VascularSpecialists
of Central Florida, Inc.

Patient Name ______________________________

SUPERCONFIDENTIAL INFORMATION

PAST MEDICAL HISTORY Please check any disease diagnosed at any time - items left blank indicate a negative response.

☐ alcoholism ☐ depression / anxiety ☐ other ____________

☐ hepatitis ☐ controlled substance (Rx drugs) abuse

☐ HIV / AIDS ☐ illegal drug use

Females Only -
Pregnant? ☐ Yes ☐ No ☐ Uncertain

CONSENT TO EXAMINATION / TREATMENT
INSURANCE ASSIGNMENT, RECORDS AUTHORIZED AND INFORMATION ACKNOWLEDGEMENT

I HEREBY CONSENT TO EXAMINATION AND TREATMENT AS DEEMED NECESSARY BY VASCULAR SPECIALISTS OF CENTRAL FLORIDA AND IT'S PHYSICIANS. I HEREBY AUTHORIZE VASCULAR SPECIALISTS OF CENTRAL FLORIDA AND IT'S PHYSICIANS TO FURNISH PATIENT HEALTH INFORMATION CONCERNING MY RELEVANT MEDICAL HISTORY (INCLUDING BUT NOT LIMITED TO THE SUPERCONFIDENTIAL INFORMATION LISTED ABOVE) TO ANY OF THE FOLLOWING: OTHER HEALTHCARE PROVIDERS INVOLVED IN MY CARE, INSURANCE CARRIERS, ATTORNEYS AND ADJUSTORS. I HEREBY ASSIGN TO VASCULAR SPECIALISTS OF CENTRAL FLORIDA AND IT'S PHYSICIANS ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I ACKNOWLEDGE THAT THE INFORMATION IN THIS FORM IS ACCURATE, TO THE BEST OF MY KNOWLEDGE.

SIGNATURE ______________________________ DATE ____/____/____

PARENT/GUARDIAN SIGNATURE (IF PATIENT IS A MINOR) ______________________________

AUTHORIZATION FOR MEDICARE BILLING PURPOSES
LIFETIME FILE (MEDICARE PATIENTS ONLY)

I hereby certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I hereby authorize any holder of medical or other information about me to be released to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I hereby request that payment of authorized benefits be made on my behalf and hereby assign the benefits payable for physician services to the physician if he/she chooses to accept assignment.

SIGNATURE ______________________________ DATE ____/____/____

PARENTAL RELEASE (IF PATIENT IS A MINOR)

I, ______________________________ (legal guardian's name), hereby authorize Vascular Specialists of Central Florida and its physicians to release any or all patient health information including superconfidential information regarding my child to the person(s) listed below. (Example: A relative or someone other than a legal guardian may accompany your child on a future appointment).

SIGNATURE ______________________________ DATE ____/____/____

Name ______________ Relationship to patient ______________ Ph (____) ____________

When providing information to me, information may be transmitted to me by any or all of the following means (initial all that apply):

_____ Telephone messages on an answering machine

_____ Messages to the following family members or friends: ______________________________

____

_____ E-mail to the following address: ______________________________

_____ Text Messages for Appointment reminders.