



PATIENT INFORMATION

LAST NAME*		FIRST NAME*		MIDDLE*		PREFERRED		DATE OF BIRTH*	
GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		SOCIAL SECURITY NUMBER*		RACE		STATUS* <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED			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			CELL PHONE*		PRIMARY PHONE*	
SPOUSE/GUARDIAN NAME*			SPOUSE/GUARDIAN SOCIAL SECURITY NUMBER*			SPOUSE/GUARDIAN DATE OF BIRTH*			
PHARMACY NAME AND ADDRESS*							AUTOMATIC RX UPDATE? <input type="checkbox"/> YES <input type="checkbox"/> NO		
PRIMARY CARE PROVIDER*					WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?				

EMPLOYMENT INFORMATION

PATIENT EMPLOYED BY*		POSITION/DEPARTMENT*			WORK PHONE*		
EMPLOYER ADDRESS*				CITY*		STATE*	ZIP*

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 IS REQUIRED.

PERSON RESPONSIBLE FOR MEDICAL EXPENSES*		RELATIONSHIP TO PATIENT*			PRIMARY PHONE*	
ADDRESS*			CITY*		STATE*	ZIP CODE*
SOCIAL SECURITY NUMBER*				DATE OF BIRTH*		

EMERGENCY CONTACT

PERSON TO CONTACT IN CASE OF EMERGENCY*		RELATIONSHIP*		PHONE NUMBER*	
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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/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 check-in. 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 in 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, co-insurance, 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 towards your next visit.

PATIENTS WITH INSURANCE PLANS WITH WHICH WE ARE NOT CONTRACTED: Our practice is committed to providing you 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 15 minutes late to their ultrasound appointment may be asked to reschedule the appointment.

MINOR PATIENTS: The adult accompanying a minor and the parents (or guardian 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, VISA & MASTERCARD.

Thank you for understanding our Financial Policy. Please let us know if you have any 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



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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

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

Phone Number

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's 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

Phone: (910) 343-0811

Fax: (910) 343-5719 (Front Office Staff) or (910) 202-0827 (Clinical Staff)

Patient/Guardian Signature

Date

CVI Employee Signature

Date

Patient Name: _____ Date of Birth: _____

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 (COPD)
- 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
- Gastroesophageal 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/Ministroke (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: Left Right
- Carotid Artery Surgery: Left Right
- 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

- No Significant Family History
- Abdominal Aorta Aneurysm (AAA)
- 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 Vein