Ashfaq H. Siddiqui,MD,FACS
PATIENT INFORMATION FORM

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

PATIENT (Please **print legible** and please complete all items)

Name_____Date of Birth_____Age_____
Last First Initial
Address_____Phone_____
City State/Zip
Sex M / F Marital Status M S D W SS#_____Cell_____

Spouse's Name_____Phone_____
Guarantor (if patient under 18)_____Phone_____

Employer_____Address_____Phone_____

Referring Physician_____Phone_____

Emergency Contact (Not living with you)_____**Relation**_____
Name **Phone**
CHIEF COMPLAINT_____**Allergies**_____
Work Related?_____Date of Injury_____

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_____

SECONDARY INSURANCE_____**Phone**_____
Subscriber#_____Group#_____Subscriber Name_____
Subscriber Date of Birth_____Employer Name_____
Employer Phone_____Claims Address_____

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 as 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_____

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,what type & 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

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

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:_____

Please fill out completely.Please print information.

Patient name (please print)_____

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.

Facsimile Number:_____

[ ] Fax my protected health in formation to this number.

[ ] Specify protected health information:

_____

[ ] Fax general Information (non-protected health information) to this number

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 wil 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 revoke or terminate the authorization by submitting a written request to the Privacy Manager.

Patient Signature_____Date_____

Authorization for the Release of Medical Records

Patient Name:_____Date of Birth_____
(list maiden name/other names used)

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

_____To Disclose Information To: _____To Receive Information from:

Provider Name:_____
Address: _____
City/State/Zip:_____

Information to be disclosed include copies of:

_____Entire Record
_____Progress Notes
_____Physical Exam Forms
_____Daily Chart Notes
_____X-ray Reports
_____X-ray Films
_____Other,Specify:
_____

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.

CONDITIONS OF ADMISSION AND/OR TREATMENT

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.

2. Release from Responsibility for Valuables .

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 benfits 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 dirctly to the provider for treatment. I understand I am finacially 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

AKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

Attached please find Total Vascular, Vein and Wound Clinic 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 Vascular, Vein & Wound Clinic Notice of Privacy Practices,please do not hesitate to contact the Privacy Officer at (817) 225-2716 or in writing at Total Vascular, Vein & Wound Clinic, 309 Regency Parkway,Suite 207 Mansfield,Tx 76063.

_____Date_____

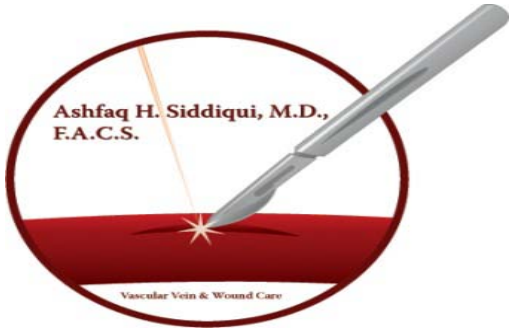
Printed Name of Patient

_____

Signature

_____

Authority to Sign if Not Patient



LEGAL FINANCIAL AGREEMENT OF BENEFITS FORM

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 another 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