Thomas C. Lackey II, D.O.
Board Certified General Surgeon
Vein Specialist

FLORIDA LAKES
VEIN CENTER

Lauren Fazenbaker, PA-C
Francesca Mertan, PA-C
Vein Specialists

Nombre del Paciente: _____Fecha Nacimiento: _____

Número Seguro Social: _____

Dirección: _____

Dirección Fuera del Estado: _____

Teléfono Hogar: _____Número Celular: _____

Circular Uno: **Empleo** **Retirado** **Incapacitado** **Desempleado**

Empleado (Lugar de trabajo): _____

Seguro Primario: _____ Seguro Secundario: _____

Contacto Emergencia (Nombre/#Teléfono):

_____

Doctor Primario: _____Telefono del Dr._____

Cardiologo: _____ Teléfono del Dr._____

Cómo escuchó usted de Florida Lakes Vein Center? _____ Referido por Doctor?_____

Nombre Amigo _____ Periódico: _____

Farmacia: _____

Paciente o Tutor Legal: _____***Fecha:*** _____

Nombre del Paciente:_____ Fecha Nacimiento: _____

MEDICAMENTOS

Favor de escribir o proveer una copia de la lista de medicamentos al asociado de la oficina.

EN LETRA DE MOLDE ESCRIBA EL NOMBRE DEL MEDICAMENTO, DOSIS, RAZON POR LA CUAL TOMA EL MISMO.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.
16.
17.
18.

Alergia a Medicamentos:

Medicamento anticoagulante: _____ *Concentración de Medicamento:* _____

FLORIDA LAKES
VEIN CENTER

Financial Agreement, Patient Statement, and Assignment of Benefits

I, the patient, authorize Florida Lakes Surgical, PLLC (dba Florida Lakes Vein Center), and/or Thomas C. Lackey II, D.O. and/or Gregg Shore, M.D., to release any and all information necessary to secure reimbursement from any insurance company to which I have subscribed. The insurance policy is a contract between me and the insurance company, and I understand that I am responsible for all charges incurred whether or not paid by the insurance company. Our office will file your claim with insurance company as a courtesy. I also authorize and direct payment to be made directly to Florida Lakes Surgical, PLLC (and its dba) and/or Thomas C. Lackey II, D.O. for service rendered either medically or surgically. However, it is the patient's responsibility to have all the insurance information at the time service is rendered. All co-payments, deductibles, percentages, co-insurances, etc. are the patient responsibility and will be collected **prior** to services rendered. All payments are to be paid in full upon receipt of a bill. Furthermore, the patient will assist in billing appropriate insurance companies. If for any reason there is an outstanding balance or delinquent account, it is the patient's responsibility to pay in full or appropriate actions will be taken to collect the payment. I agree and understand that I am responsible for any costs incurred in collection of said balance should that become necessary. Depending on circumstances, payment arrangements or payment plans can be made with the billing manager.

Paciente o Tutor Legal: _____ *Fecha:* _____

Consent for Treatment

I, undersigned patient, parent, or legal guardian, present myself (or the patient) for care/treatment at the office of Florida Lakes Vein Center and/or Thomas C. Lackey II,D.O., Francesca Mertan, PA-C, and/or Gregg Shore, M.D., and voluntarily consent to the rendering of such care or treatment, including but not limited to consultation, performance of diagnostic testing, and/or surgical procedures that may be rendered in the office or other facility needed for appropriate care. I understand that the physician may rely on other services to help facilitate my care (i.e. radiology, laboratory, pathology, physicians).

Paciente o Tutor Legal: _____ *Fecha:* _____

FLORIDA LAKES
VEIN CENTER

Autorización para Devulgar Registros Médicos/ Obtener Registros Médicos

Nombre del Paciente: _____

Fecha de Nacimiento: _____Teléfono: _____

Dirección:_____

_____

Divulgación de Información

Thomas C. Lackey II, D.O. - Gregg Shore, M.D.

Certifico que esta solicitud se ha realizado de forma voluntaria y que la información proporcionada anteriormente es precisa según mi major conocimiento. Entiendo que puedo revocar esta autorización en cualquier momento, excepto en la medida en que ya se haya tomado acción para cumplirla. Aquellos que reciban la información por escrito sin mi conosimiento, no pueden divulger mi información médica. Al firmar a continuación, autorizo a Florida Lakes Vein Center a divulger/ obtenercopias de mis registros medicos, incluida la información relacionada con la evaluación psicológica/ psiquiátria, los resultados y tratamiento de las pruebas de VIH/ SIDA y el tratamiento por abuso de alcohol/ sustancias.

*Paciente o Tutor Legal:*_____*Fecha:*_____

FLORIDA LAKES
VEIN CENTER

HIPAA

Our Notice of Privacy provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to a copy our Notice before signing the Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations as it pertains to the law. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent in writing and signed by you. However, such a revocation shall not affect any disclosures we have already made on reliance of your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that: 1) Protected health information may be disclosed or used for treatment, payment or health care operations; 2) The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice and receive a copy; 3) The Practice reserves the right to change the Notice of Privacy policies; 4) The patient has the right to restrict the use of their information as it pertains to the law; 5) The patient may revoke this Consent in writing at any time and all future disclosures will cease; and 6) The Practice may condition treatment upon the execution of this Consent.

I authorize Thomas C. Lackey II, D.O. and the medical staff of Florida Lakes Vein Center and/or Adam N.Phillips, D.O., to release my health care information to the following person(s):

Pareja: _____ Otro: _____

Miembros de Familia: _____

La información puede divulgarse a los enumerados anteriormente por teléfono, mensaje en el contestador automático, fax, correo, en persona, mensaje de texto, correo electrónico u otros medios.

Paciente o Tutor Legal: _____ ***Fecha:*** _____

FLORIDA LAKES
VEIN CENTER

Fecha _____

HISTORIA MÉDICA DEL PACIENTE

Nombre del Paciente: _____Fecha de nacimiento: _____

Problema: _____

Cuanto tiempo han estado presente los sintomas?_____

Historia Pasada-- por favor marque, si aplica.

GERD
COPD
Cardiac Disease
Obesity
Hypertension/ High blood pressure

Varicose Veins
Osteoarthritis / Arthritis Diabetes
DVT/ Blood Clot
Cancer: (type) _____

HIV
High Cholesterol
IBS
Hepatitis

Otro: _____

Past Surgical History: (please check mark if applicable)

Gallbladder
Breast
Hemorrhoids

Colon
Appendectomy
Total Abdominal Hysterectomy

Hernia (type): _____
Cancer (type): _____
Stents: _____

Otro: _____

Alimentos: _____

Historia Social-- por favor marque, si aplica.

Tobacco: **SI / NO** (packs per day)
Alcohol: **SI / NO** (drinks per day)

Married **Divorced** **Widowed** **Single**

RACE/ETHNICITY: HISPANIC

Family History: (please check mark, if applicable)

Hypertension
Pulmonary
Diabetes Mellitus
Cardiac
Varicose Veins
Cancer (type):_____

Please indicate on the medication sheet if you are taking any blood thinning medication!