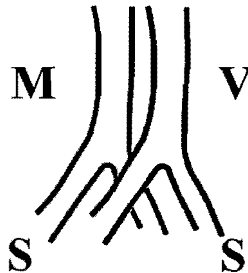
METROVIEW VASCULAR AND SURGICAL SPECIALISTS, PA

Vascular Surgery – General Surgery



Augustine R. Eze, M.D., F.A.C.S.

WELCOME TO METROVIEW VASCULAR & SURGICAL SPECIALIST, PA

Date ____________ Patient Account Number ____________

PATIENT NAME: ______________________________
LAST *FIRST* *MI*

Date of Birth: ____________ Social Security #: ____________

Address: ______________________________
Street *Apt. #*

____
City *State* *Zip code*

Home Phone: ____________ Work Phone: ____________

Cell Phone: ____________ Preferred mode of contact: ____________

Gender: ________ Race: ________ Marital Status: ____________

If Female are you currently pregnant? ____________
Ethnicity or Language Spoken: ____________ Religion: ____________
Mother's Maiden Name: ____________ Education: ____________
Drivers License #: ____________ State: ____________
Patient's Employer: ____________
Emergency Contact 1: ____________ Relationship: ____________
Phone: ____________ Work: ____________ Cell: ____________
Emergency Contact 2: ____________ Relationship: ____________
Phone: ____________ Work: ____________ Cell: ____________
Spouse Full Name: ____________ Home Phone: ____________
Work Phone: ____________ Cell Phone: ____________
Date of Birth: ____________ Social Security #: ____________

With whom may we discuss your medical condition with? ____________
Referred By: ____________

Please complete all additional pages and attach all insurance cards and driver's licenses or picture identification card so they may be photocopied. Thank you!

411 Wendover Road • Charlotte, NC 28211 • Telephone (704) 365-3480 • Fax (704) 365-3482
825 Majestic Court, Suite F • Gastonia, NC 28054 • Telephone (704) 864-6500 • Fax (704) 864-0104

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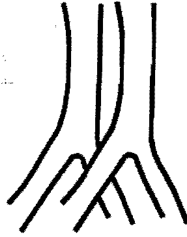

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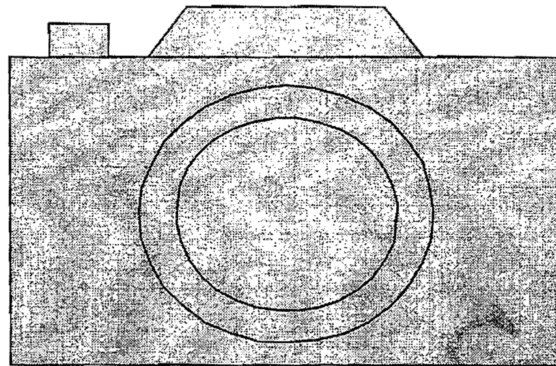

Please be advised your picture is requested for Electronic Medical Records

If you do not wish to have picture taken, please notify clinical staff

Thank you, Management of Metroview Vascular and Surgical Specialists, P.A.

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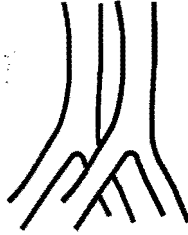

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PRIVACY POLICY

This Notice Describes How Medical Information About You May be Used and Disclosed and How You Can Get Access to This Information. Please Review Carefully.

This Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this statement of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

Treatment means providing, coordinating, or managing heath care and related services by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance carrier for payment.

Health care operations include business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, expect to the extent that we have already taken action relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

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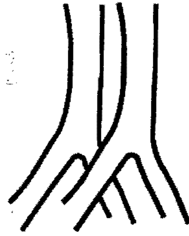

Augustine R. Eze, M.D., F.A.C.S.

The right to request restrictions on certain uses and discloses of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless to agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to inspect and copy your protected health information.

The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of June 10, 2002, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a review Notice of Policy Practices from this office.

You have recourse if you feel that your privacy protects have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
(202) 619-0257
Toll Free: 1-877-696-6775

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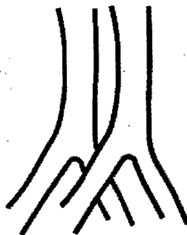

Augustine R. Eze, M.D., F.A.C.S.

Account #: ______________

Acknowledgment of Receipt
Of Notice of Privacy Practices

We are required by law (HIPPA) to provide you with our Notice of Privacy Practices, which explain how we use and disclose your health information.

We are also required to obtain your signature acknowledging that this notice has been available to you.

Signature: ________________________________ Date of Birth: ____________________
(Patient or Authorized Representative)

If signed by representative, print name of patient: ______________________________

Relationship to Patient: ______________________________

Date Signed: ______________________________

FOR OFFICE USE ONLY

We were unable to obtain a written acknowledgement of receipt of Notice of Privacy Practices because:

☐ An emergency existed & signature was not possible at the time.

☐ The individual refused to sign.

☐ A copy was mailed with a request for a signature by return mail.

☐ Unable to communicate with the patient for the following reason(s):

____

☐ Other: ______________________________________

____

Prepared By: ____________________________ Date: ________________

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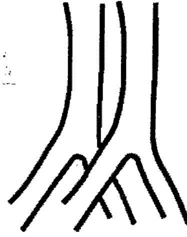

Augustine R. Eze, M.D., F.A.C.S.

Authorization for Release of Information
To Family and/or Friends

Name of Patient ______________________________ Date of Birth ___________

____ is authorized to release protected health information about the above named patient to the entities named below.

Entity to Receive Information. Initial each that is subject to this information.

_______ Leave information on the voice mail. _______ Give information to spouse.
_______ Give information to the following persons: ___________________________

Description of Information to be released

_______ Financial Information. _______ Information results from tests or x-rays.
_______ Family Billing Information
_______ Medical Information as follows: ______________________________
____
_______ Other Information as described: ______________________________
____

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by a written notification to

____.

I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

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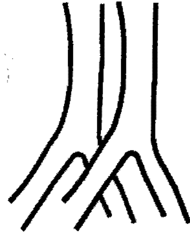

Augustine R. Eze, M.D., F.A.C.S.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

________________________________ Date ____________________
Signature of Patient or Personal Representative

____
Description of Personal Representative's Authority (attach necessary documentation)

MVS

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METROVIEW VASCULAR AND SURGICAL
INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: ______________________________

INSURED'S NAME: ______________________________

RELATIONSHIP TO THE PATIENT: ______________ INSURED'S DATE OF BIRTH: __________

GROUP NUMBER: ______________________ POLICY NUMBER: ______________

IF COVERAGE IS THROUGH AN EMPLOYER, PLEASE LIST NAME AND ADDRESS

____

SECONDARY INSURANCE CARRIER: ______________________________

INSURED'S NAME: ______________________________

RELATIONSHIP TO THE PATIENT: __________ DATE OF BIRTH: ______________

GROUP NUMBER: __________________ POLICY NUMBER: ______________

IF COVERAGE IS THROUGH AN EMPLOYER, PLEASE LIST NAME AND ADDRESS

____

PAYMENT IS REQUIRED AT TIME OF VISIT. AN INSURANCE CLAIM WILL BE FILED AS A COURTESY. THE INFORMATION ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS TO METROVIEW VASCULAR & SURGICAL SPECIALIST, PA. I DO HEREBY AGREE TO ALL MEDICAL CHARGES INCURRED BY THE ABOVE LIST PATIENT. I UNDERSTAND THAT THESE CHARGES ARE MY RESPONSIBILITY REGARDLESS OF INSURANCE COVERAGE. I FURTHER AGREE IN THE EVENT OF NON PAYMENT, TO BEAR THE COST OF COLLECTIONS, AND/OR COURT COST AND REASONABLE LEGAL FEES SHOULD THIS BE REQUIRED.

SIGNATURE: ______________________ DATE: ______________

Metroview Vascular & Surgical Specialists, PA
Practice Financial Policy

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any question about the policy, please discuss them with our office manager. We are dedicated to providing the best possible care and services to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either yourself or your health coverage carrier, full payment is due at the time of service. For your convenience we will accept VISA, MasterCard, American Express or Discover.

Your Insurance:

We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will require you to pay the authorized co-payment or deductible at the time of service. It is the policy of our office to collect the co-payment when you arrive for your appointment.

In the event your health plan determines a service to be "not covered"; you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

Minor Patients:

For all services rendered to minor patients, we will look to the adult accompanying the patient, authorizing treatment and the parent or guardian with custody for payment.

Missed Appointments:

In order to provide the best possible service and availability to all our patients it is our policy to charge our office visit fee for any appointments not cancelled at least one day prior to the appointment. Please call us as early as possible if you know you will need to reschedule your appointment.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

______________________________ ____________________
Signature of Patient or Responsible Party of Minor Date

____
Signature of Co-Responsible Party

____
Name of Patient (Please Print)

MEDICATION LOG

NAME: ______________________________ PATIENT#: ________________________

ALLERGIES: ________________________ BIRTHDATE: ________________________

PHARMACY: ______________________ PHARMACY PHONE: _______________

MEDICATION	DIRECTIONS	REFILLS

Metroview Vascular & Surgical Specialists, PA

Medical History Form

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

NAME: ______________________ DATE: ______________

MEDICAL HISTORY

DO YOU HAVE ANY OF THE FOLLOWING?

____ Hypertension	____ Lung disease	____ Seizures	____ HIV/AIDS
____ Heart disease	____ Stroke	____ Cancer	____ Diabetes
____ Liver disease	____ Ulcers	____ Reflux	

Please list any recent illnesses or hospitalizations and conditions ______________

____

____

Give year of surgeries:

_______ No surgeries	_______ Breast biopsy	_______ Hernia repair
_______ Mastectomy	_______ Gallbladder	_______ Hysterectomy

Please list any other surgeries and year performed ______________________

____

SOCIAL HABITS

USE OF ALCOHOL	___ Never	___ Occasionally	___ Daily
USE OF CAFFEINE	___ Soft drinks	___ Coffee/Tea	___ How much per day?
USE OF TOBACCO	___ Smoke	___ Chew	___ How much?
	___ Previously, but quit		___ When?

FAMILY HISTORY

Does anyone in your family have nay of the following? If so, give relationship.

Hypertension ______________	Diabetes ______________
Heart Disease ______________	Bleeding disorder ______________
Stroke ______________	Seizure Disorder ______________
Cancer ______________	Obesity ______________
Peripheral Vascular Disease ________	Other ______________

METROVIEW VASCULAR LABORATORY
VASCULAR HISTORY

NAME________________________ **AGE** ____ **SEX**____**DATE**_________

PLEASE FILL OUT COMPLETELY

Precipitating Factors:
A: Do you smoke? No___ Yes_____ Years______ Packs per day_______
Quit______

Are you being treated for:
High blood pressure No______ Yes_____ Years Treated ______
High cholesterol No______ Yes_____
Diabetes No______ Yes______ Years Treated______
Diet______ Pills______ Insulin______
Heart Condition No______ Yes______
Angina______ Heart attack_______ Failure______
Murmur____ Irregular heart beat_____ Surgery_____

CEREBROVASCULAR:
Have you had:
Stroke: ______ Temporary numbness/weakness______ Slurred or difficult speech______
Temporary loss of vision in one eye______ Blindness in both eyes______
Dizziness______
Blackouts______ Memory Loss______
Did your doctor tell you that you have a noise in your neck? ______
Are you right or left handed? ________
Do you have surgery scheduled? _______

PERIPHERIAL VASCULAR
Do you have:
Leg pain with walking? ______ Leg pain without activity?______ Discoloration of toes or feet?_____
Sores or ulcers on your feet or ankles? ______ Pain in your toes when exposed to cold? _______
Have you had bypass surgery on your leg? ______ Please specify which leg ________
Have you had an amputation of your toes, foot, or leg? ______ Please specify ____________________
Do you have pain in your arms:
With activity______ Sores or ulcers on your fingers______ Discoloration of your fingers______
Pain in your fingers when exposed to cold______

PLEASE CONTINUE ON NEXT PAGE........

METROVIEW VASCULAR LABORATORY
VASCULAR HISTORY

Have you had bypass surgery on your arms? ______ Please specify which arm__________

Have you had an amputation of your fingers, hand, or arm? ______ Please specify________________

Have you had a shunt placed for dialysis? _______ Please specify which arm____________

VENOUS CIRCULATION

Have you had in the past:
Blood clots?______

Are you currently on blood thinner? ______ If so, please specify________________________________

Do you have:
Swelling of your legs______ Pain in your legs______ Redness of your leg or foot______
Sores on your ankles______ Varicose veins______

Have you had:
Vein stripping or injections______ If so, which leg___________

ARE YOU EXPERIENCING ANY OF THE FOLLOWING?

GENERAL YES NO

FEVER
FATIGUE
RECENT WEIGHT CHANGE
INSOMNIA
STRESS

EYES, EARS, NOSE, THROAT

WEAR GLASSES/CONTACTS
EYE/VISION PROBLEMS
HEARING LOSS/RINGING
EAR ACHES
NOSE BLEEDS
SINUS PROBLEMS
FREQUENT COLDS
DENTAL PROBLEMS
SORE THROAT/HOARSENESS
SWOLLEN GLANDS

HEART AND LUNGS

CHEST PAIN/HEART ATTACK
IRREGULAR/FAST HEARTBEAT
SHORTNESS OF BREATH
SWELLING OF FEET/ANKLES
COUGH
SPITTING UP BLOOD
ASTHMA/WHEEZING

GASTROINTESTINAL

LOSS OF APPETITE
NAUSEA/VOMITING
DIARRHEA
CONSTIPATION
CHANGE IN BOWEL HABITS

GENITOURINARY

FREQUENT URINATION
PAINFUL/BURNING URINATION
BLADDER CONTROL PROBLEMS
KIDNEY STONES
CHANGE IN FORCE OR STREAM
VENEREAL DISEASE

MALES ONLY

TESTICLE PAIN
PROSTATE PROBLEMS

MUSCULOSKELETAL

JOINT PAIN/SWELLING
MUSCLE/JOINT WEAKNESS
BACK PAIN
PAIN WHEN WALKING
COLD EXTREMITIES
NUMBNESS/TINGLING-LEGS
NUMBNESS/TINGLING-ARMS
VARICOSE VEINS
PHLEBITIS

BREAST

BREAST PAIN
BREAST LUMP
NIPPLE DISCHARGE
HISTORY BREAST CANCER

NEUROLOGICAL/PSYCHOLOGICAL

FREQUENT HEADACHES
LIGHT HEADED/DIZZY
TREMORS
PARALYSIS/STROKE
MEMORY LOSS/CONFUSION
DEPRESSION/ANXIETY

ENDOCRINE

GLANDULAR PROBLEMS
HORMONAL PROBLEMS
EXCESSIVE THIRST
EXCESSIVE URINATION
INTOLERANCE COLD/HOT

SKIN

RASH/ITCHING
BLEEDING/BRUISING
CHANGE IN SKIN/HAIR

BLEEDING DISORDERS

SLOW TO HEAL
ANEMIA

WOMEN ONLY

PAINFUL PERIODS
LAST MENSTRUAL PERIOD
LAST PAP SMEAR
PREGNANCIES
DID YOU BREAST FEED
AGE STARTED PERIOD

Metroview Vascular & Surgical Specialists, PA

RECORDS RELEASE AUTHORITY

TO: ______________________________________

____

____

____

I, ______________________________, hereby request that you release a report of my diagnosis, treatment, prognosis, and recommendations, as well as other data pertinent to your treatment of me to:

____

____

____

____

________________________	____________________
Patient's Signature	Witness
________________________	____________________
Patient's Date of Birth	Date
________________________	____________________
Patient's Address	City, State, Zip Code