COASTAL
VEIN AND VASCULAR
SPECIALISTS

PATIENT REGISTRATION FORM

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ ☐ Male ☐ Female

Preferred Language: ☐ English ☐ Spanish ☐ Other_____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

May we contact you by telephone, voicemail, electronic reminder, or other means to provide appointment reminders or information about treatment or other health-related benefits and services that may be of interest to you: ☐ Yes ☐ No

Reason for Visit: _____

Please list your physician care team (ex: Cardiologist, Endocrinologist, Podiatrist, etc.)

Referring Physician: _____

Primary Care Physician: _____

Pharmacy/Contact Number: _____

Whom should we contact in the event of an emergency:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

MEDICAL DOCTORS ARE LICENSED AND REGULATED BY THE MEDICAL BOARD OF FLORIDA

Our office will bill your insurance. You are responsible for the deductible, share of cost, co-payment at the time of your visit, as well as any costs that many not be covered by your plan. If you do not have insurance, payment is due on the same date of service. I understand that my physician extender at CVVS does not carry medical malpractice insurance* and I would still like to be evaluated and treated. Our staff is available if you have any questions.

I authorize payment of medical benefits to be made directly to the physician provider for the services rendered. I authorize my doctor to release any medical or other information necessary to process claims with my insurance companies. I request payment of any government benefits to the party who accepts the assignment. I authorize the use of information from this form to bill my insurance companies.

**458_320(5)(g) – "Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. Your doctor has decided not to carry medical malpractice insurance. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law."*

Patient Signature: _____ Date: _____

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REVIEW OF SYSTEMS

PLEASE PRINT

Name: _____ Date of Birth: _____

Referring MD: _____ Primary MD: _____

Medication allergies: _____

Medications: (Name, Mg. Dose) _____

_____

Family history of: ❑ Heart Disease ❑ Lung Disease ❑ Hypertension ❑ Kidney Disease

Social History of:

Tobacco: # of packs per day _____ #of year's smoked _____ Date quit: _____

Alcohol: # of drinks per day _____ #of year's _____ Date quit: _____

Current Medical Illness and/or Past Major Surgeries: _____

_____

Review of Systems: Please circle any that are appropriate

Constitutional:	*Weight Loss | Fever | Fatigue | Weakness*
Eyes:	*Double Vision | Loss of Vision | Blind Spots | Cataracts*
Ear, Nose, Throat:	*Nosebleeds | Gum Disease | Hoarseness | Difficult Swallowing*
Cardiac:	*High Blood Pressure | Chest Pain | Shortness of Breath | Murmurs* *Previous Heart Attack | Heart Failure | Rheumatic Fever*
Respiratory:	*Coughing up blood | Sputum Production | Emphysema | Wheezing Tuberculosis | Pneumonia*
Gastro Intestinal:	*Ulcer Disease | Heartburn | Liver Disease | Black Stool | Jaundice | Hepatitis*
Musculo-Skeletal:	*Cramps with Walking | Varicose Veins | Joint Injuries | Arthritis |* *Swelling in Legs and/or Feet | Gout | Numbness*
Skin:	*Rashes | Cuts | Cancers*
Neurological:	*Strokes | Dizziness | Tremors | Headache | Seizures | Transient | Blindness |* *and Loss of Arm or Leg Function*
Psychiatric:	*Anxiety | Depression | Sleep Disturbance | Hallucinations*
Endocrine:	*Thyroid*

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MEDICAL RECORDS REQUEST

Patient Name: _____

Date of Birth: _____

The above patient is under the care of **Coastal Vein and Vascular Specialists**

Please forward the following information from their medical record:

- Consult Reports, Operative Reports, Discharge Summaries
- X-ray, CT, MRI, Ultrasound, and any other imaging studies

I hereby authorize the requested information contained in my medical record to:

Coastal Vein and Vascular Specialists

3401 PGA Boulevard, Suite 325

Palm Beach Gardens, FL 33410

Phone: 561-295-4110

Fax: 561-295-4116

Patient Signature:_____ **Date:**_____

COASTAL VEIN AND VASCULAR SPECIALISTS

CANCELLATION POLICY

Coastal Vein and Vascular Specialists is committed to helping you manage and maintain your healthcare needs. When you schedule an appointment with one of our physicians or technicians that time is reserved exclusively for you to discuss and review your medical concerns. We do understand that on occasion, unforeseen circumstances do arise and the need to cancel your scheduled appointment may be necessary. If you know that you will be unable to keep your appointment, we ask you to show consideration by calling our office 24 hours in advance. Providing our office with adequate notice will allow us to offer that appointment time to another patient. Beginning January 1, 2019, the following no-show and/or late cancellation fees will be assessed:

- A $25 charge will be assessed for "no showing" or for failing to give 24-hour notice of the need to cancel all routine appointments and ultrasound appointments.

- A $100 charge will be assessed for "no showing" or for failing to give 24-hour notice of the need to cancel all scheduled procedures.

Please be advised that these charges are not billable to your insurance and will ultimately be the responsibility of the patient*. All no show charges will need to be paid before your next appointment.

Your signature below indicates that you have read and agree to the above policy.

Patient Name:_____ **Date:**_____

Patient Signature:_____

**Patients with a documented emergency or who were emergent admitted to a hospital facility for any reason may have their fee waived at the discretion of the administrative team.*

3401 PGA Boulevard, Suite 325 | Palm Beach Gardens, FL 33410 | P: 561-295-4110 | F: 561-295-4116
www.coastalvascular.com

Your rights and responsibilities as a patient at Coastal Vein and Vascular Specialists

You have a right to:

1. Be treated with courtesy, respect, and appreciation for your individual dignity and with protection of your privacy.
2. Care which includes consideration of the psychological, spiritual, and cultural variables that influence your perception of illness.
3. A prompt and reasonable response to questions and requests.
4. Know who is providing medical services and who is responsible for your care.
5. Know what patient support services are available, including whether an interpreter is available if you do not speak English.
6. Know what rules, regulations and expectations apply to your conduct as a patient.
7. Be provided, upon request, with information about advance directives and other options for healthcare decisions.
8. Receive a copy of your itemized bill.
9. Impartial access to medical treatment and care regardless of race, gender, national or ethnic origin, religion, sexual orientation, physical or mental impairment, or source of payment.
10. Receive care in a safe setting, free from verbal, or physical abuse, or harassment.
11. Know that all patient records are confidential and will not be released to other providers without consent from the patient.
12. Be given upon request, information about a diagnosis, planned course of treatment, alternatives, risks, and prognosis.

You are responsible for:

1. Treating the healthcare staff, other patients, and providers with courtesy and respect, conducting yourself in a civil manner, no matter the reason for your rage. The staff has a right to work in an environment that is safe for themselves and their patients. Therefore, the following will not be tolerated: yelling, screaming, verbal abuse, physical violence, throwing objects, and no threatening or harassing behavior either in-person, by phone, or in writing.
2. Following healthcare facility rules and regulations pertaining to patient care conduct.
3. Assuring that your financial obligations are fulfilled as promptly as possible.
4. Providing accurate and complete healthcare provider information about past illnesses, hospitalization, medications, and matters relating to your health.

Patient Name: _____

Patient Signature: _____ Date: _____