

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



**Lauren Fazenbaker, PA-C**  
Vein Specialist

**Francesca Mertan, PA-C**  
Vein Specialist

**FLORIDA LAKES**  
VEIN CENTER

Patient Name: \_\_\_\_\_ Date of Birth: : \_\_\_\_\_ SSN# \_\_\_\_\_

**\*\*Failure to provide SSN could result in any balance transferred to patient responsibility for all Federal programs.**

Address: \_\_\_\_\_

Out-of-State Address: \_\_\_\_\_

Home telephone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Circle one:**                      **Employed**                      **Retired**                      **Disabled**                      **Unemployed**

Employer: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Emergency Contact- Name/Phone: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Cardiologist: \_\_\_\_\_ Telephone: \_\_\_\_\_

How did you hear about Florida Lakes Vein Center? \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_

***Patient Signature:*** \_\_\_\_\_ ***Date:*** \_\_\_\_\_

**\*\*You may be seen by any of the providers in our practice during various appointments.**



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Date: \_\_\_\_\_

## MEDICAL HISTORY

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

How long have symptoms been present? \_\_\_\_\_

### Past History

GERD  
COPD  
Cardiac Disease  
Obesity  
Hypertension/ High blood pressure

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

HIV  
High Cholesterol IBS  
Hepatitis  
PFO (Patent Foramen Ovale)  
Atrial Septal Defect

Other: \_\_\_\_\_

### Past Surgical History: (please check mark if applicable)

Gallbladder  
Breast  
Hemorrhoids  
Coronary Artery Bypass Graft

Colon  
Appendectomy  
Total Abdominal Hysterectomy  
Vein Stripping

Hernia (type): \_\_\_\_\_  
Cancer (type): \_\_\_\_\_  
Stents: \_\_\_\_\_

Other: \_\_\_\_\_

### Social History:

Tobacco: YES/ NO (packs per day) \_\_\_\_\_  
Alcohol: YES/ NO (drinks per day) \_\_\_\_\_

Married    Divorced    Widowed    Single

RACE/ETHNICITY:    CAUCASIAN    BLACK    HISPANIC    ASIAN    NATIVE AMERICAN    OTHER

### 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!

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

### MEDICATIONS

Please print medications below or give a copy of medication list to the office staff.

**Medication, Dosage, and Reason for taking the medication.**

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

**Please list ALL Allergies:**

*Blood-thinning medication:* \_\_\_\_\_ *Dosage:* \_\_\_\_\_



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### **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 any Physician Assistants under supervision 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.

***Patient Signature:*** \_\_\_\_\_ ***Date:*** \_\_\_\_\_

### **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, Thomas C. Lackey II, D.O, Francesca Mertan, PA-C, and/or Lauren Fazenbaker, PA-C, 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). I understand that I will be seen by any provider employed by the practice.

***Patient Signature:*** \_\_\_\_\_ ***Date:*** \_\_\_\_\_

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## 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 the medical staff of Florida Lakes Vein Center to release my health care information to the following person(s):

Spouse: \_\_\_\_\_

Other/Relationship: \_\_\_\_\_

The information may be released to those listed above by phone, voicemail, fax, mail, email, text, in person, or by other means.

***Patient Signature:*** \_\_\_\_\_ ***Date:*** \_\_\_\_\_

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### Authorization to Release and/or Obtain Medical Records

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

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#### Release of Information

Thomas C. Lackey II, D.O.  
Francesca Mertan, PA-C - Lauren Fazenbaker, PA-C

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I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken. Those receiving the information without my further written consent, may not disclose my medical information. By signing below, I authorize Florida Lakes Vein Center to release and/or obtain copies of my medical records.

***Patient Signature:*** \_\_\_\_\_ ***Date:*** \_\_\_\_\_

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### PATIENT CONSENT FOR PHOTOGRAPHY AND/OR VIDEOGRAPHY

PATIENT: \_\_\_\_\_

DATE: \_\_\_\_\_

I consent for medical imaging (photo, video, and/or audio) to be made of me. I understand that the information may be used in my medical record, for purposes of medical teaching, and for marketing purposes designated by Florida Lakes Surgical PLLC (dba Florida Lakes Vein Center). By consenting to this medical photography, I understand that I will not receive payment from any party. Refusal to consent to photographs, video, and/or audio recording will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future, I may contact the staff at Florida Lakes Surgical/Florida Lakes Vein Center.

By signing this form, I confirm that this consent form has been explained to me in terms which I understand. I consent for these photographs to be used in medical publications, electronic publications, and all forms of marketing. I understand that the image may be seen by members of the public. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

9114 Town Center Pkwy., Ste. 101, Lakewood Ranch, FL 34202 – O: 941-866-8989 – F: 941-899-8988  
1217 Jacaranda Blvd., Venice, FL 34292 – O: 941-257-0765 – F: 941-257-0766  
19790 Wellen Park Blvd., Suite 201B, Venice, FL 34293 – O: 941-777-7771 – F: 941-777-7774  
4759 Lakeview Dr., Sebring, FL 33870 – O: 863-402-5600 – F: 863-402-5602  
[floridalakesveincenter.com](http://floridalakesveincenter.com)