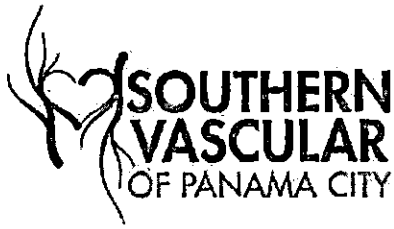

1399 Jenks Ave
Building 12/J
Panama City, Fl 32401

404 US HWY 90
Bonifay, Fl 32425

Ashish K Gupta MD, FACS, RVT

2441 HWY 98
Suite 102
Santa Rosa Beach, Fl 32459

301 20th Street
Port Saint Joe, Fl 32456

10800 PCB pkwy
Suite #200
Panama City Beach, Fl 32407

Patient Information

Social Security Number:_____

FirstName:_____M.I._____LastName:_____Suffix:_____

Gender: MaleorFemale DateofBirth:____/___/___

MaritalStatus: Single Married Divorced Widowed Legally Separated

Race:_____Ethnicity: Not Hispanic/Latino or Latino/Hispanic Primary Language:_____

MailingAddress:_____Apt./Unit#: _____

City:_____State:_____Zip:_____

EmailAddress:_____

*Please list phone number in the order in which you would like to be contacted. Thank you!

1st: (_____)_____ Home Cell Work (this number will be used for confirmation calls)

2nd: (_____)_____Home Cell Work

3rd: (_____)_____Home Cell Work

EmergencyContact:_____ _____(_____)_____

Name Relationship Phone

Pharmacy: _____ _____(_____)_____

Name Address Phone

SOUTHERN VASCULAR OF PANAMA CITY

Ashish K Gupta MD, FACS, RVT

Patient Name:_____

Primary Insurance:_____ Secondary Insurance: _____

*If you are not the primary card holder (including Tricare) we will need the following information to process your insurance.

Policy Holder Name	D.O.B.	SSN
_____	_____	_____

Patient HIPPA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

-Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)

-Obtaining payment from third party payers (e.g. my insurance company)

-Healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use of disclose that occurred prior to the date I revoke the consent is not affected.

I authorize the release of any healthcare information necessary to process this bill to my insurance company, and request payment of benefits to Southern Vascular.

Signature of Patient/ Legal Guardian:_____ Date:_____

SOUTHERN VASCULAR OF PANAMA CITY

Privacy Information

Patient Name:_____

I authorize the following individuals to retrieve/discuss all of my medical information. Without their names on this list, Southern Vascular WILL NOT be allowed to release ANY information. I can refuse to sign this form, or revoke it at anytime by completing a new form. I understand that if information is shared with the below individuals it may be subject to exposure by the individual.

☐ I do not authorize anyone other than myself to retrieve/discuss my information.

☐

Name:_____ Phone:(_____)_____ Relationship: _____

Name:_____ Phone:(_____)_____ Relationship: _____

Name:_____ Phone:(_____)_____ Relationship: _____

Signature of Patient/ Legal Guardian:_____ Date:_____

SOUTHERN VASCULAR OF PANAMA CITY

Practice Financial Policy

Southern Vascular has a financial policy that clearly outlines patient and practice financial responsibilities. We are committed to making a positive difference in lives of our patients by providing the best possible and most cost effective medical care. This financial policy has been established with these objectives in mind to avoid any misunderstanding or disagreement concerning payment for professional services. Please carefully read the outlined policy below and sign at the bottom:

1. If a patient has insurance in which we do not participate, our office is happy to file the claim upon request; however, payment in full is expected at time of service. Please note, that while our office will perform verification of benefits, this does not guarantee insurance payment.

2. Our practice participates with numerous insurance companies. For patients who are beneficiaries of one of these insurance companies, our billing office will submit a claim for services rendered. All necessary insurance information, including special forms, must be completed prior to being evaluated by our providers.

3. By law, it is the patient's responsibility to pay any deductible, copayment, or any portion of the charges as specified by their insurance plan. The patients financial portion is due upon check in. Prior balances will need to be paid prior to being seen. Payments can be made with cash, check, credit card, or debit card. Additionally, we now offer Care Credit for patients who qualify. If patients do not qualify for Care Credit, they will meet with our billing department to discuss financing options.

4. Financial assistance is available for qualified patients. If a patient feels that he or she may qualify for assistance, the billing department will be notified. Patients who do not have insurance are expected to pay for professional services at the time of service unless prior arrangements have been made with us.

5. It is the patient's responsibility to ensure that any required referrals or authorizations for treatment are provided to the practice prior to the visit. Visits may be rescheduled, or the patient may be financially responsible due to lack of a required referral.

6. It is the patient's responsibility to provide us with all current insurance information and to bring his/her insurance card with a form of photo identification to each visit.

7. Our staff is happy to help with insurance questions in relation to how a claim was filed or regarding any additional information a payer might need to process the claim. Specific coverage issues, however, can only be addressed by the insurance company member services department. (Telephone number is printed on the insurance card)

8. We have an Appointment No-Show fee of $25 if patients do not cancel or reschedule appointments 24 hours prior to appointment.

9. We do fill out payment protection, FMLA, and disability forms, however please note that there is a $25 fee prior to receipt of a completed form. We do reserve the right to refuse completion of forms if deemed not applicable to our specialty.

I have reviewed and understand the financial policy of Southern Vascular.

_____ _____ _____

Signature Printed Name Date

SOUTHERN VASCULAR OF PANAMA CITY

PATIENT HISTORY INFORMATION

Name:_____ DOB:_____Date:_____

ReferringMD: _____ Primary Care Physician: _____

Cardiologist:_____ Neurologist:_____

Nephrologist: _____ Other Physicians: _____

Brieflydescribeyourreasonforvisittoday: _____

Allergies:Yes(Pleaselistbelowwithreaction)/No(NoKnownDrugAllergies)1)_____2)_____3)_____4)_ AreyouallergictoIV Contrast,IodineorShellfish? YES / NO

AreyouallergictoLatex? YES / NO

Social History (Please circle all that apply)

MaritalStatus: Single Married Divorced Widowed Separated Children: Y / N

Currently Living: Alone With Family With Friends with significantother

Profession: Working(job)_____ Retired

Smoker: Y / N Past orPresent QuitDate: _____

Type: Cigars/Pipe/Cigarettes Howmany?_____pack/Day HowLong?_____Years

Alcohol: Y / N Daily Weekends Socially

Family History (Please check all that apply)

Aortic Aneurysm (AAA) Heart Disease/Attack Diabetes Cancer Stroke

DVT(blood clots) ArterialDiseaseofLegs VaricoseVeins Bleeding Disorder

Your Surgical History (Please check all that apply)

□Peripheral Angioplasty/Stenting (Non-Heart)□Coronary Artery Stenting/Bypass □Arterial Bypass of the Leg

□ Carotid Artery Surgery/Stent □Aortic Aneurysm Repair

□ IVC Filter Placement□Thrombolysis/Thrombectomy (clot busting)

□ SaphenousVeinHarvesting □VeinStripping □EVLT/ThermalAblationofVeins

□ Sclerotherapy □Phlebectomy

□Any other surgeries _____

_____

Continued on next page...

SOUTHERN VASCULAR OF PANAMA CITY

Your Medical History(Please check all that apply)

Raynaud's Disease	Diabetes	High blood pressure
Varicose Veins	High Cholesterol	Bleeding Disorder
Chronic Renal Failure	Kidney problems	Peripheral vascular disease
Carotid Stenosis	TIA/Stroke	Clot in lung/legs (DVT/PE)
Heart Attack/CAD/Angina	HIV/AIDS	Cancer
Abdominal Aneurysm (stomach)	Heart Valve Disease	

Are you Currently on Dialysis? YES or NO Hemodialysis or Peritoneal Dialysis

If Yes, Where:_____ What days? M W F or T TH S

REVIEW OF SYSTEM(Check all that apply)

Constitutional

Fatigue Unexplained weight loss

Eyes, Ears, Nose & Throat

Blurry vision Loss of vision in one eye Hearing loss Nosebleeds

Psychological symptoms

Depression/Anxiety/Insomnia Neurological

Seizures/Fainting(syncope)/Difficulty in balance Respiration

Shortness of Breath Wheezing Cough

Cardiovascular

Chest Pain Heart Palpitation Irregular Heartbeat

Gastrointestinal

Abdominal Pain Change in Appetite Heartburn

Musculoskeletal

Leg pain Leg swelling

Endocrine

Excessive sweating Excessive Thirst

Hematological

Blood Clotting Easy bruising

Print Name_____ Signature_____ DOB_____

Date:_____

SOUTHERN VASCULAR OF PANAMA CITY

MEDICATION LIST

Name:_____ DOB:_____Date:_____

Please check if you are on any of the following medications and fill in the dosage you are taking:

☐ Medication containing Metformin/Glucophage_____mg

☐ Plavix ☐Aspirin_____mg ☐ Warfarin/Coumadin_____mg ☐Xarelto

☐ Arixtra/Lovenox ☐Pradaxa ☐Anyotherbloodthinner_____mg

Pleaselistanyothermedicationsyouarecurrentlytaking,thedosageandhowoften(youmayattachprintedtyped sheet):
