Artery & Vein
SPECIALISTS OF IDAHO

Idaho Physicians Clinic
98 Poplar Street, Third Floor
Blackfoot, Idaho 83221
208-233-4938

Physicians & Surgeons Clinic of Pocatello
1151 Hospital Way, Bldg D, Ste. 100
Pocatello, Idaho 83201
208-233-4938

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I _____ hereby authorize and request:
(Print name of patient or legal representative)

Name of Medical Records Information Custodian: _____

Fax: _____ Address:_____

To disclose medical information on: _____ Birth Date: _____
(Patient's Name)

(Kind and amount of information to be disclosed.)

_____

_____

Please send them to:

Physician and Surgeons Clinic of Pocatello
Dr. David Shelley, MD
1151 Hospital Way, Building D
Pocatello, Idaho 83201

Phone (208) 239-8008 Fax (208) 782-2974

This authorization for medical release remains in force until _____ .
Expiration Date

_____ _____
Signature of Patient/Parent/Guardian/Responsible Party Date

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PATIENT INFORMATION SHEET

Date: _____ Current Physician: _____

Patient Information

Name: _____

(Mark One) Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Widowed

Address: _____
Street City State Zip

Phone: _____
Home Work Cell or Other

Birth Date: _____ Social Security#: _____

Employer: _____ Referred by: _____

Note: The responsible party or guardian is defined as the person of legal age, who is responsible for the payment of any services provided.

Responsible Party/Guarantor Information

Name of Responsible Party: _____ Birth Date: _____

Address: _____
Street City State Zip

Phone: _____ Social Security#: _____

Employer: _____ Work Phone: _____

Emergency Contact

Name: _____ Relationship: _____

Address: _____
Street City State Zip

Phone: _____
Home Work Cell or Other

Medical Insurance Information

Primary Insurance Company: _____ Group#: _____

Policy Holder Name: _____ Policy#: _____

Address: _____
Street City State Zip

Secondary Insurance Company: _____ Group#: _____

Policy Holder Name: _____ Policy#: _____

Address: _____
Street City State Zip

Medicaid#: _____ Medicare#: _____

Assignment of Benefits

Medicare Assignment of Benefits

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by Physicians and Surgeons Clinic of Pocatello. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits of the benefits payable for related services.

I, **the undersigned**, as the patient (or authorized person), consent to any treatment and/or procedures rendered to me that may, under my judgment and instruction of the treating provider, be considered advisable or necessary. I understand that if any extensive medical procedure or surgery is to be performed, it will be fully explained to me, including the risks and alternatives, and my specific consent will be necessary. **I understand** that any ancillary services (x-rays, lab tests, etc.) that may be ordered by the provider while I am in the clinic are not included in my clinic bill and that I will be billed separately for these services. **I authorize** any holder of medical or other information about me to release this information to the Social Security Administration, Health Care Financing Administration, my insurance company or its intermediaries or carriers, or to this physician's office or my attorney or other doctor's office. While we assist with billing your insurance company, you are primarily responsible for determining what your insurance will cover, whether you require a referral, and/or the payment of your bill. I authorize direct payment of medical benefits to Bingham Memorial Hospital. I understand that I am financially responsible for all charges whether or not paid by said insurance.

Signature: _____ ***Date:*** _____

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PATIENT MEDICAL HISTORY

Date: _____

Name: _____ Age: _____ Birth Date: _____

(Mark One) Gender: ☐ Male ☐ Female Height: _____ Weight: _____

Referring Doctor: _____ Pharmacy: _____

Additional Doctor(s): _____

Reason for visit: _____

How has this affected your daily living? _____

_____

For Patients With Leg Problems

Have you ever had:

Unsightly Veins	☐ Right Leg	☐ Left Leg	Aches & Pain	☐ Right Leg	☐ Left Leg
Heavy/Tired Legs	☐ Right Leg	☐ Left Leg	Pain Level (0-10)	☐ Right Leg	☐ Left Leg
Itching	☐ Right Leg	☐ Left Leg	Ankle Swelling	☐ Right Leg	☐ Left Leg
Bleeding Vein	☐ Right Leg	☐ Left Leg	Dermatitis (Rash)	☐ Right Leg	☐ Left Leg
Restless Legs	☐ Right Leg	☐ Left Leg	Night Cramps	☐ Right Leg	☐ Left Leg
Discolored Skin	☐ Right Leg	☐ Left Leg	Burning	☐ Right Leg	☐ Left Leg
Ulcer (Open Sore)	☐ Right Leg	☐ Left Leg	Throbbing	☐ Right Leg	☐ Left Leg

Other: _____

Do you have:

Pain with walking	Yes ○	No ○	How far can you walk? _____ (Blocks)		
Bleeding disorder	Yes ○	No ○	Clotting disorder	Yes ○	No ○

Conservative Therapy:

Walking	Yes ○	No ○	Anti-Inflammatory	Yes ○	No ○
Elevation	Yes ○	No ○	Ice/Heat	Yes ○	No ○
Compression Stockings	Yes ○	No ○	How long? _____		

Other: _____

Previous Treatment:

Laser/Radio Frequency	Yes ○	No ○	Angiograms	Yes ○	No ○
Scierotherapy	Yes ○	No ○	Stents	Yes ○	No ○
Vein Stripping	Yes ○	No ○			

Other: _____

For Pelvic Pain Patients

Do you have:

Pelvic Pain	Yes ○	No ○	If yes: How long? _____		
Pain Increase through the day	Yes ○	No ○	Pain with Intercourse	Yes ○	No ○
Heavy Bleeding	Yes ○	No ○	Frequent urination	Yes ○	No ○

For All Patients

Have you ever had:

Blood clots	Yes ○	No ○	If yes: When & where: _____
Blood Thinners	Yes ○	No ○	If yes: When & why: _____
Imaging related to your visit	Yes ○	No ○	If yes: When & where: _____

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Have you ever had:

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Arthritis
- ☐ Gout
- ☐ Heart Murmur
- ☐ Keloids/Scarring
- ☐ Kidney Probs
- ☐ Bladder Probs
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Pacemaker
- ☐ Glaucoma
- ☐ Poor Circulation
- ☐ Stroke
- ☐ Artificial Joint(s)
- ☐ Mitral Valve Probs
- ☐ Asthma
- ☐ Respiratory Probs
- ☐ Thyroid Disease
- ☐ Seizures
- ☐ Depression
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Anemia
- ☐ Hayfever
- ☐ Allergies
- ☐ Radiation Therapy
- ☐ Chemotherapy

Surgeries/Hospitalizations

Date	Facility	Surgery

Allergies to Medications:

Please list:
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Are you allergic to Xylocaine, Tetracaine, or Lidovaine? Yes ◯ No ◯

Current Medications:

Please list:
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Social History

Alcohol consumption #_____ per_____
Smoking/Tobacco use #_____ per_____

Married Yes ◯ No ◯
Children Yes ◯ No ◯ If yes, how many? _____ Age at first child: _____
Occupation: _____ Company: _____

Ethnicity

- ☐ Caucasian
- ☐ Hispanic
- ☐ African American
- ☐ Asian
- ☐ Native American
- ☐ Other

Family History

Maternal

- ☐ Diabetes
- ☐ Varicose Veins
- ☐ High Blood Pressure
- ☐ Bleeding/Clot Probs
- ☐ Cancer
- ☐ Other: _____

Paternal

- ☐ Diabetes
- ☐ Varicose Veins
- ☐ High Blood Pressure
- ☐ Bleeding/Clot Probs
- ☐ Cancer
- ☐ Other: _____

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REVIEW OF SYSTEMS: Have you recently had any of these problems?

Constitutional:
- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Other:_____

Skin:
- ☐ Rash/Hives
- ☐ Suspicious Lesions
- ☐ Itching
- ☐ Jaundice (Yellow Skin)
- ☐ Tattoos
- ☐ Other:_____

Eyes:
- ☐ Loss of Vision
- ☐ Blurring of Vision
- ☐ Double Vision
- ☐ Glaucoma
- ☐ Corrective Lenses
- ☐ Other:_____

Ear, Nose and Throat:
- ☐ Sores in Mouth
- ☐ Nosebleeds
- ☐ Hoarseness
- ☐ Other:_____

Cardiovascular:
- ☐ Chest Pain
- ☐ Chest Pain with Exercise
- ☐ Irregular Heart Beat
- ☐ Palpitations
- ☐ Swelling of Feet
- ☐ Difficulty Breathing Lying Down
- ☐ Difficulty Breathing with Exercise
- ☐ Fainting
- ☐ Other:_____

Respiratory:
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Asthma
- ☐ Coughing
- ☐ Spitting up Blood
- ☐ Other:_____

Genitourinary:
- ☐ Difficulty Urinating
- ☐ Frequent Urination
- ☐ Nocturnal Urination
- ☐ Dark Urination
- ☐ Other:_____

(Women Only ☐ Possibly Pregnant
- ☐ Missed Periods
- ☐ Heavy Periods
- ☐ Other:_____

Musculoskeletal:
- ☐ Joint Pain
- ☐ Back Pain
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Other:_____

Neurologic:
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Headaches
- ☐ Paralysis
- ☐ Other:_____

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty Sleeping
- ☐ Abnormal Stress
- ☐ Panic Attacks
- ☐ Suicidal Thoughts
- ☐ Therapy or Counseling
- ☐ Other:_____

Endocrine:
- ☐ Heat Intolerance
- ☐ Cold Intolerance
- ☐ Excessive Thirst
- ☐ Other:_____

Hemolymphatic:
- ☐ Easy Bruising
- ☐ Prolonged Bleeding
- ☐ Immunologic:
- ☐ Persistent Infections
- ☐ HIV Exposure
- ☐ Other:_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the information.

_____ _____
Patient Name (Print) Date

_____ _____
Patient/Representative Signature Relationship to Patient

_____
Witness

Artery & Vein
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Notice of Privacy Practices (Regulation §164.520)

Bingham Memorial Hospital, Skilled Nursing and Rehabilitation Center, Idaho Physicians Clinic, and Physicians Offices

THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. Bingham Memorial Hospital, Skilled Nursing and Rehabilitation Center, Idaho Physicians Clinic, and Physicians Offices is permitted to make uses and disclosures of protected health information for treatment, payment and health care operations, as described in the following examples:
   a. Treatment – ie. X-ray's, laboratory testing, surgeries.
   b. For payment – ie. Charges to Insurance Companies, co-payments, Medicare/Medicaid.
   c. For health care operations – ie. Health Information Management, Information Systems.
2. Bingham Memorial Hospital, Skilled Nursing and Rehabilitation Center, Idaho Physicians Clinic, and Physicians Offices is permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization. [If a use or disclosure for any purpose prescribed in the Privacy Regulation is prohibited or materially limited by other applicable State law, the description of such use or disclosure must reflect the more stringent law.]
3. Other uses and disclosures will be made only with the Individual's written authorization, and the individual may revoke such authorization.
4. Bingham Memorial Hospital, Skilled Nursing and Rehabilitation Center, Idaho Physicians Clinic, and Physicians Offices intends to engage in one or more of the following activities:
   a. Bingham Memorial Hospital, Skilled Nursing and Rehabilitation Center, Idaho Physicians Clinic, and Physicians Offices may contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual or patient.
   b. Bingham Memorial Hospital, Skilled Nursing and Rehabilitation Center, Idaho Physicians Clinic, and Physicians Offices may contact the individual/patient to raise funds for Bingham Memorial Hospital, Skilled Nursing and Rehabilitation Center, Idaho Physicians Clinic, and Physicians Offices; or
   c. A group health plan, or a health insurance issuer or HMO with respect to a group health plan, may disclose protected health information to the sponsor of the plan.
5. The Individual has the following rights regarding protected health information:
   a. The right to request restrictions on certain uses and disclosures of protected health information. Bingham Memorial Hospital, Skilled Nursing and Rehabilitation Center, Idaho Physicians Clinic, and Physicians Offices is not required to agree to a requested restriction, however.
   b. The right to receive confidential communications of protected health information, as applicable.
   c. The right to inspect and copy protected health information, as provided in the Privacy Regulation.
   d. The right to amend protected health information, as provided in the Privacy Regulation.
   e. The right to receive an accounting of disclosures of protected health information.
   f. The right to obtain a paper copy of the Notice from the covered entity upon request. This right extends to an individual who has agreed to receive the Notice electronically.
6. Bingham Memorial Hospital, Skilled Nursing and Rehabilitation Center, Idaho Physicians Clinic, and Physicians Offices is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and Privacy practices with respect to protected health information.
7. Bingham Memorial Hospital, Skilled Nursing and Rehabilitation Center, Idaho Physicians Clinic, and Physicians Offices is required to abide by the terms of the Notice currently in effect.
8. Bingham Memorial Hospital, Skilled Nursing and Rehabilitation Center, Idaho Physicians Clinic, and Physicians Offices reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains.
9. Bingham Memorial Hospital, Skilled Nursing and Rehabilitation Center, Idaho Physicians Clinic, and Physicians Offices will provide individuals or patients with a revised Notice by posting the new notice, and replacing with an updated notice and also being distributed to the patient at time of admission.
10. Individuals may complain to Bingham Memorial Hospital, Skilled Nursing and Rehabilitation Center, Idaho Physicians Clinic, and Physicians Offices and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated. A brief description of how the individual may file a complaint follows: There are two ways that the complaint could be filed:
    a. The first option being the patient or individual may contact the Privacy Officer listed in number 11.
    b. The second option is for the patient or individual to request a grievance form which may be obtained from any admissions personnel. The grievance form may then be returned to the admissions personnel or mailed to Bingham Memorial Hospital at the address provided in number 11.
11. Bingham Memorial Hospital, Skilled Nursing and Rehabilitation Center, Idaho Physicians Clinic, and Physicians Offices contact person for matters relating to complaints is:
    a. Tina Cobia, Privacy Officer (208) 785-3850
       98 Poplar Street, Blackfoot, ID 83221
    b. Linda Valentine, (208) 785-3804
       98 Poplar Street, Blackfoot, ID 83221
12. This Notice is first in effect on April 14, 2003. The effective date must not be earlier than the date on which the Notice is printed or otherwise published.
13. Bingham Memorial Hospital, Skilled Nursing and Rehabilitation Center, Idaho Physicians Clinic, and Physicians Offices elects to limit the uses or disclosures that it is permitted to make, as according to policy.