TOTAL VASCULAR WELLNESS

Ashfaq H. Siddiqui, MD, FACS

PATIENT INFORMATION FORM

309 Regency Parkway, Suite 207, Mansfield, Tx 76063
817-225-2716 • 817-225-2719 Fax

(PLEASE PRINT LEGIBLE AND COMPLETE ALL ITEMS.)

Patient Name _____ Date of Birth _____
Last First Initial

Address _____ Phone (_____) _____-_____

_____ Cell (_____) _____-_____

City _____ State _____ Zip _____

Sex:M F Marital Status: MSD W SS# _____-_____-_____ Age_____

Spouse's Name _____ Phone (_____) _____-_____

Guarantor (If patient under 18) _____ Phone (_____) _____-_____

Employer _____ Phone (_____) _____-_____

Referring Physician/Family Doctor _____ Phone (_____) _____-_____

Emergency Contact _____ (_____) _____-_____ _____
(Not living with you) Name Phone Relation

CHIEF COMPLAINT_____ Allergies _____

Work Related Injury? YN Date of Injury _____ Pharmacy Phone (_____) _____-_____

IF YOU ARE A NEW PATIENT AND DO NOT HAVE YOUR INSURANCE CARDS, YOU WILL BE ENTERED AS SELF-PAY

PRIMARY INSURANCE _____ Phone (_____) _____-_____

Subscriber # _____ Group # _____ Subscriber Name _____

Subcriber Date of Birth _____ Employer Name _____

Employer Phone (_____) _____-_____ Claims Address _____
(on back of insurance card)

SECONDARY INSURANCE_____ Phone (_____) _____-_____

Subscriber #_____ Group # _____ Subscriber Name _____

Subcriber Date of Birth _____ Employer Name _____

Employer Phone (_____) _____-_____ Claims Address _____
(on back of insurance card)

I authorize payment to be made to Ashfaq Siddiqui,MD.I authorize any holder of medical information about me to release to my insurance carier and/or Health Care Administration and its agents and/or my Medigap insurer any information needed to determine these benefits or the benefits payable for related services. As a courtesy to me, Ashfaq Siddiqui,MD will file all insurance claims, but I understand that, with the exception of Workers Compensation and some governmental insurance plans (e.g. Medicare or Medicaid), I am responsible for the full amount of the charges. If I have no insurance, I will pay all charges at the time of services unless other arrangements have been made. I also authorize the release of any medical or other information to my referring physician. I voluntarily consent to examination and Treatment.

Patient/Guarantor Signature _____ Date _____

PATIENT INFORMATION FORM

Ashfaq H. Siddiqui, MD, FACS

PATIENT NAME_____

(PLEASE PRINT LEGIBLE AND COMPLETE ALL ITEMS.)

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING?

Change in Weight	[ ] YES [ ] NO		
Increase _____	Decrease _____		
Aching/pain in legs	[ ] Yes L / R	[ ] No	
Heaviness	[ ] Yes L / R	[ ] No	
Tiredness	[ ] Yes L / R	[ ] No	
Swollen Ankles	[ ] Yes L / R	[ ] No	
Leg cramps	[ ] Yes L / R	[ ] No	
Restless legs	[ ] Yes L / R	[ ] No	
Throbbing	[ ] Yes L / R	[ ] No	
Problems walking	[ ] Yes L / R	[ ] No	
Phlebitis	[ ] Yes L / R	[ ] No	

Do you have any wounds? [ ] Yes L / R [ ] No

Have you had any TEST for circulation on your legs?

[ ] Yes L / R [ ] No

If yes, what _____

Do you elevate your legs to relieve discomfort? [ ] Yes [ ] No

Do you wear support hose? [ ] Yes [ ] No

If yes, How long have you worn them _____

Do they provide any relief? [ ] Yes [ ] No

Do you stand much at home? [ ] Yes [ ] No

Do you stand much at work? [ ] Yes [ ] No

How long have you had symptoms? _____

Do you Smoke ? [ ] Yes [ ] No If Yes, How long? _____ Packs _____ Per _____

HAVE YOU EVER BEEN TREATED FOR OR BEEN DIAGNOSED WITH

Diabetes	[ ] Yes	[ ] No	Arthritis	[ ] Yes	[ ] No
Cancer	[ ] Yes	[ ] No	Convulsions/Seizures	[ ] Yes	[ ] No
Anemia	[ ] Yes	[ ] No	Vein Reflux	[ ] Yes	[ ] No
Hypertension	[ ] Yes	[ ] No	Bleeding problem	[ ] Yes	[ ] No
Heart disease	[ ] Yes	[ ] No	Breathing problem	[ ] Yes	[ ] No
Infection [ ] Yes	[ ] No		Blood Clots	[ ] Yes	[ ] No

Other _____

Past Surgeries _____

_____

FAMILY HISTORY

Diabetes	[ ] Yes	[ ] No	If yes who: _____
Hypertension	[ ] Yes	[ ] No	If yes who: _____
Stroke	[ ] Yes	[ ] No	If yes who: _____
Bleeding Problems	[ ] Yes	[ ] No	If yes who: _____
Heart Disease	[ ] Yes	[ ] No	If yes who: _____
Infections	[ ] Yes	[ ] No	If yes who: _____
Cancer	[ ] Yes	[ ] No	If yes who: _____
Arthritis/Gout	[ ] Yes	[ ] No	If yes who: _____
Leg Ulcers	[ ] Yes	[ ] No	If yes who: _____
Swollen Legs	[ ] Yes	[ ] No	If yes who: _____
Varicose Veins	[ ] Yes	[ ] No	If yes who: _____

PATIENT INFORMATION FORM

Ashfaq H. Siddiqui, MD, FACS

PATIENT NAME_____

(PLEASE PRINT LEGIBLE AND COMPLETE ALL ITEMS.)

PURPOSE OF REQUEST: I authorize Dr. Ashfaq Siddiqui staff to disclose my protected health information in the following manner.

HOME TELEPHONE _____

[ ] Leave detailed messages on my answering machine/voicemail.

[ ] Leave message with only call-back number (includes staff name and doctor's office) on my answering machine/voicemail.

WORK TELEPHONE _____

[ ] Leave detailed message on my answering machine/voicemail.

[ ] Leave message with only call-back number (includes staff name and doctor's office) on my answering machine/voicemail.

MOBILE TELEPHONE _____

[ ] Leave detailed messages on my answering machine/voicemail.

[ ] Leave message with only call-back number (includes staff name and doctor's office) on my answering machine/voicemail.

Person / or Persons I authorize to receive protected health information only, excluding financial responsibility to my treatment or my care to Ashfaq Siddiqui,MD.

Name _____ Relation _____

Contact Number (_____) _____ - _____

Name _____ Relation _____

Contact Number (_____) _____ - _____

Name _____ Relation _____

Contact Number (_____) _____ - _____

Expiration or termination of authorization - This authorization will remain in effect until terminated by patient, the patient's representative, or another individual of legal entity authorized to do so by court or law.

Right to revoke or terminate - As stated in our Notice of Privacy Practices, you have the right to or terminate the authorization by submitting a written request to the Privacy Manager.

Patient Signature _____ Date _____

PATIENT INFORMATION FORM - Authorization for the Release of Medical Records

Ashfaq H. Siddiqui, MD, FACS

PATIENT NAME_____ Date of Birth ____ /____ /____

(List maiden name / other names used)

(PLEASE PRINT LEGIBLE AND COMPLETE ALL ITEMS.)

I hereby request and authorize: Ashfaq Siddiqui, MD FACS
Vascular Surgeon
309 Regency Parkway, Suite 207
Mansfield, Tx 76063
Ph. 817-225-2716 Fax 817-225-2719

____ To Disclose Information To: _____ ____ To Receive Information from: _____

Provider Name: _____

Address: _____

City _____ State _____ Zip _____

Information to be disclosed include copies of:

_____ Entire Record _____ X-ray Reports
_____ Progress Notes _____ X-ray Films
_____ Physical Exam Forms _____ Other, Specify: _____
_____ Daily Chart Notes _____

Purpose for disclosure:

_____ Treatment, Payment or _____ Other (specify) _____

This authorization will be effective for six months after date signed,unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is valid as the original.

_____ Date _____

Signature of Patient

OR

_____ Date _____

Signature of Legal Representative/Relationship

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

Notice to recipient of Information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.

PATIENT INFORMATION FORM - Conditions of Admission and/or Treatment

Ashfaq H. Siddiqui, MD, FACS

PATIENT NAME_____

(PLEASE PRINT LEGIBLE AND COMPLETE ALL ITEMS.)

CONSENT TO TREATMENT: I HAVE AUTHORIZE MY PHYSICIAN AND THE STAFF,AGENTS,AND EMPLOYEES OF Total Vein & Wound care perform and I hereby consent to, such medical care, including diagnostic procedures, medical treatment and examination, as may, in the opinion of my physicians, be necessary. I acknowledge that no guarantees have been made to me as to the effect of such examination or treatment or my condition.

1. The office of Ashfaq Siddiqui, MD will bill your insurance as a courtesy to you, however financial responsibility of this visit belongs to the undersigned. The undersigned agrees to pay, in addition to the amounts herein provided, all costs and expenses, including reasonable attorney's fees.

STATEMENT TO PERMIT PAYMENTS OF MEDICARE BENEFITS TO PROVIDER,PHYSICIANS, AND PATIENTS

I certify that the information given to me in applying for payment under TITLE XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medical claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician or organization to submit a claim to Medicare for payment to me. I have read and understand the above paragraphs and received a copy of any important message from Medicare.

INSURANCE ASSIGNMENT

I, the undersigned authorize payment directly to the provider for treatment. I understand I am financially responsible to Ashfaq H. Siddiqui for charges not covered by this agreement.

[ ] PATIENT RIGHTS: I have received information upon admission concerning my patient rights.

Modifications: No changes or modifications in this agreement shall be valid unless initiated by an Authorized Representative.

DO NOT SIGN UNTIL YOU HAVE READ & UNDERSTAND ALL INFORMATION SET OUT ON THIS FORM

_____ _____

Signature Printed Name

_____ _____ _____ _____

Date Time Witness Relationship

PATIENT INFORMATION FORM – Acknowledgement of Notice of Privacy Practices

Ashfaq H. Siddiqui, MD, FACS

PATIENT NAME_____

(PLEASE PRINT LEGIBLE AND COMPLETE ALL ITEMS.)

Attached please find Total Vein and Wound Care Notice of Privacy Practices. Your name and signature on this cover sheet indicate that you have received a copy of our Notice of Privacy Practices on the date indicated. The notice is yours to keep.

If you have any questions regarding the information set forth in Total Vein & Wound Care Notice of Privacy Practices, please do not hesitate to contact the Privacy Officer at (817) 225-2716 or in writing at total Vein & Wound Care, 309 Regency Parkway, Suite 207 Mansfield, Tx 76063.

_____ Date _____

Printed Name of Patient

_____

Signature

_____

Authority to Sign if Not Patient

PATIENT INFORMATION FORM - Legal Financial Agreement Of Benefits Form

Ashfaq H. Siddiqui, MD, FACS

PATIENT NAME_____

(PLEASE PRINT LEGIBLE AND COMPLETE ALL ITEMS.)

SECTION I: FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

PLEASE INITIAL IN AKNOWLEDGEMENT OF THE INFORMATION BELOW

_____ In consideration for the services to be rendered to me, I hereby assume full responsibility to pay for those services in accordance with the rates now in effect at Ashfaq Siddiqui, MD, FACS to the extent that I am legally responsible for such payment. Payments that I am responsible for may include, but are not limited to:

[ ] Balance after insurance [ ] Non-covered services [ ] Deductibles

_____ I hereby assign to Ashfaq Siddiqui, M.D. any and all benefits for services rendered under insurance policies, reimbursement, or pre-paid healthcare plans. I acknowledge any balance not covered or paid by such policies is my legal responsibility. I understand that if my account is turned over to a collection agency, a 35% service charge will be added to the balance.

_____ I understand that my account must be current before any future appointments can be scheduled with Ashfaq Siddiqui,M.D.

_____ I understand that a $25.00 charge will be added to the balance if I fail to call and cancel my appointment within 24 hrs. I understand that I am required to inform Ashfaq Siddiqui, M.D., of any address, phone number, or insurance changes.

SECTION II: MEDICAL RECORDS RELEASE AND FORMS

_____ I understand that If I request a copy of my medical records to be sent to new doctor, I must allow 15 business days for processing from the time I submit signed authorization. I understand that if I request a copy of my medical records for personal use, I must pre-pay $25 and allow 15 days for processing from the the time I submit a signed authorization.

By signing below, I have read each of the sections on this page.
I understand each section and consent to and agree with the information stated in each section.

**BE SURE ANY QUESTIONS YOU MAY HAVE ARE ANSWERED BEFORE YOU SIGN.

_____ Date _____

Patient Signature

_____ Date _____

Signature of Legal Representative/Relation