



## CONSENT FOR MEDICAL TREATMENT

To the Patient: You have the right to be informed about your condition and the recommended examination, surgical, medical, or diagnostic procedure to be used, so that you may make the decision whether or not to undergo the procedure after knowing the risk and hazards involved. This disclosure is simply an effort to make you better informed so that you may give or withhold your consent.

1. I, \_\_\_\_\_ hereby voluntary consent to treatment at Genesis Vascular of Pooler, LLC and authorize examinations, diagnostic procedures and treatments including but not limited to the use of x-rays, lab specimens, medications, anesthesia of surgical procedures as by my be ordered by the provider on duty.
2. The nature, purpose and goals of the proposed examination, procedure(s), risks, benefits, possible discomforts and recuperations involved, any reasonable alternatives, and the possibility of complications have been explained to my satisfaction.
3. The relevant risks, benefits, and side effects related to alternatives, including the possible results or not receiving care, treatment and services have been discussed with me.
4. I consent to the photographing or closed circuit televising of the operation(s) or procedure(s) to be performed including appropriate portions of the body, for medical, scientific, or educational purposes proved that the identity is not revealed by the pictures or by the descriptive texts accompanying them.
5. For the purposes of advancing medical education, I consent to the admittance of observers to the operating and/or procedure room, including but not limited to, medical students, nursing students, and representatives of manufacturers of medical equipment.
6. I understand that my physician may have a financial interest in the facility that I am having my procedure done.

**If any of the first six items are stricken or altered, this informed consent form may not be effective the physician must concur before proceeding further.**

I have been given the opportunity to ask questions about my condition, alternative forms of treatment and anesthesia, risks of non-treatment, the procedures to be used, and the risks and hazards involved. I believe that I have sufficient information to give this informed consent. I certify that I have read and fully understand this consent form, that the explanations referred to were made, that I have no further questions about the treatment to be given, and that all blanks or statements requiring insertion or completion were filled in or stricken before I signed.

Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Time: \_\_\_\_\_

Signature of Patient or Family Member: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_

Provider Signature: \_\_\_\_\_



We, at Genesis Vascular of Pooler, LLC, are committed to safeguarding the privacy and confidentiality of your medical records including the personal information that you with us. We comply with the Health Insurance Portability and accountability Act of 1996 (HIPAA). From time to time it may be necessary or desirable to contact patients by phone. To expedite your health care and in the interest of convenience, if you are not available to speak with us directly, we would like to leave a message whenever possible. To assist us in protecting your privacy, please complete the following:

Patient Name: \_\_\_\_\_  
I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CIRCLE ALL THAT APPLY)

HOME PHONE: \_\_\_\_\_  
LEAVE A DETAILED VOICE MAIL MESSAGE? YES NO  
LEAVE A MESSAGE WITH CALL BACK NUMBER? YES NO

WORK PHONE: \_\_\_\_\_  
MAY WE CALL YOU AT WORK? YES NO  
LEAVE A DETAILED VOICE MAIL MESSAGE? YES NO  
LEAVE A MESSAGE WITH CALL BACK NUMBER? YES NO

CELLPHONE: \_\_\_\_\_  
LEAVE A DETAILED VOICE MAIL MESSAGE? YES NO  
LEAVE A MESSAGE WITH CALL BACK NUMBER? YES NO

May we speak to someone else regarding your medical care? YES NO

Name of Person: \_\_\_\_\_

Relationship: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## PATIENT HISTORY FORM

Date: ____/____/____		
NAME: _____		Birthdate: ____/____/____
Last	First	M. I.
Age: _____ Sex: <input type="checkbox"/> F <input type="checkbox"/> M		
Describe briefly your present symptoms:		
Please list the names of other practitioners you have seen for this problem:		
Please name the referring clinic or practitioner: _____		

CURRENT MEDICATIONS		
Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:		
Name of drug	Dose (include strength & number of pills per day)	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

DRUG ALLERGIES
Do you have any drug allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> please list them below.
1.
2.
3.
4.
5.
6.

<b>PREFERRED PHARMACY</b>
Name of Pharmacy:
Address:
Phone Number:

<b>PAST MEDICAL HISTORY</b>			
Do you now or have you ever had:			
<table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Diabetes  <input type="checkbox"/> High blood pressure  <input type="checkbox"/> High cholesterol  <input type="checkbox"/> Hypothyroidism  <input type="checkbox"/> Goiter  <input type="checkbox"/> Cancer (type) _____  <input type="checkbox"/> Leukemia  <input type="checkbox"/> Psoriasis  <input type="checkbox"/> Angina  <input type="checkbox"/> Heart problems                 </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Heart murmur  <input type="checkbox"/> Pneumonia  <input type="checkbox"/> Pulmonary embolism  <input type="checkbox"/> Asthma  <input type="checkbox"/> Emphysema  <input type="checkbox"/> Stroke  <input type="checkbox"/> Epilepsy (seizures)  <input type="checkbox"/> Cataracts  <input type="checkbox"/> Kidney disease  <input type="checkbox"/> Kidney stones                 </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Crohn's disease  <input type="checkbox"/> Colitis  <input type="checkbox"/> Anemia  <input type="checkbox"/> Jaundice  <input type="checkbox"/> Hepatitis  <input type="checkbox"/> Stomach or peptic ulcer  <input type="checkbox"/> Rheumatic fever  <input type="checkbox"/> Tuberculosis  <input type="checkbox"/> HIV/AIDS                 </td> </tr> </table>	<input type="checkbox"/> Diabetes <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Goiter <input type="checkbox"/> Cancer (type) _____ <input type="checkbox"/> Leukemia <input type="checkbox"/> Psoriasis <input type="checkbox"/> Angina <input type="checkbox"/> Heart problems	<input type="checkbox"/> Heart murmur <input type="checkbox"/> Pneumonia <input type="checkbox"/> Pulmonary embolism <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Stroke <input type="checkbox"/> Epilepsy (seizures) <input type="checkbox"/> Cataracts <input type="checkbox"/> Kidney disease <input type="checkbox"/> Kidney stones	<input type="checkbox"/> Crohn's disease <input type="checkbox"/> Colitis <input type="checkbox"/> Anemia <input type="checkbox"/> Jaundice <input type="checkbox"/> Hepatitis <input type="checkbox"/> Stomach or peptic ulcer <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Tuberculosis <input type="checkbox"/> HIV/AIDS
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Other medical conditions (please list):			
<hr/> <hr/>			

<b>FAMILY HISTORY</b>			
	IF LIVING		IF DECEASED
	Age (s)	Health	Age(s) at death Cause
Father			
Mother			
Siblings			
Children			
EXTENDED FAMILY PROBLEMS PAST & PRESENT:			
Maternal Relatives:			
Paternal Relatives:			

**SYSTEMS REVIEW**

**In the past month, have you had any of the following problems?**

**GENERAL**

- Recent weight gain; how much\_\_\_\_\_
- Recent weight loss: how much\_\_\_\_\_
- Fatigue
- Weakness
- Fever
- Night sweats

**MUSCLE/JOINTS/BONES**

- Numbness
  - Joint pain
  - Muscle weakness
  - Joint swelling
- Where?

**EARS**

- Ringing in ears
- Loss of hearing

**EYES**

- Pain
- Redness
- Loss of vision
- Double or blurred vision
- Dryness

**THROAT**

- Frequent sore throats
- Hoarseness
- Difficulty in swallowing
- Pain in jaw

**HEART AND LUNGS**

- Chest pain
- Palpitations
- Shortness of breath
- Fainting
- Swollen legs or feet
- Cough

**NERVOUS SYSTEM**

- Headaches
- Dizziness
- Fainting or loss of consciousness
- Numbness or tingling
- Memory loss

**STOMACH AND INTESTINES**

- Nausea
- Heartburn
- Stomach pain
- Vomiting
- Yellow jaundice
- Increasing constipation
- Persistent diarrhea
- Blood in stools
- Black stools

**SKIN**

- Redness
- Rash
- Nodules/bumps
- Hair loss
- Color changes of hands or feet

**BLOOD**

- Anemia
- Clots

**KIDNEY/URINE/BLADDER**

- Frequent or painful urination
- Blood in urine

**Women Only:**

- Abnormal Pap smear
- Irregular periods
- Bleeding between periods
- PMS

**PSYCHIATRIC**

- Depression
- Excessive worries
- Difficulty falling asleep
- Difficulty staying asleep
- Difficulties with sexual arousal
- Poor appetite
- Food cravings
- Frequent crying
- Sensitivity
- Thoughts of suicide / attempts
- Stress
- Irritability
- Poor concentration
- Racing thoughts
- Hallucinations
- Rapid speech
- Guilty thoughts
- Paranoia
- Mood swings
- Anxiety
- Risky behavior

**OTHER PROBLEMS:**

Smoking    How many\_\_\_\_\_pks/day

Type: \_\_\_\_\_ times/day

Alcohol    \_\_\_\_\_drinks/wk

Illegal Drugs    \_\_\_\_\_times/day

Have you quit in the last 3 years? \_\_\_\_\_



## AUTHORIZATION TO RELEASE HEALTHCARE RECORDS/INFORMATION

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I request and authorize \_\_\_\_\_ to  
release healthcare information of the patient named above to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

This request and authorization applies to:

All records

Laboratory/Pathology records

X-ray/Radiology records

Billing records

Pharmacy/Prescription records

Other: \_\_\_\_\_

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Yes  No I authorize the release of my medical records regarding all treatments, procedures and/or visits to the person(s) listed above.

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_



**PATIENT INFORMATION**

Patient Last Name:		First:	Middle:	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former Name):	Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Email address:			Alternative Email (if any):		
Street address:		Social Security No:	Phone Number: (    )		
P.O. box:	City:	State:	ZIP code:		
Are you currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employer:		Employer Phone No: (    )		
Do you currently reside in a Nursing Home or Rehab Facility? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Referred to center by:					

**INSURANCE INFORMATION**

**PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST**

Person responsible for bill:	Birth date: (if different) / /	Address (if different):	Phone Number: (    )		
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please indicate <b>PRIMARY</b> insurance		<input type="checkbox"/> MEDICARE	<input type="checkbox"/> MEDICAID	<input type="checkbox"/> Other: _____	
Subscriber name:	Subscriber's SSN	Birth date: / /	Group No:	Policy No:	
Patient relationship to subscriber:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other: _____		
Name of <b>SECONDARY</b> insurance	Subscriber's name:		Group No:	Policy No:	
Patient relationship to subscriber:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other: _____		
Name of <b>TERTIARY</b> insurance	Subscriber's name:		Group No:	Policy No:	
Patient relationship to subscriber:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other: _____		

**IN CASE OF EMERGENCY**

Name contact:	Relationship to patient:	Home Phone Number: (    )	Cell Phone Number: (    )
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## PATIENT CONSENT

**Please Initial**

\_\_\_\_\_ The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Genesis Vascular of Pooler, LLC (GVP) or the insurance company to release any information required to process my claims.

\_\_\_\_\_ I authorize the release of medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, healthcare providers, and insurance case managers, for the purposes of processing my claims.

\_\_\_\_\_ I am responsible for all charges for all service provided. In the unfortunate event that my insurance company denies payment, or makes a partial payment, I am responsible for any balance due. I authorize direct payment of medical benefits to GVP for services billed.

\_\_\_\_\_ I hereby give my consent for GVP to use & disclose my protected health information (PHI) about me to carry out treatment, payment & health care operations. (The GVP Notice of Privacy Practices describes information used.)

\_\_\_\_\_ I have the right to review the Notice of Privacy Practices prior to sign this consent. GVP reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices prior to signing this consent. GVP reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by written request to the Facility Manager.

\_\_\_\_\_ With this consent, GVP may call my home or other alternative locations and leave a message on a voice mail or with a person of reference to any items that assist the practice such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, and other medical information.

\_\_\_\_\_ With this consent, GVP may mail to my home or other alternative location any item that assists the practice in carrying out healthcare operations, such as appointment reminder cards and patient statements.

\_\_\_\_\_ With this consent, GVP may email the address provided with any item that assists the practice in carrying out healthcare operations, such as appointment reminder cards and patient statements. I have the right to request that GVP restrict how it used or discloses PHI. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow GVP to use & disclose my PHI to carry out healthcare operations. I may revoke my consent in writing except to extent that the practice has already make disclosure in reliance upon my prior consent. If I do not sign this consent or later revoke it, GVP may decline to provide me treatment.

\_\_\_\_\_  
*Patient/Guardian Signature*

\_\_\_\_\_  
*Print Name*

\_\_\_\_\_  
*Date*