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 **Saba Thangam, MD**

Welcome!

Thank you for trusting us with your health care. We promise to provide you with the finest care available. The information on this cover sheet answers common questions our patients have. We hope you will find this information helpful and reassuring. Should you have any further questions, please do not hesitate to call us. We look forward to seeing you in the office soon!

It is **VERY IMPORTANT** that you fill out the enclosed forms before your visit. Upon completion, you may bring them with you to your appointment.

Bring your **INSURANCE CARD(S)** with you for every visit. We will scan them before your first visit and check for any changes each visit thereafter. Please notify the front desk of **ALL** insurance and demographic changes before your visit so that our files are current.

If your insurance requires **CO-PAY** for a specialist visit, payment is due at time of check in. We accept cash, check, and all major credit cards. If paying by credit card, it may take up to 2 weeks for transaction to process. Please be aware that **CO-PAY** will be required for **ALL** visits, including testing appointments. We understand that you may have to come for multiple tests and an office visit for results and apologize for any hardship this may cause, however it **IS NOT** our requirement, it is your insurance companies requirement that the co-pay is made EACH time you come to the office.

It is **YOUR RESPONSIBILITY** to obtain a **REFERRAL** from your primary care Physician, if it is required by your insurance. Please bring it with you to your appointment. If we do not have your referral, *WE WILL NOT BE ABLE TO SEE YOU due to insurance requirements.*

Please bring a **LIST OF ALL MEDICATIONS** you are currently taking to every visit. If you have had recent labs, EKG, Echo or Stress test please bring a copy of the reports with you to your visit.

Thank you for your cooperation. And again, if you have any questions, feel free to contact our office.

Sincerely,

**HEART & VEIN CENTER, P.A.**

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***Patient Demographics*** *(Confidential)*

# (AS A COURTESY TO OUR PATIENTS, OUR OFFICE WILL FILE YOUR INSURANCE)

# Date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male / Female

# Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#  Relationship Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BIRTHDATE: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

# Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May We Leave Message: Yes / No

# Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May We Leave Message: Yes / No

# Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Work #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May We Leave Message: Yes / No

### Single / Married / Divorced / Widowed

## Spouse Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Work #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May We Leave Message: Yes / No

# Primary Insurance Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May We Leave Message: Yes / No

# Nearest Relative Not Living with You: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ May We Leave Message: Yes / No

Do You Reside Anywhere Else During the Year: Yes / No?

# Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May We Leave Message: Yes / No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient Signature

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***Acknowledgement Receipt of Notice Privacy Practices***

**I Understand That as Part of My Health Care, The Practice Originates and Maintains Paper And/or Electronic Records Describing My Health History, Symptoms, Examination, Test Results, Diagnosis, Treatment and Any Plans For Future Care Or Treatment (Including But Not Limited To HIV/Hep Reports).**

**I Understand That This Information Serves as:**

\*A Basis for Planning My Care and Treatment

\*A Means of Communication Among the Health Professionals Who Contribute to My Care

\*A Source of Information for Applying My Diagnosis and Treatment Information to My Bill

\*A Means by Which a Third-Party Payer Can Verify That Services Billed Were Actually Provided

\*A Tool for Routine Healthcare Operations, such as Assessing Quality and Reviewing the Competence of Staff

\*I Authorize Heart & Vein Center, P.A to Download My Medication History and Prescription Benefits

**I Have Been Provided the Opportunity to Review “Notice of Patient Information Practices” That Provides a More Complete Description of Information Uses and Disclosures.**

**I Understand That I Have the Following Rights:**

\*The Right to Review The “Notice” Prior to Acknowledging This Consent

\*The Right to Restrict or Revoke the Use or Disclosure of My Health Information for Other Uses or Purposes

\*The Right to Request Restrictions as to How My Health Information May Be Used or Disclosed to Carry Out

 Treatment, Payment or Health Care Operations

**Restrictions:**

**I Request the Following Restrictions to The Use or Disclosure of My Health Information:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**May Discuss Treatment, Payment or Healthcare Operation with The Following Persons:**

**Please Check All That Apply: Spouse ( ) Children ( ) Parents ( ) Others ( )**

**Please List Names:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I Understand That as Part of Treatment, Payment or Healthcare Operation, It May Become Necessary to Disclose Health Information to Another Entity. Examples: Referrals to Other Healthcare Providers, Labs And/or Other Individuals or Agencies as Permitted or Required by State or Federal Law.**

**I Fully Understand and Accept the Information Provided by This Consent.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature Print Name Date

\*If Person Other Than Patient Is Signing, Are You: Parent, Legal Guardian, Custodian or Have Power of Attorney: Yes ( ) No ( )

FOR OFFICE USE ONLY

( ) Patient Refused to Sign Consent Form

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***Medical Release***

DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TO (OFFICE USE ONLY)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 I Request That a Copy of My All Medical Records Be Released to:

 Saba Thangam, M.D.

Please Send to: Heart & Vein Center, P.A.

 533 Medical Oaks Ave.

 Brandon, FL 33511

 Fax: 833 -994-1953

I Hereby Authorize You to Send Any and All Medical Records, Especially Reports on Cardiac Catheterizations, EKG tracing, H&P, Discharge notes, Previous Cardiology consult notes, Labs, ECHO, Nuclear Stress Test, Operative Reports, CTA’s, Arterial Doppler, Carotid Doppler, Office notes, and ER reports. PTCA’s and CABG’s, Labs

In Addition, I Also Authorize Heart & Vein Center, P.A. To Provide Copies of the Results of Any Special Procedures Performed to My Referring Physician as Noted in My Records.

A Copy or Fax of This Authorization May Be Used in Lieu of the Original.

Patient Name (Print) Date of Birth

Patient Signature Social Security Number



***Medical History***

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_

Have You Been Treated by Our Us Before Yes / No When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When Was the Last EKG: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Stress Test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What Pharmacy Do You Use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do You Have a History of?**

Heart Disease Yes / No Murmur Yes / No Chest Pain / Angina Yes / No

Palpitations Yes / No Sleep Apnea Yes / No Shortness of Breath Yes / No

Heart Attack Yes / No When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Cath Yes / No When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Angio / Stent Yes / No When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bypass Surgery Yes / No When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pacer / Defib Yes / No When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Adult Illnesses:**

High Cholesterol Yes / No Stroke / Paralysis Yes / No

High Blood Pressure Yes / No Congestive Heart Disease Yes / No

Cardiomyopathy Yes / No Arthritis Yes / No

Thyroid Disease Yes / No Hepatitis / Jaundice Yes / No

Diabetes Yes / No Cancer Yes / No

Asthma / COPD Yes / No Gallstones / Kidney Stones Yes / No

Depressive Disorder Yes / No Epilepsy / Seizures Yes / No

**Surgeries:**

Year \_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Year \_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Year \_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Year \_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:**

Father: Living/Deceased Age \_\_\_\_\_\_\_ Heart Disease: Yes / No Cause of Death \_\_\_\_\_\_\_\_\_\_\_\_\_

Mother: Living/Deceased Age \_\_\_\_\_\_\_ Heart Disease: Yes / No Cause of Death \_\_\_\_\_\_\_\_\_\_\_\_\_

# Of Brothers/Sisters with Heart Disease: \_\_\_\_\_\_\_\_\_

Family History of Abdominal Aortic Aneurysm: Yes / No

**Social History:**

Do You Smoke: Yes / No How Much: \_\_\_\_\_\_\_\_\_\_\_\_ Current Illegal Drug Use: \_\_\_\_\_\_\_\_\_\_\_\_

Have You Ever Smoked: Yes / No When Did You Quit: \_\_\_\_\_\_\_\_ Past Illegal Drug Use? \_\_\_\_\_\_\_\_

Do You Drink Alcohol Yes / No How Much: \_\_\_\_\_\_\_\_\_\_\_\_ Caffeine Intake? \_\_\_\_\_\_\_\_\_\_\_

**Medications**: Name Strength How Often

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

**Allergies to Medications**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



***PAD SCREENING FORM***

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

If You Have Lower Extremity Pain, Please Describe:

Location (Buttocks, Thighs, Knees, Feet): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Timing (Continuous, Occasional, Episodic): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do You Experience Any of the Following? Comments

1. Leg Cramping? Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Numb/Cold/Pale Feet? Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Pain When Leg Is Elevated and Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Improves When Leg Is Dangled?

1. Symptoms Relieved with Rest and Start Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

During exercise?

1. Decreased Ability to Walk for Any Reason? Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Leg Heaviness/Tiredness/Fatigue? Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Itching/Burning/Red/Hot/ Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Swollen/Throbbing Legs?

1. Have Your Veins Gotten Worse in Recent Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Months?

1. Have You Ever Had a Blood Clot in Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Legs or Phlebitis?

1. Do You Use Any Type of Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Compression/Support Hose?

Do They Provide Relief?

1. Are You Taking Any Pain Medicine? Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What Type and How Often?

1. Are You Taking Any Iron Supplements or Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vitamins with Iron?

1. Have You Ever Had Your Veins evaluated before? Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where and When?

1. Painful/No bleeding Ulcers on Feet or Toes? Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



***CANCELLATION/NO SHOW POLICY***

**It is our goal to provide high quality cardiology care in a timely manner. We have**

**Implemented a No Show and Cancellation policy which enables us to better utilize available appointments for our patients in need of cardiology care. A Confirmation call is a courtesy done by our office and not an obligation, so there will not be a reason to waive a No -Show fee.**

 **Patients are required to call or leave message, at least 24 Hours before their appointment time for Office visits, Ultrasound, and other Office Procedures.**

 **There will be a Charge of $25.00 for Non-Cancellation or No Show for Office visits, Ultrasound Procedures, and a Charge of $150.00 for Nuclear Stress Test Procedures. We appreciate your Cooperation!**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name Patient Signature Date**

**HEART AND VEIN CENTER, P.A**

533 Medical Oaks Ave. Brandon, Fl. 33511

Phone number: 813-295-5800 Fax number: 833-994-1953

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

For your convenience, we have answered a variety of commonly asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a Billing Specialist or the Practice Manager.

**How May I Pay?**

We accept payment by Cash, Check, VISA, MasterCard, American Express and Discover.

**Do I Need a Referral?**

If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, we have a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled.

**Which Plans Do We Contract With?**

Please see attached list.

**What Is My Financial Responsibility for Services?**

Your financial responsibility depends on a variety of factors, explained below.

|  |  |  |
| --- | --- | --- |
| **IF YOU HAVE….** | **YOU ARE RESPONSIBLE FOR…** | **OUR STAFF WILL:**  |
| Commercial Insurance also known as “regular” insurance  | Payment of the patient responsibility for all office visits, imaging, and other charges at the time of office visit. | Call your insurance company ahead of time to determine deductibles and coinsurance. |
| HMO and PPO plans with which we are contracted | If the services, you receive are covered by the plan: All applicable co pays and deductibles are due at the time of serviceIf the services, you receive are not covered by the plan: Payment in full is due at time of the visit.  | Call your insurance company ahead of time to determine deductibles and coinsurance. |
| Medicare | If you have Regular Medicare, and have not met your deductible, we ask that it be paid at the time of serviceCharges for any services not covered by Medicare are due at the time of the visit. If you have Regular Medicare as primary and have secondary insurance: No payment is necessary at the time of the visit. | File the claim on your behalf, as well as any claims to your secondary insurance. |
| No Insurance | Payment in full at the time of the visit. | Work with you to settle your account. Please ask to speak with our staff if you need assistance. |

**If you have a unique situation that has not been addressed in the above paragraphs please ask to speak to the office manager.**

**I have read, understand, and agree to the above Financial Policy.**

**I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility and due at the time of service.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Today’s Date: Patient Name Printed: Patient Signature:**