Florida Vascular Specialists
3 SW 129th Ave Suite 101-102, Pembroke Pines, FL 33027
T: 954-852-3831 F: 954-852-3832
E: frontdesk@floridavascularcare.com

NEW PATIENT REGISTRATION

Last Name: _____ **First Name:** _____ **Middle Name:** _____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Date Of Birth: _____ **Gender:** ☐ M ☐ F **Race:** ☐ White ☐ African American ☐ Other
Primary Language: ☐ English ☐ Spanish ☐ Other _____ **Marital Status:** ☐ S ☐ M ☐ D ☐ W
Home Phone: _____ **Cell Phone:** _____ **E-mail Address:** _____

Emergency Contact Name: _____ **Relationship:** _____
Emergency Contact Phone Number: _____

***Primary Care Physician Full Name:** _____
Primary Care Physician Address: _____
***Primary Care Physician Phone Number:** _____ **Fax Number:** _____
***Referring Physician Full Name:** _____
***Referring Physician Phone Number: (** _____ **)** _____ **Fax Number: (** _____ **)** _____

***Preferred Pharmacy Name:** _____ ***Pharmacy Phone Number:** _____
Pharmacy Address: _____

INSURANCE INFORMATION

Primary Insurance Name: _____ **Member ID:** _____
Policy Holder's Name: _____ **Policy Holder's Date of Birth:** _____
Relationship to Patient: ☐ Self ☐ Spouse ☐ Family
Secondary Insurance Name: _____ **Member ID:** _____
Policy Holder's Name: _____ **Policy Holder's Date of Birth:** _____
Relationship to Patient: ☐ Self ☐ Spouse ☐ Family

INFORMATION VERIFICATION

By signing below, I verify that the above information is correct to the best of my knowledge. I will not hold my doctor, or any staff member, responsible for any errors or omissions that I have made in the completion of this form.

X _____ **X** _____
Signature of Patient (Parent or Guardian in Minor) **Date**

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MEDICAL HISTORY

Full Name: _____

Reason for Visit? _____

_____

_____

Past Medical History:

ARTHRITIS			☐ YES ☐ NO
KIDNEY DISEASE			☐ YES ☐ NO
HEART ATTACK	☐ YES ☐ NO	IF YES, DATE	
DIABETES			☐ YES ☐ NO
HIGH BLOOD PRESSURE			☐ YES ☐ NO
CONGESTIVE HEART FAILURE			☐ YES ☐ NO
HEART DISEASE			☐ YES ☐ NO
HEART VALVE DISEASE/REPLACEMENT			☐ YES ☐ NO
HEART STENTS	☐ YES ☐ NO	IF YES, DATE	
HEART MURMUR			☐ YES ☐ NO
LUNG DISEASE			☐ YES ☐ NO
FIBROIDS			☐ YES ☐ NO

Family History:

CANCER	☐ MOTHER	☐ FATHER	☐ OTHER	
HEART DISEASE	☐ MOTHER	☐ FATHER	☐ OTHER	
DIABETES	☐ MOTHER	☐ FATHER	☐ OTHER	
AMPUTATION	☐ MOTHER	☐ FATHER	☐ OTHER	
FIBROIDS	☐ MOTHER	☐ FATHER	☐ OTHER	
STROKE	☐ MOTHER	☐ FATHER	☐ OTHER	

Social History:

SMOKING		☐ YES ☐ NO
	IF YES, HOW MANY PACKS PER DAY, FOR HOW MANY YEARS	( ) PACKS ( ) YEARS
ALCOHOL		☐ YES ☐ NO
ILLICIT DRUGS		☐ YES ☐ NO

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Surgical History: **Year:**

Medication Name: **Dosage:** **Frequency:**

Please List Any Allergies:

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OPTIONAL AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize Florida Vascular Specialists (FVS) to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, test results or medical care.

1. **Full Name:** _____

   Relationship: _____ **Phone Number:** _____

2. **Full Name:** _____

   Relationship: _____ **Phone Number:** _____

NOTICE OF PRIVACY PRACTICE OF FLORIDA VASCULAR SPECIALISTS, LLC

This notice describes how Health Information about you as a patient of the Doctors of Florida Vascular Specialist, LLC may be used and disclosed, and how you can obtain access to your protected health information. As required by the privacy regulations created as results of Health Insurance Portability and Accountability Act of 1996 (HIPAA).

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your protected health information. In conducting our Practice, we will create records pertaining to you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information the identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your protected health information. By federal and state law, we must follow the terms of the notice privacy practice that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your protected health information.
- Your privacy rights in your protected health information.
- Our obligation concerning the use and disclosure of your protected health information.

The terms of this notice apply to all records containing your protected health information that are created and/or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all your records that we may create or maintain in the past, and for any of the records that we may create or maintain in the future. Our practice will post a copy of our current Noice in our office in a visible location and may request a copy of our most current Notice at any time.

I hereby acknowledge that I have received the Notice of Privacy Practices from Florida Vascular Specialists, which sets forth the ways in which my personal health information may be used or disclosed by Florida Vascular Specialists and outlines my rights with respect to such information.

The consent will remain active until I withdraw my consent in writing.

Patient's Signature: _____ **Date:** _____

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AUTHORIZATION TO OBTAIN MEDICAL RECORDS

Last Name: _____ **First Name:** _____ **Middle Name:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

_____

Date Of Birth: _____ **Home Phone:** (____) _____ **Cell Phone:** (____) _____

I hereby authorize and request the release of my following medical information to:

Physician/Hospital/Facility:
Florida Vascular Specialists
Address: 3 SW 129TH Ave, Suite 101 Pembroke Pines, FL 33027
Phone Number: 954-852-3831
Fax Number: 954-852-3832

Requesting Medical Records to be released from Physician/Hospital/Facility:
Name of Physician/Hospital/Facility: _____
Address: _____
Phone Number: _____ Fax Number: _____

Information Needed (Most Recent):
☐ Progress Notes
☐ Lab Report
☐ Entire Medical Records
☐ Operative Reports
☐ Biopsy Reports
☐ Radiology Reports:

- ☐ CTA ☐ MRA ☐ X-Ray - (Of the Foot and/or Knee) ☐ Ultrasound - (Of the leg and/or Pelvic/Bladder/Prostate) ☐ MRI - (Of the Knee, Pelvis, and/or Prostate)

☐ Other: _____

PLEASE FAX MEDICAL RECORDS TO 954-852-3832

I understand that my consent is required to release my health care information. As required by state and federal law, Florida Vascular Specialists may not use or disclose my health information without my authorization. My signature on this form indicates that I am giving permission to obtain the protected health information described on the form above. I hereby authorize the release of this information to Florida Vascular Specialists.

Patient's Signature: _____ **Date:** _____

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CONSENT, PERMISSION, AND RELEASE FOR USE OF PHOTO, VIDEO, AND/OR AUDIO

I hereby give consent and permission to **Florida Vascular Specialists, LLC** to record the appearance, physical likeness and/or voice on videotape, on film or digital video disk, or other means, and/or take photographs of the appearance of **(PRINT NAME)** _____.

Notwithstanding any prohibition as may be contained in Section 540.08, Florida Statutes, I hereby freely and voluntarily consent to the use and publication of my name, participation, pictures, and/or likeness by **Florida Vascular Specialists, LLC** and/or it's employees and/or agents, as well as the entity seeking this consent, and photographs, video and/or audio for any and all purposes including, but not limited to, educational, promotional, advertising, and trade, through any medium or format, including, but not limited to, film, photograph, television, radio, digital, internet, or exhibition, at any time from this date forward until I revoke this consent in writing.

I acknowledge the **Florida Vascular Specialists, LLC** the sole owner of all rights in, and to, this visual and/or sound production and/or photograph(s) and the recordings, thereof, and that it has the right to use or reproduce the resulting images and/or sound as often as it finds necessary. I acknowledge that the photographs, video and/or audio may be used indefinitely television, radio, newspapers, magazines, newsletters, brochures, internet, intranet, or in other media once released.

Florida Vascular Specialists, LLC has the rights, among other things, to edit and/or otherwise alter the visual or sound recording or photographs, as needed. I understand I will receive no compensation for the appearance of the above-named person or for participation in said productions. I agree to hold **Florida Vascular Specialists, LLC** it's employees and other parties harmless against claim, liability, loss, or damage caused by, or arising from, my participation in this production.

I have read this consent before signing and fully understand the contents, meaning and impact of this consent. I understand that I am free to address any specific questions and have done so prior to signing this consent.

Patient's Signature: _____ **Date:** _____

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CONSENT TO TREAT AND TELEHEALTH CONSENT

This consent provides us with your permission to perform reasonable and necessary medical examinations and treatment. It also permits us to provide these services as telehealth services. By signing below, you are indicating that you understand that this consent is continuing in nature, even after a specific diagnosis has been made and treatment recommended. You always have the right to ask additional questions, to discontinue services or decline services.

TELEHEALTH SERVICES

All telehealth services will be provided in a HIPAA compliant manner. For all online telehealth services, service will be from a private office space where your privacy is ensured. Patients can connect to telehealth services using any approved digital device (computer, smart phone, etc.). An internet connection is necessary in order to participate in most telehealth services. It is the responsibility of the patient to ensure your privacy on your end when participating in telehealth services. All other procedures regarding informed consent for treatment, privacy practices, and rights & responsibilities will be followed as per in person services.

CONSENT FOR TREATMENT

I voluntarily consent and agree to *Florida Vascular Specialists* to perform reasonable and necessary medical examination, testing and treatment for the condition that has brought me to seek care at this practice. I understand some services may be provided as telehealth services. I understand telehealth services involve the use of audio, video, or other electronic communication technologies. I understand it is my responsibility to find a secure and private location for the telehealth services. I understand that there are potential risks related to use of telehealth such increased risk for breach of confidentiality if I am not in a private place during the session. I understand that there may be limits to treatment modalities utilized with use of telehealth vs in person treatment options. I further understand technical difficulties may arise that could affect the quality or time of the telehealth session; I will not hold the provider responsible for any technology-related problems.
I understand that I may withdraw my consent at any time I choose to do so either in writing or verbally.

This form has been fully explained to me, and I certify that I understand and agree to its contents and the purpose thereof. I agree to be contacted by telephone, text message and email. I also certify that I am legally able to provide consent for the person named above.

Patient's Signature: _____ **Date: _____**

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RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFITS

For those health care providers who accept assignment, I hereby authorize any insurance carrier with whom I have a policy to direct to that provider any benefits of any policies of insurance to those health care providers who have rendered services to me and who accept such assignment. I agree to pay all charges that are not paid in full under any policies of insurance. If such amounts due to health care providers are not paid after reasonable notice, that account shall be deemed delinquent, and a service charge shall be added to the amount due. If I default on payment of an account, I agree to be responsible for collection fees and interest due on amounts in default, including court costs and reasonable attorney's fees. If the debt is assigned to a third party for collection, I agree to be responsible for collections fees and interest due on amounts in default.

RELEASE OF INFORMATION

The health care provider involved in my care may release information about me necessary to substantiate insurance claims.

MEDICARE LIFETIME BENEFICIARY CLAIM AUTHORIZATION AND RELEASE OF INFORMATION

I request that payment of authorized medical benefits be made either to me or on my behalf to *Florida Vascular Specialists* for any services furnished to me by the physician/supplier. I authorize any holder of medical information about me to release to *Florida Vascular Specialists* and its agents any information needed to determine benefits or the benefits payable for related services.
I understand my signature requests that payment be made, and I authorize the release of medical information necessary to pay the claim. If other health insurance is indicated on Item 9 of the HCFA-1500 claim form or elsewhere on the approved claim form or cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

Patient's Signature: _____ **Date:** _____

Submit Now