Coastal Vascular Institute, PA

The Premier Vascular Practice Serving the Coastal Carolinas

PATIENT INFORMATION

LAST NAME *	FIRST NAME *	MIDDLE *	PREFERRED	DATE OF BIRTH *

☐ MALE * ☐ FEMALE	SOCIAL SECURITY NUMBER *	RACE	☐ MARRIED ☐ DIVORCED ☐ SINGLE * ☐ WIDOWED ☐ SEPARATED	DRIVERS LICENSE NUMBER

PRIMARY LANGUAGE	ETHNICITY ☐ HISPANIC/ LATINO ☐ NON- HISPANIC/ LATINO	

ADDRESS *	CITY *	STATE *	ZIP CODE *	E-MMAIL 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

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.

(**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

Coastal Vascular Institute, PA

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, P.A.

_____ _____

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 person 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**

Coastal Vascular Institute, PA

Patient History and Physical Form

Today's Date: _____

NAME: _____ **DOB:** _____ **AGE:** _____

Reason for today's visit: _____

Referring Physician: _____

Primary Care Physician: _____

Please list all **ALLERGIES & REACTIONS**: _____

Please list all MEDICATIONS (including over the counter medication Ex: Vitamins, Aspirin, etc.)

Medication	Dose	Frequency

SOCIAL HISTORY
(Please X all that apply)

Marital Status: □ Single □ Married □ Separated □Divorced □Widowed

Occupation:_____

Tobacco Use: □ Never □ Quit/When?:_____ □ Current Smoker/Packs Per Day: ____

Alcohol Use: □ Never/Quit When?:_____□ Rarely □ Moderate □ Daily/How Many Drinks?:____

Illicit Drug Use: □ Never □ Quit/When?:_____ □ Type & Frequency: _____

PAST MEDICAL HISTORY

(Please X all that apply)

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

PAST SURGICAL HISTORY

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

FAMILY MEDICAL HISTORY

[ ] Abdominal Aortic Aneurysm:
[ ] Alcoholism:
[ ] Anemia:
[ ] Cancer / Type / Who? & Age of Onset:

_____

[ ] Carotid Stenosis:
[ ] Deep Vein Thrombosis (DVT):
[ ] Family History of Arthritis:
[ ] Family History of Diabetes :
[ ] Family History of Stroke:
[ ] Fibrocystic Breast Disease:
[ ] Heart Attack:
[ ] High Cholesterol:
[ ] High Blood Pressure:
[ ] Kidney Problems:
[ ] Mental Illness
[ ] Obesity
[ ]Peripheral Vascular Disease
[ ] Thyroid Disease:
[ ] Varicose Veins:
[ ] No Significant Family History

Patient Name:

_____

Date of Birth:

_____

Coastal Vascular Institute, PA

Patient History and Physical Form

Please mark any symptoms you are having TODAY

Constitutional
[ ] Good General Health
[ ] Recent Weight Change
[ ] Night Sweats, Fever
[ ] Fatigue

Ears/Nose/Mouth/Throat
[ ] Hearing Loss or Ringing
[ ] Sinus Problems
[ ] Nose Bleeds
[ ] Sore Throat/Voice Change

Eyes
[ ] Wear Glasses/Contacts
[ ] Blurred/Double Vision
[ ] Eye Disease/Injury
[ ] Glaucoma

Cardiovascular
[ ] Chest Pain
[ ] Palpitations
[ ] Heart Trouble
[ ] Swelling Hands/Feet

Respiratory
[ ] Shortness of Breath
[ ] Cough
[ ] Wheezing/Asthma
[ ] Coughing up Blood

Musculoskeletal
[ ] Muscle Pain or Cramps
[ ] Stiffness/Swelling Joints
[ ] Joint Pain
[ ] Trouble Walking

Gastrointestinal
[ ] Nausea/Vomiting
[ ] Abdominal Pain
[ ] Rectal Bleeding
[ ] Bowel Problems

Neurological
[ ] Frequent Headaches
[ ] Paralysis or Tremors
[ ] Convulsions/Seizures
[ ] Numbness/Tingling

Integumentary
[ ] Change in Hair/Nails
[ ] Rashes or Itching
[ ] Breast Lump
[ ] Breast Pain or Discharge

Endocrine
[ ] Excessive Thirst/Urination
[ ] Thyroid Disease
[ ] Hormone Problems

Hematologic/Lymphatic
[ ] Bruise Easily
[ ] Delayed Healing
[ ] Enlarged Glands

Allergic/Immunologic
[ ] Food Allergies
[ ] Aspirin Allergies
[ ] Antibiotic Allergies
[ ] Environmental Allergies

Psychiatric
[ ] Insomnia
[ ] Confusion
[ ] Memory Loss
[ ] Depression

Genitourinary
[ ] Blood in Urine
[ ] Kidney Stones
[ ] Sexual Problems
[ ] Male Only – Testicle Problems
[ ] Female Only – Menstrual Problems

Have you had any:

New illness/conditions, hospitalizations, or surgeries since your last visit? YES / NO

(IF YES PLEASE LIST)_____

_____

_____

Medication Changes since last visit? YES / NO

(IF YES PLEASE LIST)_____

_____

_____

Any Concerns you would like addressed today? YES / NO

(IF YES PLEASE LIST)_____

_____

_____

Patient Name: **Date of Birth:**