Santa Barbara Vascular Specialists
Kevin M. Casey MD, FACS
Edward N. Li, MD, FACS
Michael J. Paisley, MD, FACS
2621 De La Vina St., Santa Barbara, CA 93105
1300 E. Cypress St., C-1, Santa Maria 93454

Ventura County Vascular Specialists
Sydney S. Guo, MD, FACS
2605 Loma Vista Rd., Ventura, CA 93003
2051 Solar Drive, Suite 150
Oxnard, CA 93036

PATIENT INFORMATION

LAST_____ **FIRST**_____ **MI**_____

SEX: M F **BIRTHDATE**: _____ **SS#**_____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOW

ADDRESS: _____ **CITY**:_____ **ST**: _____ **ZIP**:_____

HOME PHONE#_____ **CELL PHONE #**_____

PERSONAL EMAIL: _____ (*Please complete for patient portal access*)

EMPLOYMENT STATUS: FULL-TIME PART-TIME SELF-EMPLOYED RETIRED NOT EMPLOYED

EMPLOYER:_____

PRIMARY CARE DOCTOR: _____ **REFERRING DOCTOR**:_____

PREFERRED PHARMACY:_____

IS YOUR VISIT RELATED TO A WORKPLACE ACCIDENT OR INJURY? ☐ **YES** ☐ **NO**

INSURANCE INFORMATION

	Primary Medical Insurance	**Secondary Medical Insurance**
	Ins. Co. Name	Ins. Co. Name
	Policy Holder Name:	Policy Holder Name:
	Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
	Policy ID Number:	Policy ID Number:
	Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

EMERGENCY CONTACT

LAST_____ FIRST_____ RELATIONSHIP_____

HOME PHONE#:_____ WORK/CELL PHONE#:_____

GENERAL CONSENT AND BILLING AUTHORIZATION

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT AND THAT I AM THE PATIENT OR SOMEONE LEGALLY AUTHORIZED TO SIGN ON THE PATIENTS' BEHALF.
I CONSENT TO ANY MEDICAL TREATMENT RENDERED AT THE TIME OF THE OFFICE VISIT(S) UNDER THE GENERAL AND SPECIAL INSTRUCTIONS OF THE PHYSICIAN, UNLESS I STATE OTHERWISE AND COMMUNICATE SAME TO THE PHYSICIAN OR PRACTICE STAFF.
I, HEREBY, ASSIGN ALL BENEFITS TO SANTA BARBARA / VENTURA COUNTY VASCULAR SPECIALISTS FOR SERVICES RENDERED. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION NEEDED TO DETERMINE BENEFITS FOR ME/THE PATIENT, TO RELEASE IT TO MY INSURANCE COMPANY THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.
I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE TO THE PRACTICE AND AUTHORIZE RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. I HAVE GIVEN ALL MY INSURANCE INFORMATION FOR BILLING PURPOSES AND UNDERSTAND THE BILLING PROCEDURES.
I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE INCLUDING BUT NOT LIMITED TO, CO-PAYMENTS, DEDUCTIBLES, AND NON-COVERED SERVICES. I ALSO AGREE TO COMPLETE ALL NECESSARY PAPERWORK IN ORDER FOR MY CLAIM TO BE PAID BY MY INSURANCE COMPANY AND ACCEPT FULL LIABILITY FOR ALL CHARGES IF PAYMENT IS NOT MADE ON MY BEHALF BY MY INSURANCE COMPANY.

SIGNED, PATIENT OR LEGAL REPRESENTATIVE _____ **DATE:**_____

PRINT NAME_____ **RELATIONSHIP TO PATIENT**_____

CANCELLATION AND NO SHOW POLICY

If you must cancel your appointment, please provide 24 hour notice. Those who do not provide such notice will be subjected to a $75.00 cancellation fee for office visit, $150.00 for both an ultrasound and office visit or $250.00 for a procedure.
We understand some circumstances are unavoidable and unexpected, exceptions to this policy will be reviewed by the physicians and waived only with their approval. The Practice reserves the right to terminate the physician/patient relationship after 2 no shows.
Please sign below confirming you have read and understand our Cancellation and No Show Policy.

Printed Name of Patient or Legal Representative _____

Signature of Patient or Legal Representative _____**Date**_____

DEMOGRAPHIC INFORMATION

[Check box if you decline to report demographic information ☐]

The following **optional** information is being requested to better accommodate our patients' preferences and understand individual genealogical history, which can indicate propensity for certain medical conditions.

GENDER: _____ **PREFERED LANGUAGE**: _____

RACE:

__American Indian or Alaska Native Asian
__Black or African American
__Native Hawaiian or Other Pacific Islander
__White

ETHNICITY:

__Hispanic or Latino
__Not Hispanic or Latino

PATIENT, FAMILY & SOCIAL INFORMATION

Patient Name:_____ Date of Birth:_____ Sex: Male Female

Marital Status: Married Single Divorced Widow - If Married, Spouses State of Health:_____

Primary Physician:_____ Referred By:_____

Reason for Referral:_____

- Current Living Situation (Check all that apply): ☐ Single Family Household ☐ Homeless ☐ Shelter ☐ Multi-generational Household ☐ Skilled Nursing Facility ☐Other: _____
- Do you smoke? ___YES ___NO ____QUIT If smoking, how long? ___ How many packs a day? ____ If you have quit, how long ago?_____
- Do you drink alcohol? ___YES ___NO ____QUIT If yes, how many drinks per day? _____ If you have quit, how long ago?_____
- Do you have any history of substance abuse or IV drugs use? ___YES ___NO
- Have you completed a Durable Power of Attorney for Healthcare, also known as an Advance Medical Directive?

  __YES *If yes, please provide a copy for your medical record in our office.

  __NO *If no, are you interested in information regarding an advanced directive? ___YES ___NO

FAMILY HISTORY

- Father: Living____ Deceased _____ If deceased, at what age? ___ Cause of Death _____
  _____
- Mother: Living____ Deceased_____ If deceased, at what age? ___ Cause of Death _____
  _____
- Brothers: Number Living ____ Number Deceased____ If deceased, at what age? ___Cause of Death_____
  _____
- Sisters: Number Living ____ Number Deceased____ If deceased, at what age? ___Cause of Death_____
  _____
- Children: Number Living ____ Number Deceased____ If deceased, at what age? ___Cause of Death_____
  _____

Circle any disease which your father, mother, brothers, sisters, or children have experienced:

Heart Disease Bleeding Disorder Cancer Kidney Disease High Blood Pressure

Stroke Diabetes Alcoholism Tuberculosis Seizures/Epilepsy Psychiatric Problems

MEDICAL AND SURGICAL HISTORY

Medical History—List all serious conditions for which you have been treated by a doctor. Examples include, but are not limited to, anemia, diabetes, cancer, heart trouble, kidney disease, epilepsy, high blood pressure and hypercholesterolemia:

Condition	Date	Treating Physician

Surgical History---List all operations below, and any significant complications related to the operations:

Operation	Date	Significant Complications

Diagnostic Test--- List any recent diagnostic tests, including angiograms, ultrasounds, or x-rays:

Name of Test/X-ray	Date	Where Performed

Review of Systems: Please circle any condition or symptoms you have experienced:

Diabetes	Pain/weakness in legs/arms	Numbness/tingling	Pacemaker	Fatigue	Chest Pain
Swelling in feet/legs	Abdominal Pain	Weight Loss	Decreased Hearing	Back Pain/Joint Pain	
Dizziness/Fainting	Blurred Vision	Headaches	Bruise/Bleed Easily	Difficulty Urinating	
Stroke/CVA/TIA	Poor Healing				

MEDICATION LIST

NAME: **DATE OF BIRTH:**

ALLERGIES: **PHARMACY:**

REACTIONS: **DIABETIC:** **YES** **NO**

PLEASE LIST YOUR CURRENT & OVER-THE-COUNTER MEDICATIONS, THE DOSAGE & FREQUENCY TAKEN:

MEDICATIONS:	**Dosage**	**Frequency**

VITAMINS:	**Dosage**	**Frequency**

SANTA BARBARA/VENTURA COUNTY VASCULAR SPECIALISTS HIPAA Privacy Rule

Authorization Agreement/ Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations

I_____(patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

-A basis for planning my care and treatment;

-A means of communication among the health professionals who may contribute to my healthcare;

-A source of information for applying my diagnosis and surgical information to my bill;

-A means by which a third-party payer can verify that services billed were actually provided;

-A tool for routine healthcare operations such as assessing quality and reviewing the competence of health professionals.

- I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified above for the purpose and to the parties designated by me.
- I have been provided with a copy of the Notice of Privacy Practices that provides a more complete description of information uses and disclosures.

Consent Agreement/ Consent for the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations

I understand that:

- This facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested.
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.
- It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

Receipt of Notice of Privacy Practices Written Acknowledgement Form Acknowledgement of receipt of Information Practices Notice

I,_____,(patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

-I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement;

-This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Printed Name of Patient or Legal Representative_____

Signature of Patient or Legal Representative _____**Date:**_____

OFFICE USE ONLY:

Signature of Witness (Staff)_____**Date:**_____

PERSONAL REPRESENTATIVE AUTHORIZATION FOR MEDICAL RELEASE FORM

I authorize this facility to speak to the following family members or my personal representative (**check one**)

☐ All medical information, including but not limited to records pertaining to examinations, treatments, consultations, billing records, x-rays, and reports history, laboratory findings, admissions and discharge reports, treatment records, diagnosis and prognosis and records, nurse's and doctor's notes and any other non-medical information in my file.

☐ Only the following types of information:

_____
_____
_____.

The above medical information shall only be released to the following persons:

Family Member/Personal Representative Relation

_____

_____

_____

I understand that I may terminate this Medical Authorization form. I must notify this facility in writing regarding termination and effective date.

This authorization shall remain valid (check one)

☐ Until revoked in writing.
☐ Until_____,20_____

I know that I am entitled to receive a copy of this agreement.

Printed Name of Patient or Legal Representative _____

Signature of Patient or Legal Representative _____

Date: _____