



CLAREMORE SURGEONS, INC & THE VASCULAR & VEIN LASER CENTER, INC

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have read a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
{Signature}

Date: \_\_\_\_\_ Patient refused to sign: \_\_\_\_\_

## IN ORDER FOR US TO TALK WITH YOUR FAMILY MEMBERS ABOUT YOUR CARE YOU MUST LIST THEM BELOW:

_____	_____
_____	_____
_____	_____
_____	_____

I hereby authorize L.K. HRDLICKA to release to your insurance company or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical or Surgical care.

I also authorize and request your insurance company to pay directly to the above named doctor, the amount due me in my pending claim for Basic Medical, Major Medical and/or Surgical treatment or services, by reason of such treatment or services rendered, upon presentation of the original or photocopy of this signed authorization

**I AGREE TO ACCEPT RESPONSIBILITY FOR PAYMENT OF ANY SERVICES WHICH MAY NOT BE COVERED UNDER THE TERMS OF MEDICARE AND/OR MY HEALTH INSURANCE BENEFIT PLAN. Signature of Insured/and or Responsible Party:**

**X** \_\_\_\_\_ **Date:** \_\_\_\_\_



**Review of Systems**     Please circle any current or past conditions you have experienced

Constitutional

Fatigue  
 Fevers or chills  
 Weight gain/loss (        pounds)

Skin

Itching  
 Rashes  
 Skin lesions/growths

HEENT

Hearing changes  
 Nosebleeds  
 Vision changes

Cardiovascular

Angina (chest pain)  
 Artificial heart valve  
 Atrial fibrillation  
 Heart attack  
 Heart failure (CHF)  
 Heart stents  
 Heart surgery (CABG)  
 High blood pressure  
 Irregular heart beat  
 Pacemaker or AICD  
 Pain in legs or hips with exercise  
 SOB with exertion  
 SOB when laying down  
 Swelling of legs or feet

Pulmonary

Asthma  
 COPD/emphysema  
 Cough  
 Lung cancer or mass  
 Pneumonia  
 Productive cough  
 Sleep apnea  
 SOB  
 Tuberculosis

Gastrointestinal

Abdominal pain  
 Bloody or tarry stools  
 Change in bowel habits  
 Cirrhosis  
 Constipation or diarrhea  
 Crohn's disease  
 Gallstones  
 Hepatitis  
 Jaundice  
 Nausea or vomiting  
 Pancreatitis  
 Peptic ulcer disease  
 Reflux (GERD)  
 Ulcerative colitis

Musculoskeletal

Arthritis  
 Herniated discs in back

Renal

Dialysis  
 Kidney failure  
 Kidney stones  
 Urinary tract infection

Breast

Mass or cysts  
 Nipple discharge  
 Biopsies  
 Pain or skin changes

Endocrine

Adrenal disease  
 Diabetes  
 Parathyroid disease  
 Thyroid disease

Hematologic/Lymph

Anemia  
 Blood clots (DVT)  
 Easy bleeding or bruising  
 HIV/AIDS  
 Swollen lymph nodes

Neurologic

Dementia  
 Seizures  
 Stroke  
 TIAs (ministrokes)  
 Weakness, numbness or tingling

Miscellaneous

Artificial prosthesis  
 Blood transfusions  
 Cancer or tumors  
 Recent use of steroids  
 Use of blood thinners

Patient's Signature: \_\_\_\_\_ Reviewer's Signature \_\_\_\_\_

**If you are uncomfortable answering any question, please leave it blank and you may discuss it with the doctor or nurse.**