



PATIENT'S INFORMATION

Date: _____

Social Security #: _____

Patient Name: _____
Last Name Legal First Name MI Suffix

Permanent Mailing Address: _____

Physical Address: _____
If different from mailing

Home Phone: _____ Employer Phone: _____ Cell Phone: _____

Sex at Birth: ☐ M ☐ F DOB: _____

Employer Name: _____

Employer Address: _____

Patient's E-Mail: _____
No email for children under the age of 18

Primary Care Physician: _____ PCP Phone: _____

PCP Address and/or City: _____ Marital Status: _____

INSURANCE INFORMATION

Is this visit due to one of the following? ☐ Worker's Comp ☐ Liability ☐ Motor Vehicle Date of Injury: _____

Primary Insurance Co.: _____ Relationship to Subscriber: _____
If the patient is not the subscriber, complete the following.

Subscriber Name: _____
Last Name Legal First Name MI Suffix

Subscriber Mailing Address: _____

Employer Phone: _____ Cell Phone: _____

Sex: ☐ M ☐ F Subscriber DOB: _____ Subscriber SS#: _____

Subscriber Employer: _____

Employer Address: _____

Secondary Insurance Co.: _____ Relationship to Subscriber: _____
If the patient is not the subscriber, complete the following.

Subscriber Name: _____
Last Name Legal First Name MI Suffix

Subscriber Mailing Address: _____

Employer Phone: _____ Cell Phone: _____

Sex: ☐ M ☐ F Subscriber DOB: _____ Subscriber SS#: _____

Subscriber Employer: _____

Employer Address: _____

Would you like to be called by another name other than your legal first name? _____

Race: _____ Ethnicity: ☐ Hispanic ☐ Not Hispanic Language: _____

Patient's Gender Identity: ☐ Female-to Male/
Transgender Male ☐ Male-to-Female/
Transgender Female ☐ Non-Binary/
Genderqueer ☐ Others

Referring Physician _____ Referring Phone: _____

Referring Address and/or City: _____

Preferred Pharmacy: _____ Pharmacy Location: _____

Mail Order Pharmacy Name: _____



Medical History

Patient Name _____ Date of birth _____

Medications:

We prefer if you bring all bottles of your medications with you, however we understand this can be difficult for some people. If you are unable to bring the bottles, please take the time to fill out the medication table below. All sections need to be filled out completely. This will help us to ensure that whatever information we have obtained prior to your arrival is up to date and there are no errors.

[illegible]

Allergies: List all **medication** allergies and reactions you have had.

[illegible]

Patient Name: _____

Medical History: Place a check next to any conditions you have been diagnosed with previously.

☐ Abdominal Aortic Aneurysm (AAA)	☐ Gout	☐ Cancer, type _____
☐ Anemia, low blood count	☐ Hyperthyroidism	☐ Chest pain, angina
☐ Antibiotic resistant infection (MRSA)	☐ Kidney disease (failure/insufficiency)	☐ Colitis
☐ Anxiety	☐ Pregnancies, how many _____	☐ Depression
☐ Arthritis	☐ Reflux (GERD)	☐ COPD
☐ Asthma	☐ Hepatitis A, B, or C	☐ Heart Attack
☐ Atrial fibrillation or other rhythm problem	☐ Hiatal Hernia	☐ Hypothyroidism
☐ Prostate problems	☐ High cholesterol	☐ Liver disease
☐ Carotid disease	☐ High blood pressure	☐ Pulmonary embolism
☐ Chronic bronchitis	☐ HIV/AIDS	☐ Stomach Ulcer
☐ Congestive Heart Failure	☐ Bleeding disorders	☐ TB Exposure
☐ Diabetes, Type (I or II) _____	☐ Blood clots/ DVT	☐ Other: _____
☐ Stroke (CVA) or Mini Stroke (TIA)	☐ Thoracic Aortic Aneurysm	

Surgical History: Please list your surgeries/procedures along with the year it was performed.

Procedure	Year

Family History: Provide age and diagnosis for family members.

	Mother	Father	Brother	Brother	Sister	Sister
Age if alive						
Age deceased						
Aneurysm						
Cancer, type						
Heart Disease						
High Blood Pressure						
Stroke						

Other family medical problems:

Social History/ Risk factors: Please check for all the following that apply to you.

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Current Smoker: ☐ Yes ☐ No # Packs/day _____ Quit? What year _____

Occupation: _____ Retired? ☐ Yes ☐ No

Alcohol intake: # drinks _____ ☐ day ☐ month ☐ year Type: _____

Review of Systems: Place a check next to any symptoms that you have had in past 6 months

<u>General</u> ☐ Normal ☐ Wt loss? Lbs ____ Since _____ ☐ Wt Gain? Lbs ____ Since _____ ☐ Fevers ☐ Chills ☐ Night Sweats ☐ Fatigue	<u>Eyes/ENT</u> ☐ Normal ☐ Vision Loss ☐ Hearing Loss ☐ Sore throat ☐ Hoarseness ☐ Sinus Infection ☐ Dizziness	<u>Neurological</u> ☐ Normal ☐ Headaches ☐ Weakness ☐ Confusion ☐ Stroke ☐ Temporary Paralysis ☐ Seizures	<u>Respiratory</u> ☐ Normal ☐ Shortness of breath lying flat ☐ Shortness of breath at rest ☐ Shortness of breath with exercise ☐ Wheezing ☐ Dry Cough ☐ Coughing up blood
<u>Cardiovascular</u> ☐ Normal ☐ Irregular heartbeat ☐ Racing heart ☐ Chest discomfort/pain ☐ Black out/passing out ☐ Heart murmur ☐ Bilateral leg swelling	<u>Hematologic</u> ☐ Normal ☐ Easy bruising ☐ Blood nose ☐ Swollen lymph nodes ☐ Bleeding problems ☐ Blood clots, vein clots, milk leg	<u>Endocrine</u> ☐ Normal ☐ Hyperthyroidism ☐ Hypothyroidism ☐ Hot Flashes ☐ Heat Intolerance ☐ Cold Intolerance ☐ Excessive Thirst ☐ Excessive Urination	<u>Psychiatric</u> ☐ Normal ☐ Depression ☐ Anxiety ☐ Panic Attacks
<u>Gastrointestinal</u> ☐ Normal ☐ Jaundice ☐ liver problem ☐ Abdominal pain ☐ Nausea ☐ Vomiting ☐ Blood in stool ☐ Diarrhea ☐ Constipation ☐ Indigestion/reflux ☐ Heartburn ☐ Difficult swallowing ☐ Decreased Appetite	<u>Genitourinary</u> ☐ Prostate enlargement ☐ Urinate frequently ☐ Urinary incontinence ☐ Bladder infection ☐ Kidney failure ☐ Blood urine ☐ Impotence ☐ Erectile dysfunction ☐ Post-menopausal	<u>Musculoskeletal</u> ☐ Normal ☐ Arthritis ☐ Back pain ☐ Leg swelling ☐ Arm swelling ☐ Varicose veins ☐ Leg ulcers (sores) ☐ Neck pain ☐ Leg cramp/discomfort ☐ Foot pain at night ☐ Weakness ☐ Extremity pain	<u>Socioeconomic</u> ☐ No concern ☐ Financial burden ☐ Food insecurity ☐ No Shelter ☐ No Primary Care Doctor ☐ No support system ☐ Lack of reliable transportation

Patient Signature: _____

Date: _____

Patient Name: _____

UNITY HEALTHCARE, LLC
DISCLOSURE AND RELEASE AUTHORIZATION

CONSENT TO TREAT: I request and give consent to my Unity Healthcare, LLC ("Unity") healthcare professional to provide and perform such medical/surgical care, therapy, tests, procedures, drugs, and other services and supplies as my healthcare professional, in their professional judgment, deems necessary or beneficial. I acknowledge that no representations, warranties, or guarantees as to the results or cures have been made to me or relied upon by me.

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have been offered a copy of the Unity Notice of Privacy Practices and understand that my protected health information ("PHI") may be used by Unity as described in such Notice.

OWNERSHIP DISCLOSURE: I acknowledge that Unity and indirectly, Unity's physicians, have an ownership interest in Unity Surgical Center ("USC"), and InnerVision Advanced Medical Imaging Center ("InnerVision"). I understand that I am free to determine which facility to utilize for health care services, and neither Unity nor my physician shall discriminate in the care provided to me should I desire to use a facility other than USC and InnerVision.

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I authorize Unity and my healthcare professional to release information from my medical records to my insurance carrier(s), governmental agency, or my employer in the case of work-related injuries or services for the purpose of processing claims for medical/workers compensation benefits and state on such claims that my signature is on file. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my healthcare professional on my behalf.

FINANCIAL AGREEMENT: I understand and agree to all the following:

- a. All accounts are the full responsibility of the patient and/or the patient's responsible party guarantor.
- b. No conditional payments accepted, and payments with attempted conditions will be applied to any amounts owed.
- c. Unity will assist me in obtaining insurance benefits when those benefits are assigned to my/the patient's healthcare professional. I have provided complete information regarding my/the patient's primary and secondary health insurance, as applicable.
- d. I am responsible for making sure insurance payments are processed and paid promptly to my healthcare professional. In addition, I must provide my prompt payment of any amount owed to Unity that is deemed "Patient Responsibility" under my insurance contract (for those payors with which Unity is a participating healthcare professional or "in-network"). Otherwise, it is my responsibility if my insurance does not cover such services or Unity is a non-participating healthcare professional or "out-of-network".
- e. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts. I agree that reasonable attorney fees shall be interpreted as 40% of any balance due at the time the account is sent to an attorney or collection agency for collection, or \$300.00, whichever is greater.
- f. Tippecanoe County, Indiana, shall be the preferred venue for any legal action related to this financial agreement, and I agree to waive my right to a trial by jury.
- g. This financial agreement is being entered into individually and as an authorized agent for my spouse, if any. This financial agreement may be assigned by Unity to an attorney who purchases Unity's delinquent accounts, and the terms of this agreement shall remain binding.
- h. A fee may be charged for any appointments not cancelled at least twenty-four (24) hours in advance or missed for any other reason. These are generally not payable by insurance. I am responsible for these fees.
- i. Unity Immediate Care (UICC) is not a participating provider with or under the Indiana Medicaid program. As a result, any medical or related services provided by the UICC will not be covered or paid for by the Medicaid program.

OTHER PROVIDERS: I understand that in addition to the attending physician, other healthcare professionals, such as radiologists and pathologists, and other providers, such as laboratories and other medical professionals, may be involved in my care and may separately bill me for their services.

INDIANA LAW AND JURISDICTION: I understand that I am being provided treatment in the State of Indiana, and I agree that if I should have any claim with regard to my care or treatment, such will be decided in accordance with Indiana law and such action will be brought and decided in a Court in the State of Indiana.

NOTICE OF NONDISCRIMINATION: Unity complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, sex, or gender identity.

MEDICARE CERTIFICATION: (IF APPLICABLE) I certify that the information given by me, or by Unity on my behalf, in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my treating healthcare professional to release information from my medical record to the Social Security Administration and/or Medicare program or its intermediaries or carriers, or the Professional Standards Review Organizations for the purpose of the processing of claims for medical benefits and state on such claims that my signature is on file. I request that payment of such authorized benefits be made directly to Unity or my treating physician on my behalf.

AUTOMATED CONTACT: I understand that Unity and its affiliates and agents will utilize automated messages to contact me using the e-mail and phone numbers I have provided. These messages will provide information to me, such as *appointment information, closure messages, health services, account information, and statements*. These may come as a text message, automated call (whether a cell phone or a landline), or email and will be left at the number or e-mail provided to any Unity healthcare professional. If I receive treatment from multiple Unity healthcare professionals, I may receive multiple messages referencing appointments/services from each office. I understand that I have the right to opt out of any of these contact methods at any time by an opt-out within the text or e-mail message. For voice calls, I can speak to my healthcare provider's office to opt out of voice messages. Different companies are providing the above information to me, and I may need to opt out of each vendor.

PHOTO CONSENT: My healthcare professional may request photos. I consent to have my photographs taken by my healthcare professional or designated associate if required and permit the use of photographs for identification, medical records, education, and lectures.

My signature below constitutes my acknowledgment and agreement that I have read and understand the consent, notices, disclosure, and other information provided.

Patient/Parent/Guardian

Print Patient Name: _____ Signature: _____ Date: _____



If available, I hereby request access to MyChart and understand that to gain access to MyChart I will be given an activation link or activation code and will create a confidential password.

I agree to keep all codes and passwords confidential and not share it with anyone else.

I agree to review MyChart terms and conditions before accessing MyChart and further agree that by using my MyChart password I am agreeing to the terms and conditions and to abide by the MyChart terms and conditions.

To gain proxy access for children less than 18, a separate MyChart proxy access for will be used.

Patient Signature: _____ Date: _____

PATIENT RECORDS REQUEST

Patient information:	Name _____ Date of Birth _____ Address _____ Last 4 of SSN _____ City _____ State _____ Zip _____ Phone _____
Clinic / Practice / Health Care Provider:	Name _____ Address _____ City _____ State _____ Zip _____
Receiving Party: 	Unity Healthcare, LLC Unity Practice Name <u>Lafayette Vein & Vascular</u> Address <u>3900 St Francis Way Ste 201</u> City <u>Lafayette</u> State <u>IN</u> Zip <u>47905</u> Phone Number <u>(765) 400-0204</u> Fax Number <u>(765) 428-1614</u>
Information to be Released: (What do you want sent or released? Check the appropriate box.)	Date(s) of Service: From _____ To _____ ☐ Discharge Summary/Note ☐ Radiology Reports ☐ Office Visit Records ☐ History & Physical Exam ☐ Rehab Records (PT/OT) ☐ Immunization Records ☐ Operative Report ☐ Laboratory Reports ☐ Pathology Reports ☐ Consultations ☐ Copies of Films/Images ☐ Other _____

If the Special Authorization Section is not required, this can now be faxed.

If the following Special Authorization is requested, then a signature is required.

Special Authorization Section	State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate): Alcohol, Drug, or Substance Abuse Records ☐ Yes ☐ No HIV Testing and Results ☐ Yes ☐ No Mental Health Records ☐ Yes ☐ No Psychotherapy Records ☐ Yes ☐ No Genetic Records ☐ Yes ☐ No
_____ Patient/Legal Guardian Signature _____ Date	

UNITY HEALTHCARE, LLC

RELEASE OF INFORMATION

Name: _____ Patient Number: _____ DOB: _____

Due to HIPAA rules and regulations, we are not permitted to discuss your medical information with anyone, including your family, without your consent or unless an exception to the rule applies (e.g. provider-to-provider discussions related to your treatment or to collect payment).

If you want to allow us to communicate with any person, please complete the following. You may change your mind at a later date.

Please list individuals (other than providers) we may speak with regarding your care:

Name:	Relationship:	Phone:	Emergency Contact
1. _____	_____	_____	☐
2. _____	_____	_____	☐
3. _____	_____	_____	☐

A photocopy of this authorization shall be considered as valid as the original. **This Release of Information will remain in effect until terminated by the patient in writing.**

Patient Signature: _____ Date: _____