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

Sydney S. Guo, MD
2605 Loma Vista Rd., Ventura, CA 93003
1901 Outlet Center Drive, Suite 210
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:______________________________

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.
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: ______________________________