Dr. Peter Dovgan M.D., FACS
655 S. Apollo Blvd
Melbourne, FL 32901

1395 N. Courtenay Pkwy
Suite 203
Merritt Island, FL 32953
(321)751-2707
Fax: (321)255-2361

HISTORY OF PRESENT ILLNESS

- Patient Name: _____
- Patient Birth Date: _____ • Today's Date: _____
- Marital Status (please circle) Single Married Divorced Widowed
- Occupation: _____ Employer: _____
- Reason for today's visit: _____
  - -Have you had any Labs, Ultrasounds, X-rays, MRI's, CT's, etc.? YES NO
  - -If yes, explain which: _____
- In case of a surgical emergency, are you willing to receive blood or blood products? YES NO
- Are you pregnant, nursing or planning a pregnancy in the near future? YES NO

PAST MEDICAL HISTORY

Please provide dates and results for the following:
Date of most recent cardiac stress test _____ Passed? YES NO

Date of most recent heart catheterization _____ Stents? YES NO

Do you smoke? **YES** ____# Packs/ Day **NO** Date Quit _____

Do you drink alcohol? **YES** Qty/ Frequency: _____per week **NO** Date Quit _____

Allergies: _____

Past Surgeries: ___None ___Carotid ___Aneurysm ___Vascular Bypass ___Hernia ___Hysterectomy

___Tonsils ___Appendix ___Gallbladder other: _____

Do you have problems/ complications with anesthesia? YES NO

Have you had any Falls in the past year? ___Yes ___No Two or more Falls with injury? ___Yes ___No

MEDICATIONS

Name	Dosage	How Often

Patient Name:_____Patient D.O.B: _____

Have you had any of the following?

✓	DISEASE	COMMENTS
	Seizure Disease?	How often?_____
	Thyroid Disease	____ Hypothyroidism ____ Hyperthyroidism ____ Goiter ____
	Pulmonary Disease	____ Asthma ____ COPD ____ Emphysema ____ TB ____ Pneumonia
	Stroke	___TIA (mini stroke) ___Sudden blindness ___Weakness in arms/legs ____ Carotid stenosis _____ Bruit
	GI Disease	_____ Ulcers ____Hiatal Hernia ___GERD _____Diverticulitis _____Crohn's ____Gallstones
	Diabetes	____Insulin dependent ___Non-insulin ___Controlled by diet
	Kidney Disease	___ESRD ____Dialysis
	Blood Disease	____Bleeding Disorder ____Clotting Disorder
	Liver Disease	____Hepatitis ___Cirrhosis
	Cancer	____Type:
	Vascular Disease	__Peripheral Vascular Disease ___ Angioplasty/Stent __ Leg/Foot Ulceration __ Claudication ___Decreased walking distance ___Foot pain at rest __ Foot pain during exercise __ Extreme discoloration changes __ Loss of limb ___ Aneurysm ___Diabetic neuropathy ____ Temperature changes
	Heart Disease	__ Heart Attack/ MI ___ Angina __Hypertension ___ CHF __Coronary angioplasty/stent/PTCA ___Open heart surgery/CABG __ AFIB ____ IRRG HR ___ Murmur ___Rheumatic heart disease __ Valve disease/repair/replacement ___Coronary heart disease

FAMILY HISTORY

Please check the boxes pertaining to your family history.

	FATHER	MOTHER	BROTHERS	SISTERS
Living				
Deceased Cause/death				
Age of death				
Cancer				
Diabetes				
Heart Attack				
Stroke				
PVD				
COPD				
TB				
Other Problems:				

MAB
MEDICAL ASSOCIATES OF BREVARD

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Space Coast Vascular

VENOUS HISTORY

Today's Date:_____ Patient DOB:_____

Patient Name:_____

Are you pregnant, nursing or planning a pregnancy in the near future? Yes No

Check box in front of ALL that apply:

SYMPTOMS:

	Aches		Heavy/full feeling		Symptoms interfere w/ activities of daily living
	Easy Bruising		Bleed/ Hemorrhage		Leg Restlessness
	Swelling		Cramping		Pelvic Symptoms
	Muscle fatigue		Itch		Ulceration___Healed ___Non-healed, How long present?____
	Pain		Burning		I am NOT able to walk a mile without symptoms

WORSE WHEN:

	Standing		Sitting		Walking/exercise
	Pre-menstrual		Night time		Other:
	Worsening of symptoms with pregnancy; Date of last pregnancy:_____				

CONSERVATIVE THERAPY:

	Leg Elevation		Elastic compression garment use; Attempted more than 3-6 months.
	Exercise		Compression garment use Helpful
	Heat		Compression garment use Failure; Reason:_____
	Medications: _____		Other:_____

PREVIOUS INVASIVE TREATMENT:

	SURGERY:		Stripped-right leg		Stripped-left leg	Date:	Complications?	Y N
	SURGERY:		Ligation-right leg		Ligation-left leg	Date:	Complications?	Y N
	INJECTIONS:		Right leg		Left leg	Date:	Complications?	Y N
	LASER:		Right leg		Left leg	Date:	Complications?	Y N

COMMENTS:

_____

_____

_____

_____

Patient signature: _____ Date_____

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PATIENT REGISTRATION

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Space Coast Vascular

Patient Name: _____ Social Security#: _____ DOB: _____

Address: _____ City: _____ Zip: _____

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

Email Address: _____ Sex: M F Marital Status: M D W S

Employment Status: Full-Time Part-Time Self Employed Retired Not Employed Disabled

Employer Name: _____

Student Status: Full-Time Student Part-Time Student Not a student

Race: _____ Ethnicity: Hispanic or Latin NON- Hispanic or Latin

Primary Care Physician: Dr._____ Referring Physician: Dr._____

Cardiologist Physician: Dr._____ Nephrology Physician: Dr. _____

Endocrinology Physician: Dr._____ Podiatry Physician: Dr._____

Pain Management Physician: Dr._____ Other Physician:_____

Pharmacy:_____ **Phone and/or location**:_____

Emergency Contact Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Do you have a Living Will? YES NO Do you have a Power of Attorney? YES NO

If you answered Yes to having a Power of Attorney, please provide legal documentation.

INSURANCE INFORMATION

Primary Insurance:_____ Policy ID:_____

Group # _____ Are you the subscriber? YES NO

If No, Subscribers Name/DOB:_____

Secondary Insurance:_____ Policy ID:_____

Group # _____ Are you the subscriber? YES NO

If No, Subscribers Name/DOB:_____

_____

LANGUAGE ASSESSMENT

English is primary language Spoken: YES NO

Patient is able to converse and comprehend English if not the primary language spoken Yes No

If no to either questions, is Spanish the primary language spoken? YES NO

If Yes, Space Coast Vascular, Inc. will utilize "The Language Line" 1-800-874-9426 for assistance with translation.

If No, what is the spoken language?_____

Assessment completed by (patient or responsible individual):_____

HIPAA FORM

Dr. Peter Dovgan M.D., FACS
655 S. Apollo Blvd
Melbourne, FL 32901
1395 N. Courtenay Pkwy Suite 203
Merritt Island, FL 32953
(321) 751-2707

Patient authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Space Coast Vascular (MAB) to use and/or disclose certain protected health information (PHI) about me to: **WHO** we may share information with? Family/ Friends/ Neighbors?

Name:_____ Relation:_____
Name:_____ Relation:_____
Name:_____ Relation:_____
Name:_____ Relation:_____

By signing, this authorization permits Space Coast Vascular (MAB) to use and/or disclose the following individually identifiable health information about me: **WHAT** information we may share with the above listed person(s)

☐ Medical information ☐ Test Results ☐ Demographics

☐ Appointment information ☐ Billing information ☐ Any/ All information

I authorize Medical Associates of Brevard to leave a detailed message on my answering machine.

☐ No ☐ Yes: Signature _____ DATE _____/_____/_____

I acknowledge that the "Notice of Privacy Practices" brochure is available for my review. The Provider Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Provider Notice of Privacy Practices also describes my right and the responsibilities of duties of Medical Associates of Brevard with respect to my protected health information.

PATIENT RIGHT TO PRIVACY: I understand that my medical information will only be released to myself, my doctors and my designated insurance company unless specifically directed by me above. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

My written revocation must be submitted to the privacy officer at 655 S. Apollo Blvd. Melbourne, FL. 32901.

Signature of Patient: _____ Date: _____

Print Patient Name: _____

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Space Coast Vascular

CONSENT TO TREAT

CONSENT TO TREAT, INSURANCE ASSIGNMENTS, FINANCIAL AGREEMENT, AUTHORIZATION TO RELEASE INFORMATION AND PRIVACY NOTICE ACKNOWLEDGEMENT

Initial Each Agreement

__1. AUTHORIZATION TO TREAT: The undersigned authorizes any treatment(s), agreed upon with the physician which may be deemed advisable. This MAY include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or other services rendered to the patient under the general and special instructions of the patient's physician.

__2. ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION: In consideration of services rendered, I hereby transfer and assign Peter S. Dovgan, MD all rights, title and interest in any payment due to me for services described herein as provided in the above mention policy or policies of insurance. The clinic may disclose all of any part of the patient's record (included psychiatric, alcohol and drug abuse family member or employer of the patient for all or part of the clinic's charge, including but limited to medical service companies, insurance companies, workman's compensation carries, welfare funds or the patient's employer).

__3. FINANCIAL AGREEMENT: The undersigned agrees, whether he/she signs as agent or as patient that in consideration of the services to be rendered to the patient he/she hereby individually obligates himself/herself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred for collection, the undersigned agrees to pay collection expenses. The undersigned certifies that he/she has read the foregoing receiving a copy thereof and is duly authorized by the patient as the patient's general agent to execute the above and accepts its terms. I hereby certify all insurance pertaining to treatment shall be assigned to the clinic treating me.

__4. MEDICARE/MEDICAID: Patient's certification authorization to release information and payment request. I certify that the information given to me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize that any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. **OR**
I certify that I do NOT have a Medicare and/or Medicaid plan as of the signed date of this authorization. _____
Initials

__5. I permit one copy of these authorizations and assignments to be used in place of the original, which is on file at the clinic.

___6. I understand that certain insurance claims may be filed as a courtesy. However, if the claim is denied for any reason, I am responsible for payment. Please remember that insurance is considered a method of reimbursing the physician for services rendered to the patient. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand that it is my responsibility to pay any deductible amount, co-insurance amount, or any other amount deemed as patient responsibility from my insurance or third party payer within a reasonable period of time not to exceed 60 days.

Patient Signature:_____Date:_____

Subscriber (if different than patient):_____

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Space Coast Vascular

CANCELLATION POLICY

OFFICE VISITS, VASCULAR LAB TESTS, SURGICAL PROCEDURES

To better serve all of our patients, it is extremely important that when you schedule your visits, *tests*, or surgical procedures that you have thoroughly checked your personal calendar to make sure the time is ideal for you. Cancelling and rescheduling causes other patients to wait longer and delay treatment times. If you have scheduled a test or visit and need to reschedule for personal reasons please allow **48 hours** so other patients may be scheduled into your appointment time.

UNPLANNED CANCELLATIONS AND NO SHOW POLICY

- Each *Office visit* will be rescheduled one time as a courtesy. After that time, a **$25 fee** will be charged to your personal account and not billed to insurance for every cancellation less than **24 hours of** the scheduled appointment or a No Show appointment.
- Each *Vascular lab test* will be rescheduled one time as a courtesy. After that time, a **$50 fee** will be charged to your personal account and not billed to insurance for every cancellation less than **24 hours** of the scheduled appointment or a No Show appointment.
- *Surgical procedures in the office* must be cancelled or rescheduled **48 hours** in advance. Failure to do so will result in a **$100 fee** charged to your personal account and not billed to insurance.
- *Surgical procedures in the Hospital* cannot be rescheduled. If you must cancel, it will need to be within 72 hours to release the time to other hospital patients. Failure to do so, will result in a **$150 fee** charged to your personal account and not billed to insurance.

- After 3 cancellations with less than 48 hours' notice or 3 No Show appointments, the patient will be required to speak with the Practice Administrator before rescheduling.

Thank you, Space Coast Vascular Staff

I have read, understand and agree to the cancellation, no show and financial policies of Space Coast Vascular.

Patient Name: _____

Signature: _____ Date: _____

Witness: _____ Date: _____