Fayetteville Vascular and Vein Center, P.A

Michael A. Leke
American Board of Surgery Certified
Vascular and Endovascular Surgery

HEALTH HISTORY

TO BE COMPLETED BY PATIENT

Name: _____DOB: _____Date: _____

Reason for Visit: _____ Primary Care Physician: _____

Medical Problems - Please indicate if you are currently experiencing any of the following: (√)

None	Cirrhosis of liver	Gallstones	Kidney disease/failure	Stroke/paralysis
Anemia	Colon Cancer	Heartburn	Kidney Stone	Thyroid problems
Anxiety	Colon Polyps	Hepatitis-Type___	Osteoporosis	Other: _____
Arthritis	Crohn's Disease	Hiatal Hernia	Pancreatitis	
Asthma	Depression	High Blood Pressure	Parkinson's Disease	
Cataracts	Diabetes	High cholesterol	Rheumatic Fever	
Chronic cough	Diverticulosis	Irregular heartbeat	Seizure	
Chronic lung disease	Fibromyalgia	Irritable bowel syndrome	Stomach/duodenal ulcer	

Surgeries/Procedures – Please indicate if you have previously had a surgery or procedure: (√)

None	C-section	Hiatal Surgery	Prostate
Appendectomy	Dialysis access surgery	Hysterectomy	Stomach
Breast surgery-KIND_____		Joint replacement	Thyroid
Cardiac Surgery	Endoscopy (EGD)-Date: _____		Tonsillectomy
Colon resection	Gallbladder surgery	Liver biopsy	Tubal ligation
Colonoscopy-Date	Hemorrhoidectomy	Obesity surgery	Other: _____

Social History: (√)

Marital Status: Single Married Divorced Widow

Current Occupation: _____Employer: _____

Do you currently smoke? _____ If you've smoked previously, when did you stop? _____
How many packs per day? _____ For how many years? _____ Do you drink alcohol? _____ How many per day? _____
per week? _____ per month? ____ Do you use illicit drugs? _____ If yes, what kind? _____

Family History: (√)

History of Heart disease (heart attack, heart failure)? Yes No Whom: _____

History of Strokes? Yes No Whom: _____

History of High Blood Pressure? Yes No Whom: _____

History of Diabetes? Yes No Whom: _____

History of Cancer? Yes No Whom: _____

HEALTH HISTORY

Allergies: (√) NONE Aspirin Morphine Penicillin Sulfa Versed Valium Shellfish IVP Dye Other:_____

Medications: Please include **STRENGTH &DOSAGE**

Medication Name	**Dosage (Amount)**	**Frequency (How Often)**
Example: Lipitor	*10mg*	*2x per day*

Do you take any non-prescription medicines, herbal remedies, or tonics? (e.g. laxatives, diet pills, vitamins, antacids, or cold remedies) Yes No If yes, specify below

Name of Medicine, Remedy, Tonic, etc.	**Dosage (Amount)**	**Frequency (How Often)**
Example: Multivitamin	*1 pill*	*1x per day*

Review of Systems: Please indicate if you are currently experiencing the following: (√)

General: None Fevers Chills Sweats Fatigue Malaise Weight Loss

Eyes: None Blurring Diplopia (Double Vision) Irritation Discharge Vision Loss Eye Pain

Ears/Nose/Throat: None Earache Ear Discharge Tinnitus (Ringing in Ear) Decreased Hearing Nasal Congestion Nosebleeds Sore Throat Hoarseness Dysphagia (Difficult Swallowing)

Cardiovascular: None Chest Pain Palpitations Syncope (Passing Out) Dyspnea On Exertion (Shortness of Breath) Orthopnea (Shortness of Breath When Lying Down) Peripheral Edema (Leg Swelling)

Respiratory: None Cough Dyspnea (Shortness of Breath) Excessive Sputum Hemoptysis Wheezing

Gastrointestinal: None Nausea Vomiting Diarrhea Constipation Change In Bowel Habits Abdominal Pain Melena (Black Stool) Hematochezia (Rectal Bleeding) Heartburn Jaundice (Yellow Skin)

Genitourinary: None Vaginal Discharge Incontinence Dysuria (Painful Urination) Hematuria (Bloody Urination) Urinary Frequency Amenorrhea (No Menstruation) Menorrhagia (Heavy Menstruation) Abnormal Vaginal Bleeding Pelvic Pain

Musculoskeletal: Non Back Pain Joint Pain Joint Swelling Muscle Cramps Muscle Weakness Stiffness Arthritis

Skin: None Rash Itching Dryness Tattoo (S)

Neurologic: None Transient Paralysis Weakness Seizures Syncope (Passing Out) Tremor Vertigo

Psychiatric: None Depression Anxiety Memory Loss Suicidal Ideation Hallucinations Paranoia

Endocrine: None Cold Intolerance Heat Intolerance Polydipsia (Excessive Thirst) Polyuria (Excessive Urination)

Heme/Lymphatic: None Abnormal Bruising Bleeding Enlarged Lymph Nodes

Allergic/Immunologic: Non Urticarial (Itching) Hay Fever HIV Exposure Eczema

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

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DEMOGRAPHIC INFORMATION

(Required by the Federal Government)

NAME: _____ **D.O.B:** _____

RACE: ❑ White ❑ Black ❑ Asian ❑ Other: _____

ETHNICITY: ❑ Non-Hispanic ❑ Hispanic

PREFERRED LANGUAGE: ❑ English ❑ Spanish ❑Other: _____

COMMUNICATION PREFERENCE: ❑ Home Phone ❑ Cell Phone ❑ US Mail

SMOKING STATUS: ❑ Never Smoked ❑ Quit Smoking

❑ Current Occasional Smoker ❑ Current Daily Smoker

MARITAL STATUS: ❑ Married ❑ Never Married ❑ Legally Separated

❑ Divorced ❑ Widowed ❑Domestic Partner ❑Annulled

HEIGHT: _____ **WEIGHT:** _____

PREFERRED PHARMACY: _____

Signature: _____ **Date:** _____

Fayetteville Vascular and Vein Center, P.A

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American Board of Surgery Certified
Vascular and Endovascular Surgery

PATIENT CONSENT

Patient Name: _____DOB: _____

Social Security Number: _____

By signing this consent form you are giving the providers and office staff permission to use and disclose your health information. Your health information will be used and disclosed to provide your care and treatment, to bill and collect payment for the services provided, and to perform necessary routine operations.

You have been provided with a copy of our "Notice of Privacy Practices" that contains a complete description of the uses and disclosures covered under this consent. You have been given time to review the "Notice of Privacy Practices" and we have encouraged you to read it and ask any questions that you may have prior to signing this consent.

Our Office reserves the right to change the privacy practices as stated in the "Notice of Privacy Practices". You will be given a copy of the revised notice with you first office visit following any change. The most current notice is prominently posted in our waiting room and our examination rooms. You may request a copy at any time.

You have the right to request that we restrict how your health information is used or disclosed. We are not required to agree to your request restriction, but if we do agree to the restriction, we will honor the restriction.

You have the right to revoke this consent except to the extent that we have already taken action covered under the consent. If you choose to revoke this consent, you must do so in writing

CONTACT INFORMATION

May we leave a message? ☐Yes ☐No

With whom may we discuss your health information? ☐Spouse Other_____

This consent must be signed the patient and dated

_____ _____

Signature of Patient or Responsible Party Relationship if Not Patient

_____

Date

Fayetteville Vascular and Vein Center, P.A

Michael A. Leke
American Board of Surgery Certified
General, Vascular and Endovascular Surgery

PATIENT INFORMATION WORKSHEET

DATE: _____

PATIENT NAME: _____ DOB: _____

PHONE: HOME _____ CELL _____ WORK _____

ADDRESS: _____ APARTMENT/SUITE #_____

CITY: _____ STATE: _____ ZIP CODE: _____

SOCIAL SECURITY NUMBER: _____

PRIMARY INSURANCE CARRIER: _____

SECONDARY INSURANCE CARRIER: _____

REASON FOR APPOINTMENT: _____

REFERRED BY: _____ TELEPHONE #: _____

PRIMARY CARE PROVIDER: _____

APPOINTMENT DATE: _____ TIME: _____

3410 Village Drive, Suite 200 • Fayetteville, North Carolina 28304 • Phone: (910)-401-0202, Fax: (901)-401-0210

Fayetteville Vascular and Vein Center, P.A.

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Vascular and Endovascular Surgery

PATIENT PAYMENT POLICY

Thank you for choosing our practice! We believe that establishing a written financial policy is mutually beneficial for all parties. It is our goal to avoid any miscommunication or concerns regarding financial matters in order to focus our energies on providing healthcare services to our patients. Your insurance coverage and benefits are a contract between you and your insurance. Each plan has different benefits for you as well as different financial obligations. Not all insurance policies cover all services. It is your responsibility to file all charges with any secondary insurance carriers for reimbursements.

If you have insurance coverage under a plan with which we do not have a contract, you will be treated as a "self-pay" patient and will be provided documentation to assist you in filing your own claim. We offer a reasonable discount for our cash paying patients. We will give you an estimate of what will be due at the time of service and payment for services is due at the time of service. Co-pays are due at the time of registration.

On occasion, a patient may need specialized testing or surgery. Diagnostic testing and surgical co-insurance/deductibles are due prior to surgery. Your financial obligation will be verified with your insurance company and communicated to you at least 24 hours prior to services being render.

Parents are financially responsible for care rendered to their minor child. The adult (parent/guardian) accompanying a minor to the first visit is responsible for any balances not covered by the insurance plan. **We do not bill another individual or estranged spouse for payment.**

The following are our financial guidelines relative to financial responsibility:

- We accept the following forms of payment: CASH, CHECK, DEBIT CARD, VISA, & MASTERCARD
- We are participating providers with Medicare, Medicaid, Worker's Compensation and most Managed Care Plans.
- We cannot extend professional courtesy discounts.
- There is a $35 fee for the completion of any disability forms.
- There is a $35 No-show fee for missed appointments; no fee will be charged if appointment is cancelled with 24 hours' notice.
- A service charge of $35 will be added for:
    - Returned checks
    - Re-filing of insurance due to incomplete or incorrect information given at the times of service
    - Administrative fee associated with accounts turned over to collection agencies
- Accounts will be turned over to a collection agency if past due 60 days or more

I understand that I am responsible for all collection costs involved with the collection of this account including court cost, reasonable attorney fees and all other expenses incurred with collection if I default on any unpaid balances.

We appreciate the opportunity to serve you. If you have any questions regarding this policy, please let us know.

Patient (or responsible person) Signature_____ Date_____

PATIENT RIGHTS & RESPONSIBLITIES

PATIENT RIGHTS

1. You have the right to receive care that is free of discrimination, respectful of your personal privacy, personal values, dignity, and beliefs. Fayetteville Vascular and Vein Center, P.A prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sexual orientation and gender identity or expression.
2. You have the right to receive care in a safe environment free from all forms of abuse, neglect, or mistreatment.
3. You have the right to be called by your proper name and to be in an environment that maintains dignity and adds to a positive self-image.
4. You have the right to confidentiality, privacy, and security of your healthcare information.
5. You have the right to confidential medical records. Except as otherwise required by law, your entire records and/or portions of your records will not be released to outside entities or individuals without you and/or your designated representatives' expressed written approval. You would be given the opportunity to approve or refuse the release of your medical records
6. You have the right to agree or refuse the use of recording, films, or other pictures used for reasons other than your care.
7. You have the right to know the identity and status of individuals providing service to you.
8. You have the right to change providers if you so choose. You would be informed of the credentials of all staff members who will be providing care during your stay.
9. Unless participation is medically contraindicated, you have the right to participate in all decisions involving your healthcare.
10. You have the right to refuse care/treatment to the extent permitted by law. Your care provider will explain the medical consequences of refusing recommended treatment. You are encouraged to discuss care objectives with your provider.
11. You have the right to have your compliments, concerns, and complaints/grievances addressed. Your concerns will not affect your access to care, treatments, or services. Please direct your comments to the medical director or office manager who will complete an" Incident

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Notification" and bring the issue to the attention of the provider in a timely manner so the grievance may be address.

12. You have the right to be provided with information regarding emergency and after-hours care.
13. You have the right to obtain a second opinion regarding the recommended procedure. Responsibility for the expense of the second opinion rests solely with the patients.
14. You have the right to have visitors at the clinic as long as visitation does not encumber clinic operations and the rights of other patients are not infringed.
15. You have the right to participate in or decline to participate in research. You may decline at any time without compromising your care or treatment.
16. You have the right to an interpreter if one is required.
17. You have the right to be provided informed consent forms as required by the laws of the State of North Carolina
18. You have the right to truthful marketing and/or advertising regarding the competence and capabilities of the clinic and its staff.
19. You have the right to receive information about advance directives (Living Will, Healthcare Power of Attorney), obtain assistance in completion of advance directives, and have advance directives honored once legally executed and available on the medical record.
20. You have the right to be provided, upon request, all available information regarding services available at the clinic, as well as information about estimated fees and options for payment.
21. You have the right to be involved in end of life care decisions to include withholding life sustaining treatments, resuscitative services, and organ/ tissue donation.
22. You have the right to approve the release of your medical records to other care providers, legal representatives and other persons you designate.

PATIENTS RESPONSIBILITIES

- You are expected to provide complete and accurate information, including your full name, address, home telephone number, date of birth, Social Security number, insurance carrier and employer when it is required.
- You are expected to provide complete and accurate information about your health and medical history, including present condition, past illnesses, hospital stays, medicines, vitamins, herbal products, and any other matters that pertain to your health, including perceived safety risks.
- You are responsible for keeping all schedule pre- and post-procedure appointments and complying with treatment plans to help ensure appropriate care.
- You have the responsibility to keep appointments, be on time, and call your health care provider if you cannot keep your appointments.
- You are responsible for reviewing and understanding the information provided by your physician or nurse. You are responsible for understanding your insurance coverage and the processes required for obtaining coverage.
- You are expected to ask questions when you do not understand information or instructions. If you believe you cannot follow through with your treatment plan, you are responsible for telling your doctor. You are responsible for outcomes if you do not follow the care, treatment, and service plan.
- You are responsible for providing insurance information at the time of your visit and for notifying the receptionist of any changes in information regarding your medical insurance or medical history.
- You are expected to meet your financial responsibility to the facility, to pay for your care (after any insurance payments have been made) or ask for financial assistance.
- You are responsible for paying all charges for co-payments, co-insurance and deductibles or for non-covered services at the time of the visit unless other arrangements have been made in advance with the clinic administrator.
- You are responsible for treating physicians, staff and other patients in a courteous and respectful manner.
- You are responsible for expressing your opinions, concerns or complaints in a constructive manner to the appropriate personnel at the Clinic.

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NOTICE OF PRIVACY PRACTICES

Effective: March 1, 2009

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

The physician and staff of Fayetteville Vascular and Vein Center, P.A. are legally required to protect the privacy of your health information and to abide by the requirements stated in this document. This Notice of Privacy Practices describes our legal duty to protect the privacy of your health information and the policies and procedures this office has in place to do so.

Our office is required to prominently post the most current notice at all times. A copy of the current Notice of Privacy Practices for Fayetteville Vascular and Vein Center, P.A. will be given to each patient on their first office visit following March 1, 2009. You will be asked to sign an acknowledgement that you received a copy. A copy of this notice will be provided to any individual upon request.

If you need additional information about anything contained in this notice, please contact out office by calling (910)401-0202. We encourage you to ask questions about anything that you do not understand.

Any changes that are made will be highlighted on the most current Notice of Privacy Practices that is posted in our office so that they are easily recognized. If changes are made to this Notice of Privacy Practices, you will be provided with a copy of the revised Notice on your first visit following the revision.

Fayetteville Vascular and Vein Center, P.A. have policies and procedures to insure that your health information is protected. These include specific guidelines for how and when your health information is used, when and how it is disclosed, how confidentiality is maintained, who has access to your health information, and when your health information can be shared with others.

Our office will use and disclose your information to provide you care and treatment, bill and collect payment for services received and carry out the routine health care operations of this office. The uses and disclosures include but are not limited to the following:

- Administrative functions within the office, assembling health information, filing records, scheduling appointments, reminding patients of appointments and other scheduled activities, billing and collecting for services.
- Record creation, documentation and monitoring of your health status.
- Communication among the workforce of this office, either verbally or in writing, information that is required for them to perform the functions of their job.
- Consulting with other providers and their workforce, providing health information as required and making referrals.
- Verifying your benefits and eligibility with your insurance company

- Obtaining authorization from your insurance company as required.
- Calling in prescriptions to your pharmacy.
- Providing health information as needed for scheduling appointments for diagnostic tests, surgery, admission, consultations, home health and other services that you require.
- Providing health information to your insurance company as requested for their administrative requirements.

Our office may contact you directly by phone, answering machine, fax, electronically or by mail for any of the following activities:

- Providing appointment reminders for this office
- Scheduling appointments for this office and or other offices as necessary and providing you with appointment information
- Describing or recommending treatment alternatives
- Providing pre-test instructions and test results
- Providing information about health released benefits and services that may be of interest to you such as classes of educational opportunities

If Fayetteville Vascular and Vein Center, P.A. needs to treat you in an emergency situation, you will be provided with a copy of the Notice after your emergency has been taken care of and a good faith effort will be made to obtain your acknowledgment of receipt of the Notice.

Your health information may be used and disclosed without your authorization in the following circumstances if you are informed and given the opportunity to agree or object. If you are not present or the opportunity for you to agree or object cannot be provided, we may decide whether the disclosure is in your best interest based on professional judgment

- To a family member or other relative, close friend, or other person identified by you, the health information relevant to that's person's involvement in your care or payment.
- To a family member, close personal friend, personal representative, or other person responsible for your care regarding your location, general condition or death
- To a public or private organization authorized by law to assist in disaster relief efforts as required by law

Your health information may be used and disclosed without your authorization or the opportunity for you to either agree or object in the following circumstances as required by law.

- For public health activities including but not limited to reporting of communicable diseases, reporting births and deaths, and public health surveillance as required by law
- For suspected child abuse and neglect as required by law.
- To the Food and Drug Administration (FDA) to report adverse events including adverse drug reactions and product defects or problems are required by law.
- To your employer if you have a work related injury or illness or a workplace related medical surveillance as required by law
- To a government authority if you are a victim of abuse, neglect or domestic violence (You must be informed of such a report unless, in the exercise of professional judgment it puts you at risk of serious harm) as required by law

- To a health oversight agency as authorized by law including audits; civil, administrative or criminal investigations; inspections; licensure or disciplinary actions as required by law
- In response to a court order or court-ordered warrant, a subpoena or summons issued by a judicial officer, a grand jury subpoena or administrative request as required by law
- To law enforcement officials for the purpose of identifying or locating a suspect, fugitive, material witness or missing person as required by law
- To law enforcement officials if you are suspected to be a victim of a crime as required by law
- To law enforcement officials of a death if we suspect that the death may have resulted from criminal conduct as required by law
- To a coroner or medical examiner for the purpose of identification, determining a cause of death or other duties authorized by law
- To a funeral director as necessary to carry out their duties as required by law
- To organ procurement organizations, banking or transplantation of cadaveric organs, eyes, tissue as required by law All other uses and disclosures of your health information will require your specific authorization

You have the following rights regarding your health information:

- The right to request restrictions on how your health information is used or disclosed. Every effort will be made to honor your request but we are not required to agree to a requested restriction
- The right to receive confidential communications of health information
  The right to see and receive a copy of your health information
- The right to request an amendment or correction to your health information
- The right to request an accounting or list of each time your health information has been disclosed

The first accounting within a twelve-month period is provided at no cost to you. The provider may charge a reasonable cost-based fee for each subsequent request within the twelve-month period

If you believe your privacy rights have been violated, you may make a complaint to our office by calling (910) 401-0202 or writing to the office address. You may also make a complaint to the Secretary of Health and human Services at the address listed below. You make a complaint to the Secretary of Health and Human Services at the below. The complaint must be in writing and contain the name of the physician or office, describe the act or omission believed to be in violation and must be filed within 180 days of the incident. You will not suffer any retaliation for filing a complaint.

Secretary of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

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Notice of Privacy Practices

Patients Acknowledgement

Patients Name: _____ Date of Birth: _____

- I have received this practice's notice of privacy practices written in plain language. The notice provides in details the used and disclosures of my health information that may be made by this practice, my individual rights and the practice's legal duties with respect of my protected health information. The notice includes:
- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the firms of notice currently in effect.
- Types of uses and disclosure that this practice is permitted to make for each of the following purposes, Treatment, Payment and Health care options.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health care information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of uses and disclosures that will be made only by my written authorization and I may revoke such authorization at any time.
- My individual right with respect to protected health information and a brief description and how I may exercise these right in relation to;
    - The right to complain to this practice and to the secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosure of my protected health information and that this practice is not required to agree to a request restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy my protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosure of protected health information.
    - The right to obtain a paper copy of the privacy practices from this practice upon request.

This practice reserves the right to change the term of its notices of privacy practices and to make new provisions of effective for all protected health information that it maintains. I understand that I can obtain this practice's current notice of privacy upon request

Signature: _____ Date: _____