rejection from your insurance company in a timely manner, we will transfer the balance to your responsibility. We request your assistance in following up with your insurance company to resolve any non-payment issue.

PATIENT RESPONSIBILITIES

Our providers recommend care based on the patient's best interest, which is independent of insurance coverage issues. We do our best to check benefits, eligibility, and obtain precertification, but we cannot know all of the benefits and exclusions of each patient's coverage. It is your responsibility to check with your insurance company so that you are aware of any deductibles, copays, coinsurance, or pre-existing exclusions. If you have any questions, about our policy, please call our Billing Dept. at 843-720-7823.

MISSED APPOINTMENTS/LATE ARRIVAL TO APPOINTMENTS

If you fail to call to cancel or reschedule an appointment, you will be charged a **$30.00 N0-SHOW FEE.**
If you arrive 15 or more minutes late for your appointment, you will not be seen and will need to reschedule your appointment.

- **I have read, understand, and agree to comply with the terms of all the above policies.**

_____ _____
Signature Date

_____ _____
Print Name Birth Date

COASTAL VASCULAR & VEIN CENTER

NEW PATIENT HISTORY

Today's Date: _____

Patient's Name: _____ **Date of Birth:**_____

Account #: _____

Referring Physician: _____ Primary Care: _____

What other physicians participate in your care?

Physician	Condition Treated
_____	_____
_____	_____
_____	_____

CHIEF COMPLAINT: What is the main reason for your visit today? (Describe your problem in detail)

_____

_____

Have you already had any tests performed regarding this problem? _____

_____

When did you first notice the problem? (days, weeks, or years?) _____

_____

Does anything help the problem or make it worse? _____

_____

Does the problem interfere with your daily activities? _____

_____

Current Medications: (include list if possible)

Name (ex. Plavix)	**Dose** (ex. 10mg)	**Frequency** (ex. Every day)	**Name** (ex. Plavix)	**Dose** (ex. 10mg)	**Frequency** (ex. Every day)

Provider Notes: _____

COASTAL VASCULAR & VEIN CENTER

PAST MEDICAL HISTORY

Please check all that apply:

Cardiovascular	**Pulmonary**	**Endocrinology**
□Heart Attack	□Lung Disease	□Diabetes
□Congestive Heart Failure	□COPD/Emphysema	□Thyroid Problems
□Heart Valvular Disease	□Asthma	
□Atrial Fibrillation		**Other Disease**
□High Blood Pressure	**Neurology**	□Depression/Anxiety
□High Cholesterol	□Migraines	□HIV
□Peripheral Artery Disease	□Stroke	□Cancer:_____
□Leg Ulcers	□TIA/Mini Stroke	□Prostate Problems
□DVT/Blood Clots	□Syncope/Black Outs	□Arthritis
□Varicose Veins	□Seizures	□Back Problems
□Phlebitis		□Kidney Disease
	Gastrointestinal	
	□GI/Stomach Bleeding	
	□Gall Bladder Disease	
	□Hepatitis	
	□Liver Disease	

Other medical problems not listed above: _____

_____

Allergies to Foods/Medications (include reactions):

_____

_____

_____

PAST SURGICAL HISTORY

Procedure	Date
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

Has anyone in your immediate family (parents, brother, sister) had any of the following problems? (Check all that apply and specify whom)

□Diabetes_____ □Stroke_____

□Heart Attack_____ □Aortic Aneurysm_____

□Cancer (specify type)_____ □DVT_____

□Phlebitis_____ □Varicose Veins_____

□Other Diseases or Illnesses_____

COASTAL VASCULAR & VEIN CENTER

SOCIAL HISTORY

Do you smoke: Yes No If so, how many years have you smoked?_____

If not, did you smoke in the past? Yes No

If so, how many years and what year did you quit?_____

Do you drink alcohol: Yes No If so, how many drinks per week?_____

□Illicit Drugs □Living Arrangements_____

Marital Status: □Single □Married □Divorced □Widowed

Occupation_____

REVIEW OF SYSTEMS

Check symptoms you currently have or have had in the past year

General	**Pulmonary**	**Genito-Urinary**	**Extremities**
□Chills □Night sweats □Fever □Weight Loss ____ lbs over ____weeks □Weight Gain ____lbs over ____weeks **Eyes** □Sudden loss of vision □Blurry vision **Cardiovascular** □Chest pain at rest □Chest pain on exertion □Irregular heart beat □Rapid heart beat □Heart Murmur	□Cough □Sputum □Wheezing □Shortness of breath while lying flat □Shortness of breath at rest □Shortness of breath with exertion **Gastrointestinal** □Constipation □Diarrhea □Rectal bleeding □Abdominal pain □Vomiting □Vomiting blood	□Blood in urine □Frequent urination □Painful urination □Waking at night to urinate **Neurologic** □Balance difficulty □Difficulty speaking □Tingling/numbness □Walk with a cane □Walk with a walker **Endocrine** □Excessive hunger □Excessive thirst □Fatigue □Cold intolerance □Heat intolerance	□Leg pain worsened by walking □Leg pain at rest □Leg swelling **Skin** □Bruise easily □Hives □Recent change in moles □Rash □Sore that won't heal **Hematology** □Easy bruising □Prolonged bleeding □Recent blood transfusion

Do not write below this line

Physical Exam

General _____

Cardiovascular _____

Chest _____

Abdomen _____

Extremities _____

Skin _____

Neuro _____

Vascular studies _____

Vascular Pulses

	R	L
FEM	_____	_____
POP	_____	_____
PT	_____	_____
DP	_____	_____
Carotids	_____	_____
Radial	_____	_____
Brachial	_____	_____