West Florida Vascular and Vein

Dear Patient:

Thank you for choosing the office of Mark Zuzga, D.O. to provide your vascular and vein care. To make your visit more efficient and pleasant, please take time to read the following information.

- Please complete the attached paperwork prior to arriving for your appointment. If you do not complete your paperwork prior to your appointment, please arrive 30 minutes early to your appointment.
- Please bring your insurance card and picture ID.
- Copays will be collected at time of service.
- As a courtesy to others, please refrain from wearing strong perfume / cologne to your appointment.
- If you must take a call on your cell phone, we ask that you step out of the office into the hallway.

If you have any questions, please feel free to contact us at #727-712-3233.

Thank you.

LOCATIONS:

- 1840 Mease Drive, Suite 319, Safety Harbor, FL 34695
- 2051 West Bay Drive, Largo, FL 33770

Phone: 727-712-3233
Fax: 727-712-1853

Visit Our Web Site at **www.westfloridavascularandvein.com**

West Florida Vascular and Vein

PATIENT INFORMATION FORM

** All information is kept confidential. Please answer honestly to assure the best possible treatment for you. Please complete all pages. **

(Please Print) Today's Date: _____

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____ Age: _____

Street Address: _____ E-Mail Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Height: _____ Weight: _____

Social Security Number: _____ Sex: □ Male □ Female

Driver License Number: _____

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

Employer: _____ Occupation: _____

PRIMARY AND REFERRING PHYSICIAN INFORMATION:

Primary Care Physician: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

SPOUSE/GUARDIAN INFORMATION:

Spouse's Name or Guardian's Name: _____

Spouse's Employer: _____ Spouse's Occupation: _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Phone Number: _____

Visit Our Web Site at **www.westfloridavascularandvein.com**

Physician's Initials _____

West Florida Vascular and Vein

CLINICAL HISTORY FORM

PATIENT NAME: _____ **DOB #:** _____ **TODAY'S DATE** _____

REASON FOR YOUR VISIT

What is the reason for this visit? _____

_____

_____

How long have you had the problem? _____

_____

_____

CURRENT MEDICATIONS *(List all medications / herbal / dietary supplements / alternative medications and treatments you are currently taking)*

PHARMACY PHONE #_____

Medication	*Dosage*	*# Per Day / Frequency*	*Reason for Taking*

****** Please list any other current medications on the other side of this sheet. *******

MEDICATION ALLERGIES *(Are you allergic to any medications?)*

Medication	*Reaction*

Do you have any problems with anesthesia? ☐ Yes ☐ No

Have you had an allergic reaction to tape? ☐ Yes ☐ No

Do you have an allergy to any latex products? ☐ Yes ☐ No

PAST SURGICAL HISTORY

Check all that apply	*Year*		*Year*		*Year*
☐ Appendectomy	_____	☐ Hernia, Inguinal	_____	☐ Colonoscopy	_____
☐ Breast Biopsy	_____	☐ Hernia, Ventral	_____	☐ Mammography	_____
☐ Chest Surgery	_____	☐ Mastectomy	_____	☐ Other _____	_____
☐ Coronary Artery Bypass	_____	☐ Prostate	_____	☐ Other _____	_____
☐ Gall Bladder	_____	☐ Tonsillectomy	_____	☐ Other _____	_____
☐ Hysterectomy, Abdominal	_____	☐ Vascular Surgery	_____	☐ Other _____	_____
☐ Hysterectomy, Vaginal	_____	☐ Tubal Ligation	_____	☐ Other _____	_____

Physician's Initials _____

West Florida Vascular and Vein

CLINICAL HISTORY FORM (Continued)

PATIENT NAME: _____ **DOB #:** _____ **TODAY'S DATE** _____

PAST MEDICAL HISTORY (Please list all major medical problems)

☐ Stroke	☐ High Blood Pressure	☐ Kidney Stones / Disease
☐ Seizures	☐ Diabetes	☐ Anemia
☐ Glaucoma	☐ Juvenile Onset Diabetes	☐ Cancer
☐ Emphysema	☐ Thyroid	☐ Bleeding Disorder
☐ Asthma	☐ Hepatitis	☐ Diverticulosis
☐ Heart Attack / Disease	☐ Elevated Cholesterol/Triglycerides	☐ Angina
☐ Gallstones	☐ Arthritis	☐ Lung Disorders
☐ Vein Trouble	☐ Other _____	☐ Other _____
☐ Other _____	☐ Other _____	☐ Other _____

FAMILY HISTORY

Family Member	*Alive/Deceased*	*Age*	*Health Problems (i.e. cancer, heart disease, etc)*
Father	_____	_____	_____
Mother	_____	_____	_____
Brother / Sister	_____	_____	_____
Brother / Sister	_____	_____	_____
Brother / Sister	_____	_____	_____
Children	_____	_____	_____

SOCIAL HISTORY

Tobacco ☐ None ☐ Currently smoke ___ packs/day and have done so for _____ years
☐ Previously smoked _____ packs/day for _____ years. Stopped in _____
☐ Smokeless Tobacco

Alcohol ☐ None ☐ Minimal ☐ Moderate ☐ Heavy ☐ Previously Heavy

Caffeine ☐ None ☐ 1-3 Servings Daily ☐ 3-4 Servings Daily ☐ More than 6 servings Daily

Drug Use ☐ _____ ☐ _____

PERSONAL HISTORY OF CANCER

Type of cancer ☐ _____ ☐ Not applicable

When was your cancer treated? _____

What type of cancer treatment did you receive? ☐ Chemo Therapy ☐ Radiation Therapy ☐ Surgery

Physician's Initials _____

West Florida Vascular and Vein

CLINICAL HISTORY FORM (Continued)

PATIENT NAME: _____ **DOB #:** _____ **TODAY'S DATE** _____

SYSTEMS REVIEW *(Please place a check next to yes if the item applies to you)*

	Yes
GENERAL	
Weight Loss	
Weight Gain	
Insomnia	
Fever	
Night Sweats	
Chills	
Fatigue	
EYES	
Blurred Vision	
Double Vision	
Episodic Blindness	
Cataract (s)	
Glaucoma	
EARS	
Earache	
Ringing	
Infection	
Drainage	
Pain	
Mild Hearing Loss	
Hearing Impaired	
NOSE/THROAT	
Frequent Nosebleeds	
Hoarseness	
Sinus	
Difficulty Swallowing	
Bleeding Gums	
Sores in Mouth of Lips	
Chronic Sinus Congestion	
Allergies	
Hay Fever	
RESPIRATORY / LUNGS	
Wheezing	
Chronic Cough	
Emphysema or COPD	
Coughing up Blood	
TB or positive skin test	
Sleep apnea	
Pulmonary Embolus	
Asthma	
INFECTIONS	
HIV Positive	
History of Hepatitis	
Staph Infections	

	Yes
CARDIO / HEART	
Chest Pain or Angina	
Heart Skips	
Rapid Heart Rate	
Poor Circulation	
Murmur	
Heart Attack	
Shortness of Breath	
Cardiac Testing within the last year (i.e. EKG)	
Hypertension	
Pacemaker	
GI / DIGESTIVE	
Poor Appetite	
Abdominal Pain	
Nausea	
Vomiting	
Bloating	
Heartburn or GERD	
Diarrhea	
Constipation	
Blood in Stool	
Hemorrhoids	
Crohn's Disease	
Irritable Bowel Disease	
Ulcerative Colitis	
Gallstones	
GENITO-URINARY	
Difficulty Urinating	
Difficulty Holding Urine	
Frequent Urination at Night	
Blood in Urine	
Kideny Stones	
Herpes	
Men: Prostate Cancer	
Men: Discharge from Penis	
Women: Menopause	
Women: Hysterectomy	
MUSCULOSKELETAL	
Pain in Joints	
Pain in Muscles	
Muscle Weakness	
Chronic Back Problems	
Swollen Ankles	
Varicose Veins	

	Yes
SKIN	
Easy Bruising	
Ulcerations	
Rash	
Itching	
Psoriasis	
Non Healing Lesions	
History of Skin Cancer	
NEUROLOGICAL	
Dizziness	
Loss of Consciousness	
Transient Loss of Function	
Stroke	
Seizures	
EMOTIONAL	
Anxiety	
Depression	
Psychiatric Therapy	
ENDOCRINE	
Thyroid Disorder	
Masses	
Heat or Cold Intolerance	
Diabetes Under Treatment	
Excessive Thirst	
Excessive Hunger	
HEMATOLOGIC	
Anemia	
Bruise Easily	
Exessive Bleeding	
Swollen Glands	
Leukemia	
Lymphoma	
Transfussions	
Blood Clots	
Phlebitis	
Deep Venous Thrombosis	
Sickle Cell	
BREAST	
Lumps	
Cysts	
Cancer	
Breast Pain	
Family History	

Physician's Initials _____

West Florida Vascular and Vein

CLINICAL HISTORY FORM (Continued)

PATIENT NAME: _____ DOB #: _____ TODAY'S DATE _____

OTHER INFORMATION *(Please write below any other information not covered in this Clinical History Form that you feel the doctor or surgical staff should know about)*

_____
_____
_____
_____
_____

PATIENT'S SIGNATURE

I certify that, to the best of my knowledge, the above information is complete and accurate.

Patient's Signature: _____

Today's Date: _____

Thank you for choosing West Florida Vascular and Vein to provide your surgical care.

West Florida Vascular and Vein

Dedicated To Delivering Quality Surgical Care

Visit Our Web Site at **www.westfloridavascularandvein.com**

West Florida Vascular and Vein

GENERAL PATIENT / PHYSICIAN AGREEMENT

Please read the following paragraphs, initial below each paragraph that you have read, understand, and agree to the same.

CONFIDENTIALITY:

In an effort to provide the most efficient and effective healthcare, your treating physician will diagnose your illness according to your complaints, symptoms, test results, and medical history. In order to treat the patient appropriately, the patient understands and authorizes treating physician and/or facility to obtain any and all medical records relating to the patient and to communicate with previous physicians by any method, and/or any physician that can assist with the care of the patient, as long as confidentiality is kept at the physician level. I have read, understand, and agree with the above.

Patient/Guardian Initials: _____ Date: _____

FAILURE TO FOLLOW PHYSICIAN ORDERS:

"Physician Orders" are meant to improve and/or resolve the patient's medical condition and/or symptoms. The patient is expected to follow orders given. In the event the patient does not follow orders given, the patient may be discharged from the treating physician care and/or facility, thus releasing treating physician and/or facility from any injury or illness claim resulting from the patient's failure to follow orders. Not following orders given can included but is not limited to missing, postponing or refusal of additional tests to rule out, confirm or discover illness. I have read, understand, and agree with the above.

Patient/Guardian Initials: _____ Date: _____

NO SHOW / LATE CANCELLATION APPOINTMENT FEE

There will be a $50.00 fee for any appointment cancelled without a 24-hour notice. Please note this includes an office visit appointment with Dr. Zuzga, an office vein procedure, and any diagnostic testing such as an ultrasound.

Patient/Guardian Initials: _____ Date: _____

West Florida Vascular and Vein

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name**:** _____

Address:_____

City:_____State:_____Zip:_____

I hereby consent to the release and disclosure of my personal health information to:

Name (Individual or Organization): _____

Address: _____

City: _____State: _____ Zip: _____

I authorize the use or disclosure of the above-named individual's health information as described below. West Florida Vascular and Vein, Mark Zuzga, D.O. is authorized to make this disclosure for the purpose of :

_____Continuing Medical Care _____Personal Use
_____Information for Insurance Co. _____Information for Attorney
_____Other (please specify)_____

This authorization for release includes my personal health information consisting of:

_____Initial Evaluation _____Operative Reports _____Medical Status
_____Progress/Office Notes _____Discharge Summary _____Work Status
_____Diagnostic Imaging Reports _____Laboratory Reports
_____Other (please specify)_____

_____(initial) I have carefully read and understand the above statements and do herein expressly and voluntarily consent to disclose of the above information about or medical records of my medical condition to those persons or agencies named above. I understand that the disclosure of my personal health information as provided for herein will now constitute an authorized use or disclosure of my personal health information (PHI) pursuant to 45 C.F.R. § 164. I also understand, upon disclosure to the above recipient, my PHI will no longer be protected by the federal regulations governing the privacy of individual identifiable health information and that West Florida Vascular and Vein will not be able to restrict the disclosure of the my PHI by the intended recipient who is not affiliated with West Florida Vascular and Vein.

This authorization will expire one year from the date of this request. This authorization is not valid if not filled out completely.

_____ _____
Signature of Patient, Guardian, or Personal Representative Date

Social Security Number**:** _____ Date of Birth**:** _____

West Florida Vascular and Vein

NOTICE OF PRIVACY PRACTICES

** This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. **

At **West Florida Vascular and Vein**, we have always kept your health information secure and confidential. The Health Insurance Portability and Accountability Act requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, reviews of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all your health information when required by law. If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to transfer copies of your health information to another practice. We will mail your files to you. You have a right to receive a copy of your health information, with a few exceptions. Please provide us with a written request regarding the information you want to have copied, however, we may charge you a reasonable fee for the copies.

You have the right to request and amend your health information. Please provide us with your request to make changes in writing. If you wish to include a statement in your file, please provide it to us in writing. We may or may not make the changes that you request but will be happy to include your statement in your file. If we agree to an amendment or change, we will neither move nor alter earlier documents, but will add new information.

You have a right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, Washington, D.C. 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Practice Manager at (727) 712-3233. This notice went into effect on April 14, 2003.

Acknowledgement: I have received a copy of **West Florida and Vascular Vein's** Notice of Privacy Practice.

_____	_____	_____
Patient / Guardian (Please Print Name)	Patient / Guardian (Signature)	Date

West Florida Vascular and Vein

INSURANCE INFORMATION

PATIENT NAME: _____ DOB #: _____ TODAY'S DATE _____

**** Even though we will copy your insurance cards, please complete all of the information requested below. ****

PRIMARY INSURANCE:

Primary Insurance Carrier: _____ Phone #: _____
PPO POS HMO Other _____
Subscriber's Name: _____ Subscriber's Date of Birth: _____
Subscriber's Social Security Number: _____ Subscriber's ID Number _____
Relationship to Subscriber: _____
Subscriber's Employer: _____ Work Phone: _____

SECONDARY INSURANCE:

Secondary Insurance Carrier: _____ Phone #: _____
PPO POS HMO Other _____
Subscriber's Name: _____ Subscriber's Date of Birth: _____
Subscriber's Social Security Number: _____ Subscriber's ID Number _____
Relationship to Subscriber: _____
Subscriber's Employer: _____ Work Phone: _____

WORKER'S COMPENSATION:

Is this a work related injury? Yes No (If yes, please provide the following information)
Claim Adjuster's Name: _____ Phone #: _____
Date of Injury: _____
Claim Number: _____
Contact at Employer: _____ Phone #: _____

FINANCIAL AGREEMENT:

I authorize West Florida Vascular and Vein (see additional entities below used for billing) to bill my insurance company for services rendered. I realize that I will be responsible for co-payments and deductibles at the time of services. Any portion not covered by insurance will be billed to me. If I am uninsured, payment is expected at the time of service. If it becomes necessary to collect any balance due through an attorney, then the patient (and/or spouse/guarantor) agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not.

I authorize West Florida Vascular and Vein to release medical information for insurance purposes. I authorize payment to be made directly to West Florida Vascular and Vein if an assignment is indicated by my insurance company. As a courtesy, West Florida Vascular and Vein will contact insurance companies for authorization for services required. West Florida Vascular and Vein is not responsible for lapses of insurance or for incorrect information.

I have read and understand the financial agreement above.

_____ _____ _____
Patient / Guardian (Please Print Name) Patient / Guardian (Signature) Date

*Entities will vary based on insurance; Surgical Associates of West Florida and/or Edward Mackay M.D. and Associates.

West Florida Vascular and Vein

Communication Release Form

Patient Name (Printed) _____

In regards to my protected health information, I authorize West Florida Vascular and Vein to:
Check all that apply:

☐ Call me at work. Phone #_____

☐ Call me at home and leave message on voice mail. Phone # _____

☐ Call my cell phone and leave voice mail. Phone # _____

☐ Send message to my e-mail. E-mail address _____

☐ Speak to the following family member(s) or friend(s):

Name _____ Phone # _____

Name _____ Phone # _____

Name_____ Phone # _____

The above information can be changed at any time in writing by sending a letter to:

West Florida Vascular and Vein
1840 Mease Drive, Suite 319
Safety Harbor, FL 34695

Patient Signature _____ Date_____