

PATIENT INFORMATION					
LAST NAME *	FIRST NAME *	MIDDLE *	PREFERRED	DATE OF BIRTH *	
<input type="checkbox"/> MALE *	SOCIAL SECURITY NUMBER *	RACE	<input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED		DRIVERS LICENSE NUMBER
PRIMARY LANGUAGE		ETHNICITY <input type="checkbox"/> HISPANIC/LATINO <input type="checkbox"/> NON-HISPANIC/LATINO			
ADDRESS *	CITY *	STATE *	ZIP CODE *	E-MAIL ADDRESS FOR PATIENT PORTAL	
HOME PHONE *	WORK PHONE *	MOBILE PHONE		PRIMARY PHONE *	
SPOUSE OR GUARDIAN NAME *		SPOUSE OR GUARDIAN SOCIAL SEC. NUMBER *		SPOUSE OR GUARDIAN DATE OF BIRTH *	
PHARMACY NAME AND ADDRESS*					
EMPLOYMENT INFORMATION					
PATIENT EMPLOYED BY:		POSTION OR DEPARTMENT		WORK PHONE	
EMPLOYER ADDRESS		CITY		STATE	ZIP CODE
INSURANCE INFORMATION					
PRIMARY INSURANCE COMPANY:		POLICY NUMBER:		GROUP NUMBER:	
SECONDARY INSURANCE COMPANY:		POLICY NUMBER:		GROUP NUMBER:	
MINORS ONLY - RESPONSIBLE PARTY INFORMATION					
NOTE: PARENT BRINGING CHILD FOR TREATMENT IS RESPONSIBLE FOR PAYMENT OF ACCOUNT. IF 18 OR OVER, YOU ARE RESPONSIBLE FOR INCURRED CHARGES. IF STUDENT, PARENT SIGNATURE REQUIRED					
PERSON RESPONSIBLE FOR MEDICAL EXPENSES *		RELATIONSHIP TO PATIENT *		HOME PHONE	
ADDRESS		CITY		STATE	ZIP CODE
SOCIAL SECURITY NUMBER		DATE OF BIRTH			
EMERGENCY INFORMATION					
PERSON TO CONTACT IN CASE OF EMERGENCY				RELATIONSHIP	
ADDRESS		CITY		STATE	ZIP CODE
PHONE NUMBER	WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?			Surgical	
CONSENT FOR TREATMENT – AUTHORIZATION OF BENEFITS – RELEASE OF MEDICAL RECORDS					
<p>I, the undersigned, consent to treatment necessary for the care of the above named patient. I hereby authorize Coastal Vascular Institute PA to furnish the protected health information to the Center for Medicare & Medicaid Services, or any other insurance carriers as described in the Notice of Privacy Practices, and I hereby assign to the physician all payments for medical services rendered to myself or dependent. In addition, I authorize release of my medical records to other health care providers as appropriate for coordination and management of my treatment. I understand this authorization will remain in effect for as long as my dependent or I remain a patient.</p>					

(Signature) Patient or Guardian _____ Date: _____



Coastal Vascular Institute, PA

The Premier Vascular Practice Serving the Coastal Carolinas

OUR FINANCIAL POLICY

Thank you for choosing Coastal Vascular Institute, PA as your health care provider. We are committed to your treatment being successful. Please read this **Financial Policy** and sign at the bottom prior to receiving treatment.

PAYMENT FOR SERVICES PROVIDED IS CONSIDERED YOUR RESPONSIBILITY!

PRIVATE PAYING PATIENTS: Patients who are not covered by an Insurance plan are expected to pay 100% of the billed amount at the time of checkout. If unable to do so you must make arrangements with our Accounts Receivable department prior to being seen. This can also include balances accrued from being seen at the hospital’s emergency room or for In-Patient surgeries prior to coming into our office.

PATIENTS WITH INSURANCE COVERAGE: **YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ARE NOT A PARTY TO THAT CONTRACT.** If you are covered by an Insurance Plan you are required to provide this information to our office staff as soon as possible. This will assist us in obtaining Prior Authorizations if required and/or informing you if our practice is not within Network with your policy. Failure to do so may cause you to have to pay out of pocket for the services.

PATIENTS WITH INSURANCE PLANS WITH WHICH WE ARE CONTRACTED: If we are participating with your insurance company, you will be expected to pay any contracted co-pays, coinsurance, and/or deductibles that apply. We will estimate your financial responsibility for the service(s) being provided. If your insurance pays less than estimated you will be responsible for the balance due. If your insurance pays more than estimated you will be refunded or that credit can be applied toward your next visit.

PATIENTS WITH INSURANCE PLANS WITH WHICH WE ARE NOT CONTRACTED: Our practice is committed to providing the best treatment for our patients, therefore we charge what is usual and customary for our area. You will be responsible for payment regardless of any nonparticipating insurance company’s arbitrary determination of usual and customary rates.

UNPAID INSURANCE CLAIMS: If your insurance company has not paid on a claim within 45 days, the balance will be billed directly to you. You will be responsible for contacting your insurance company concerning this and work to get the claim paid.

PATIENTS WITH A MEDICARE PLAN: Please be aware that some, and perhaps, all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. We will require a signed ABN from you if we know this ahead of time.

REGARDING ULTRASOUND APPOINTMENTS: In order to better serve our patients, we require at least 24 hours advance notice for cancellations of ultrasound appointments. **You will be charged a \$75 cancellation fee if you are unable to provide proper notice.** Patients who arrive over fifteen minutes late to their ultrasound appointment may be asked to reschedule the appointment.

MINOR PATIENTS: The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. It is against our policy to treat unaccompanied minors.

CHECK ACCEPTANCE POLICY: By using a check for payment, you agree to the following terms: In the event your check is dishonored or returned for any reason, you authorize us to electronically (or by paper draft) re-present the check to your bank account for collection of the amount, plus any applicable fees as permitted by state law.

METHOD OF PAYMENT: We accept **CASH, CHECKS, AMERICAN EXPRESS, DISCOVER, MASTERCARD & VISA.**

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the above Financial Policy and agree to abide by its terms.

Signature of Responsible Party

Date

Signature of Co-Responsible Party

Date

Patient’s Name if not Responsible Party Above

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned hereby acknowledges receipt of a copy of the Notice of Privacy Practices of Coastal Vascular Institute, PA

● _____
Patient/Guardian Signature

● _____
Date

FAMILY/FRIEND PHI AUTHORIZATION FORM

In accordance with Coastal Vascular Institute's *Notice of Privacy Practices* Section B, Item 5, we may share your personal health information with a family member, relative, friend or other person identified by you. Please list below the names of ALL persons you would permit to have such access to your personal health information.

Name

Relationship

Name

Relationship

Name

Relationship

Name

Relationship

Please note: In calling our physicians or our office for medication information/advice, we would prefer to speak with the patient directly. **Any person calling should be able to identify the patient's date of birth, physician name, and problem/procedure performed.** This enables us to further protect your right of privacy.

This authorization will continue until revoked or terminated by the patient upon submission and receipt of a written revocation to Coastal Vascular Institute.

● _____
Patient Name (please print)

● _____
Patient Signature

● _____
Date

Signature of Patient Representative

Relationship of Patient Representative



Coastal Vascular Institute, PA

David A. Weatherford, MD, RVT, FACS
Thomas D. Eskew, MD, RVT, FACS

To:

REQUEST FOR MEDICAL RECORDS RELEASE

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

Date(s) of records to be requested: _____

Type of records to be requested:

___ Initial Consult ___ Office Visits ___ CT/MRI
___ Radiographs ___ Pathology ___ Meds/Labs
___ Other:

PATIENT AUTHORIZATION

I, the patient or legal guardian, authorize the above requested medical records to be released by your facility to Coastal Vascular Institute, PA at the following:

Coastal Vascular Institute, PA
1411 Physicians Drive
Wilmington, NC 28401
Fax: 910-202-0827 (Clinical Staff) or
Fax: 910-343-5719 (Front Office Staff)

● Patient/Guardian Signature _____

Date _____

CVI Employee Signature _____

Date _____

PAST MEDICAL HISTORY

(Please X all that apply)

- | | |
|---|---|
| <input type="checkbox"/> No Significant Medical History | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Abdominal Aortic Aneurysm (AAA) | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Hernia Where? _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hiatal Hernia |
| <input type="checkbox"/> Angina | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Bleed easily / Clotting Disorder | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Cancer/Type: _____ | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Carotid Artery Disease (Neck Arteries) | <input type="checkbox"/> Mental Illness/Type: |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Coronary Artery Disease (Heart Disease) | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Deep Vein Thrombosis (DVT) / Blood Clot | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Degenerative Disc Disease | <input type="checkbox"/> PPD Positive |
| <input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Type I <input type="checkbox"/> Type II | <input type="checkbox"/> Pulmonary Embolus (blood clot in lung) |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Epilepsy (fits, seizures, convulsions) | <input type="checkbox"/> Stroke / Ministrokes (TIA) |
| <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Fibrocystic Breast Disease | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Gastro esophageal Reflux disease (GERD) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Other _____ |

PAST SURGICAL HISTORY

- | | |
|--|--|
| <input type="checkbox"/> No Surgical History | <input type="checkbox"/> EGD / Upper Endoscopy: |
| <input type="checkbox"/> AAA Repair: | <input type="checkbox"/> Gallbladder Removal: |
| <input type="checkbox"/> Abdominal Aortic Bypass: | <input type="checkbox"/> Heart Surgery / Type: |
| <input type="checkbox"/> Amputation / Type: _____ | <input type="checkbox"/> Hysterectomy: |
| <input type="checkbox"/> Angiogram: | <input type="checkbox"/> Knee Surgery: |
| <input type="checkbox"/> Angioplasty / Stenting / Type: _____ | <input type="checkbox"/> Lung Surgery: |
| <input type="checkbox"/> Appendectomy: | <input type="checkbox"/> Nissen Fundoplication (GERD): |
| <input type="checkbox"/> Bladder Surgery: | <input type="checkbox"/> Pacemaker Insertion: |
| <input type="checkbox"/> Breast Surgery / Type: _____ | <input type="checkbox"/> Port / Perm Catheter Placement: |
| <input type="checkbox"/> Bypass Graft Placed in legs: <input type="checkbox"/> Right <input type="checkbox"/> Left | <input type="checkbox"/> Splenectomy: |
| <input type="checkbox"/> Carotid Artery Surgery: <input type="checkbox"/> Right <input type="checkbox"/> Left | <input type="checkbox"/> Thyroidectomy: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Total <input type="checkbox"/> |
| Colon Resection: | <input type="checkbox"/> Tubal Ligation / Vasectomy: |
| <input type="checkbox"/> Colonoscopy: | <input type="checkbox"/> Varicose Vein Surgery / Type: _____ |
| <input type="checkbox"/> Colostomy: | <input type="checkbox"/> Vascular Surgery/ Type?: _____ |
| <input type="checkbox"/> C-Section: | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Dialysis Access/ Location _____ | <input type="checkbox"/> Other: _____ |

FAMILY MEDICAL HISTORY

- | | |
|--|--|
| <input type="checkbox"/> Abdominal Aortic Aneurysm: | <input type="checkbox"/> Fibrocystic Breast Disease: |
| <input type="checkbox"/> Alcoholism: | <input type="checkbox"/> Heart Attack: |
| <input type="checkbox"/> Anemia: | <input type="checkbox"/> High Cholesterol: |
| <input type="checkbox"/> Cancer / Type / Who? & Age of Onset:
_____ | <input type="checkbox"/> High Blood Pressure: |
| <input type="checkbox"/> Carotid Stenosis: | <input type="checkbox"/> Kidney Problems: |
| <input type="checkbox"/> Deep Vein Thrombosis (DVT): | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Family History of Arthritis: | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Family History of Diabetes : | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Family History of Stroke: | <input type="checkbox"/> Thyroid Disease: |
| | <input type="checkbox"/> Varicose Veins: |
| | <input type="checkbox"/> No Significant Family History |

● Patient Name:

● Date of Birth:

