TODAY'S DATE:	ACCOUNT #:

PATIENT INFORMATION

INSURANCE INFORMATION

LAST NAME:	PRIMARY INSURANCE COMPANY:
FIRST NAME:	BILLING ADDRESS:
ADDRESS:	CITY: STATE: ZIP:
CITY: STATE: ZIP:	PHONE #:
HOME PHONE #: MAY WE LEAVE A MESSAGE? Y N	ID #: GROUP #:
CELL PHONE #: MAY WE LEAVE A MESSAGE? Y N	
EMAIL*:	SECONDARY INSURANCE COMPANY:
PREFERRED METHOD TO CONTACT YOU:	BILLING ADDRESS:
DATE OF BIRTH:	CITY: STATE: ZIP:
SOCIAL SECURITY #:	PHONE #:
SEX (PLEASE CIRCLE): MALE FEMALE	ID #:
HOW DID YOU HEAR ABOUT US:	
PREFERRED LANGUAGE:	
RACE:	

PERSON TO NOTIFY IN CASE OF EMERGENCY:

NAME:	PHONE #: RELATION TO YOU:

IF INSURANCE IS NOT IN YOUR NAME, PLEASE COMPLETE:

NAME OF POLICY HOLDER:	PATIENT'S EMPLOYER:
DATE OF BIRTH:	EMPLOYER ADDRESS:
SOCIAL SECURITY #:	WORK #:
POLICY HOLDER EMPLOYER:	CITY: STATE: ZIP:
EMPLOYER ADDRESS:	MAY WE CONTACT YOU AT WORK? Y N
CITY: STATE: ZIP:	MAY WE LEAVE A MESSAGE? Y N

REFERRING PHYSICIAN AND PRIMARY CARE PHYSICIAN INFORMATION:

REFERRING PHYSICIAN:	PRIMARY CARE PHYSICIAN:
ADDRESS:	ADDRESS:
CITY: STATE: ZIP:	CITY: STATE: ZIP:
PHONE #:	PHONE #:
FAX #:	FAX #:

IF WORKERS COMPENSATION OR LEGAL CLAIM, PLEASE COMPLETE:

COMPANY NAME:	ADJUSTER NAME:
MAILING ADDRESS:	PHONE #: FAX #:
CITY: STATE: ZIP:	NURSE CASE MANAGER:
CLAIM #:	PHONE #: FAX #:
DATE OF INJURY:	INJURY YOU ARE BEING TREATED FOR:
EMPLOYER AT TIME OF INJURY:	

Vascular Solutions of North Carolina

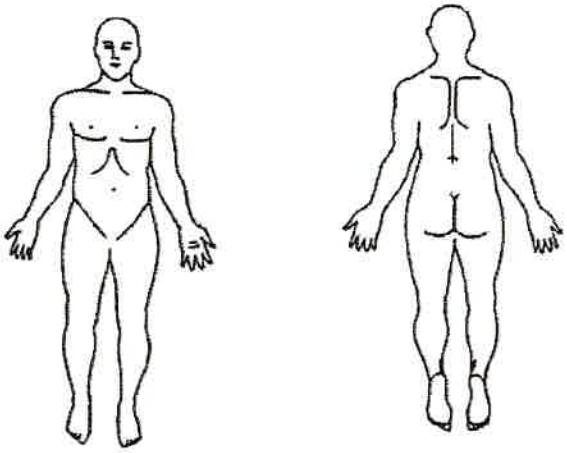
PAIN COMPREHENSIVE QUESTIONNAIRE

Patient Name _____ **DOB** _____ **Date** _____

Referring Physician _____ **Primary Care Physicians** _____

Chief Complaint (main problem seeking treatment) _____ **Side** ☐ right ☐ left

On the Diagram, shade in or circle the area where you feel pain:



R L L R

Preferred Pharmacy Name/Address:

_____

Preferred Pharmacy Phone:

_____

Are you pregnant or possibly pregnant?

☐Yes ☐No ☐N/A

---- (0 = no pain 10 = unbearable pain) ----

Pain level today

0 1 2 3 4 5 6 7 8 9 10

Over the last 4 weeks, please identify your pain levels below:

Severe pain level (on a bad day)

0 1 2 3 4 5 6 7 8 9 10

Average pain level (on an average day)

0 1 2 3 4 5 6 7 8 9 10

Allergies _____

The onset of your pain was:

☐Motor vehicle accident

Date of Accident _____

Were you wearing a seatbelt: ☐Yes ☐No

Position during the accident:

☐Driver ☐Passenger in front seat ☐Passenger in back seat

☐Falling from a height

☐Injury at work

Date of injury _____

What injury occurred? _____

☐Insidious onset ☐Lifting an object ☐Playing a sport ☐Slipping and falling ☐Trauma ☐Tripping/uneven surface

Your pain occurs: ☐Constantly ☐Intermittent ☐Worse after activity ☐Worse at the end of the day ☐Worse during activity ☐Worse during cold seasons ☐Worse during the day ☐Worse during the night ☐Worse in the morning

Describe your pain: ☐aching ☐burning ☐cramp-like ☐dull ☐in a glove distribution ☐in a stocking distribution ☐pins & needles-like ☐sharp ☐shooting ☐stabbing

Your pain has been occurring for: _____ ☐days ☐weeks ☐months ☐years

Symptoms	Associated with your pain	**Symptoms**	Associated with your pain
Arm numbness		Insomnia	
Awakens you from sleep		Leg numbness	
Changes in bladder function		Perineal numbness	
Changes in bowel function		Sexual Dysfunction	
Changes in temperature in the affected area		Shoulder numbness	
Depression		Suicidal ideation	
Finger numbness		Sweating in affected area	
Flushing in affected area		Toe numbness	
Hand numbness		Hand numbness	

PAIN COMPREHESIVE QUESTIONNAIRE

What activities aggravate/relieve your symptoms?

ACTIVITIES	AGGRAVATES YOUR PAIN	RELIEVES YOUR PAIN
All Movements		
Bending Forward		
Exercise		
Lifting Objects		
Lying Flat		
Rest		
Rotating the neck		
Sitting		
Standing for long periods		
Walking long distances		

What treatments have you used to treat the symptoms?

TREATMENTS	NO RELIEF	MODERATE RELIEF	EXCELLENT RELIEF
ACTIVITY MODIFICATION			
ACUPUNCTURE			
BRACE			
What type of Brace?	☐Back Brace ☐Neck Brace ☐Cervical traction ☐TENS unit ☐Ankle Brace (R or L) ☐Wrist Brace (R or L) ☐Knee Brace (R or L)		
How long have you had the product?			
Are you obtaining relief?			
Are your products in good condition?			
CHIROPRACTIC MANIPULATION			
HEAT TREATMENT			
ICE TREATMENT			
PHYSICAL THERAPY			
PILATES			
WEIGHT REDUCTION			
YOGA			
MEDICATIONS	**Check mark all medication that apply below**		

Opioids		NSAIDs/Tylenol		Muscle Relaxants
☐ Tramadol	☐ Methadone	☐ Tylenol	☐ Lodine	☐ Soma
☐ Demerol	☐ Morphine	☐ Aspirin	☐ Orudis	☐ Lorzone
☐ Codeine	☐ Nucynta	☐ Ibuprofen	☐ Relafen	☐ Flexeril
☐ Fentanyl (Duragesic)	☐ Butrans	☐ Naproxen	☐ Celebrex	☐ Baclofen
☐ Hydromorphone (Dilaudid,)	☐ Suboxone	☐ Daypro	☐ Toradol	☐ Zanaflex
☐ Hydrocodone (Vicodin)		☐ Indocin		☐ Robaxin
☐ Oxycodone (Percocet, Oxycontin)		☐ Feldene		☐ Skelaxin
☐ Oxymorphone (Opana)		☐ Voltaren		☐ Valium (Diazepam)

Antidepressants		Other	
☐ Elavil (Amitriptyline)	☐ Paxil	☐ Neurontin (Gabapentin)	☐ Lyrica
☐ Pamelor (Nortriptyline)	☐ Prozac	☐ Tegretol	☐ Ativan
☐ Desipramine	☐ Serzone	☐ Dilantin	☐ Xanax
☐ Impramine (Tofranil)	☐ Cymbalta	☐ Topamax	☐ Imitrex
☐ Zoloft	☐ Savella	☐ Depakote	☐ Ergotamine
		☐ Klonopin	☐ Mexillitine

PAIN COMPREHESIVE QUESTIONNAIRE

Do you have any adverse effects since starting any treatment?

☐Constipation ☐Drowsiness ☐Mental slowness ☐Other

What procedures have you had to treat the pain?

PROCEDURE	Mark if applicable
No Procedure	
Epidural Steroid Injection	
Facet Joint Injection	
Medial Branch Block Trial	
Peripheral Nerve Injection	
Rhizotomy	
Fusion, anterior	
Fusion, posterior	
Fusion, combined anterior and posterior	
Laminectomy	
Microdiscectomy	
Other	

What imaging studies have you had for the pain?

☐Bone scan

☐CT Scan

☐EMG

☐ MRI

☐ Radiographs

How has the pain limited you? (check mark all that apply)

Activities	Limit Pain	Activities	Limit Pain
No limitations		Inability to attend school	
Attending school on a limited basis		Inability to perform daily activities (ADL's)	
Difficulty getting up from chair		Inability to work	
Difficulty sitting		Requiring constant assistance	
Difficulty standing		Requiring occasional assistance	
Difficulty walking		Working on a limited basis	
Difficulty with daily activities (ADL's)		Working light duty	
Difficulty with recreational sports		Other	
Functional limitations			

Who have you seen for this problem? ☐Chiropractor ☐Emergency Room ☐General Surgeon ☐ Internist

☐Orthopedic Doctor ☐Pediatrician ☐Primary care ☐ Therapist ☐Trainer ☐Urgent Care Center ☐Walk in clinic

INTAKE AND HISTORIES

Past Medical History (please check all that apply):

- ☐ Anemia, Chronic
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bipolar Disorder
- ☐ Breast Cancer
- ☐ Chronic Pain
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Deep Venous Thrombosis
- ☐ Depression
- ☐ Diabetes, Insulin Dependent
- ☐ Diabetes, Non-Insulin Dependent
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperparathyroidism
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Multiple Myeloma
- ☐ Obesity, Morbid
- ☐ Obesity
- ☐ PBPH
- ☐ Prostate Cancer
- ☐ Radiation Therapy
- ☐ Fibromyalgia
- ☐ Sleep Apnea
- ☐ Seizures
- ☐ Stroke
- ☐ **None**
- ☐ Other_____

Past Surgical History (please check all that apply):

- ☐ Appendix (Appendectomy)
- ☐ Bladder Removed
- ☐ Breast: Mastectomy ☐Right ☐Left ☐Both
- ☐ Breast: Lumpectomy ☐Right ☐Left ☐Both
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Colon: Colostomy
- ☐ Gallbladder Removal
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Removed: TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Tonsillectomy
- ☐ Hysterectomy: Caesarean
- ☐ Hysterectomy: Uterine Cancer
- ☐ Hysterectomy: Cervical Cancer
- ☐ **None**
- ☐ Other_____

INTAKE AND HISTORIES

Interventional Pain History (please check all that apply):

- ☐ Epidural Injection(s)- ☐Lumbar ☐Thoracic ☐Cervical
- ☐ Facet Injection(s)- ☐Lumbar ☐Thoracic ☐Cervical
- ☐ Medial Branch Block- Injection(s)- ☐Lumbar ☐Thoracic ☐Cervical
- ☐ Rhizotomy- ☐Lumbar ☐Thoracic ☐Cervical
- ☐ Intrathecal Pump
- ☐ Spinal Cord Stimulator
- ☐ **None**
- ☐ Other_____

Musculoskeletal History (please check all that apply):

- ☐ Ankle Fracture
- ☐ Ankylosing Spondylitis
- ☐ Adhesive Capsulitis
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Low Back Pain
- ☐ DISH
- ☐ Epidural Injections, Spine
- ☐ Fracture
- ☐ Gout
- ☐ Hip Fracture
- ☐ HNP, Cervical
- ☐ HNP, Lumbar
- ☐ Metastatic Bone Disease
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Polio
- ☐ Primary Bone Sarcoma
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Ricketts
- ☐ RSD
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Shoulder Impingement
- ☐ Spine Fracture
- ☐ Soft Tissue Sarcoma
- ☐ Spinal Stenosis, Cervical
- ☐ Spinal Stenosis, Lumbar
- ☐ Vertebral Body Compression Fracture
- ☐ Vitamin D Deficiency
- ☐ Wrist Fracture
- ☐ **None**
- ☐ Other_____

Musculoskeletal Surgery (please check all that apply):

- ☐ Achilles Tendon Repair
- ☐ ACL Reconstruction
- ☐ Ankle Fracture ORIF ☐Right ☐Left ☐Both
- ☐ Bunion Correction
- ☐ Carpal Tunnel Decompression ☐Right ☐Left ☐Both
- ☐ Cervical Spine Surgery: ACDF
- ☐ Cervical Spine Surgery: Disc Replacement
- ☐ CMC Arthroplasty
- ☐ Distal Radius ORIF ☐Right ☐Left ☐Both
- ☐ Ganglion Cyst Excision
- ☐ Intramedullary Nailing Femur ☐Right ☐Left ☐Both
- ☐ Intramedullary Nailing Tibia ☐Right ☐Left ☐Both
- ☐ Joint Replacement: Hip ☐Right ☐Left ☐Both
- ☐ Joint Replacement: Knee ☐Right ☐Left ☐Both
- ☐ Joint Replacement: Shoulder ☐Right ☐Left ☐Both
- ☐ Knee Arthroscopy ☐Right ☐Left ☐Both
- ☐ Kyphoplasty/Vertebroplasty
- ☐ Lumbar Fusion
- ☐ Lumbar Laminectomy
- ☐ Lumbar Spine Surgery: Decompression
- ☐ Lumbar Spine Surgery: Decompression & Fusion
- ☐ Lumbar Spine Surgery: Disc Replacement
- ☐ Meniscus Repair
- ☐ Reverse Total Shoulder Replacement
- ☐ Revision of Total Hip Arthroplasty
- ☐ Revision of Total Knee Arthroplasty
- ☐ Revision of Total Shoulder Arthroplasty
- ☐ Rotator Cuff Repair ☐Right ☐Left ☐Both
- ☐ Shoulder Arthroscopy
- ☐ **None**
- ☐ Other_____

INTAKE AND HISTORIES

Medications (please list all current medications or check option, which applies):

- Complete the information below regarding all medications you are currently taking, have discontinued, or modified.
- Be certain to list both prescription and non-prescription medication, including any herbals or supplements you take.

☐ I brought a copy of my medication list (please provide the list to the front desk receptionist)

☐ Not currently taking any medications

Medication Name	Dosage	# times dosage taken per day

Allergies (please list all known allergies or check option, which applies):

☐ I brought a copy of my allergy list (please provide the list to the front desk receptionist)

☐ No known allergies

Allergy Type	Please describe allergic reaction severity & symptoms

INTAKE AND HISTORIES

Social History (please check all that apply):

Cigarette Smoking
- ☐ Never Smoked
- ☐ Quit: former smoker
- ☐ Smokes less than daily
- ☐ Smokes daily
  - # packs per day_____

Alcohol Use
- ☐ Do not drink alcohol
- ☐ Less than 1 drink a day
- ☐ 1-2 drinks a day
- ☐ 3 or more drinks a day

Exercise Frequency
- ☐ Several times a day
- ☐ Once a day
- ☐ Few times a week
- ☐ Few times a month
- ☐ Never
- ☐ Other_____

Drug Use
- ☐ Drug Use
- ☐ IV Drug Use
  - _____

Family History:
Please check appropriate box "Alive" or "Decease" and list ages for the following Blood Family Members. If Parents or Grandparents are deceased, please write in Age and Cause of Death, if known.

	Alive	Age (if known)	Deceased	Age at Death	If deceased, cause of death	Unknown Status
Father						
Mother						
Maternal Grandmother						
Maternal Grandfather						
Paternal Grandmother						
Paternal Grandfather						

	Number Alive	Age (if known)	Number Deceased	Age at Death	If deceased, cause of death	Unknown Status
Brothers						
Sisters						
Sons						
Daughters						

INTAKE AND HISTORIES

Family History (continued):

Please mark YES or NO if a Blood Family Member has ever had any of these conditions. If you mark YES, please mark the box under the relationship of the person to you

				Relationship of Person to you				
	YES	NO	DO NOT KNOW	Father	Mother	Grandparent	Brother /Sister	Son/ Daughter
Cancer								
Heart Disease								
Diabetes								
High Blood Pressure								
Stroke/TIA								
Alcohol Abuse								
Drug Abuse								
Psychiatric Illness								
Seizures								
Depression/Suicide								
Osteoarthritis								
Osteoporosis								
Scoliosis								
Other Conditions								

INTAKE AND HISTORIES

Review of Systems* (check yes or no if you are currently experiencing any of the following):

Symptom	Yes	No	Symptom	Yes	No
Joint pains			Wheezing		
Joint swelling			Pain w/ breathing		
Difficulty Walking			Palpitations		
Muscle Pain			Ankle Swelling		
Pain Radiating down to leg(s)			Labored breathing w/exertion		
Weakness			Nausea/ Vomiting		
Numbness			Diarrhea		
Tingling			Constipation		
Fever			Heartburn		
Weight Gain			Ulcers		
Rash			Blood in Stool		
Chest Pain			Urinary Incontinence		
Incontinence			Urinary hesitancy		
Shortness of Breath			Urinary retention		
Suicidal thoughts			Blood in urine		
Weight loss			Genital pain		
Chills			Excessive bruising		
Fatigue			Excessive bleeding		
Discoloration			Cancer		
Scarring			Excessive thirst		
Environmental Allergies			Heat/Cold intolerance		
Immunosuppression			Diabetes		
HIV/AIDS			Thyroid Disease		
Blurred Vision			Joint Stiffness		
Double Vision			Dizziness		
Glaucoma			Fainting		
Eye pain			Headaches		
Ringing in the Ears			Tremor		
Loss of hearing			Seizure		
Nose bleeds			Memory Loss		
Hoarseness			Depression		
Difficulty Swallowing			Anxiety		
Cough			Hallucinations		

Other Medical Conditions* (check yes or no for the following):

*Please inform the physician, medical assistant or front desk staff of any other medical conditions or concerns.

Symptom	Yes	No	Symptom	Yes	No
Blood Thinners			Rheumatoid Arthritis		
Pacemaker			Hepatitis B or C		
Defibrillator			Pregnancy or planning a pregnancy		
Premedicate Prior to Procedure			HIV/ADS		
Hepatitis B or C			Diabetes		

HIPPA Disclosure

This HIPPA form us designed to provide privacy standard to protect patient's medical records and other health information provided to health plans, doctors, hospitals, and other health care providers.

I understand that as part of the delivery of my health care, Vascular Solutions of North Carolina originates and maintains medical records describing my health history, symptoms, examinations, test results, diagnoses, treatment and plans for future care or treatment.

- I understand that this information serves as:
- A basis for planning my care and treatment.
- A means of communication among healthcare professionals who contribute to my care.
- A tool for routine healthcare operations such as assessing quality and ensuring the continued competence of health care professionals involved in my care.
- I have been provided with a Notice of Information Practices that provides a more complete description of the uses and disclosures of my health information.
- I understand that Vascular Solutions of North Carolina reserves the right to change this notice and their practices as needed and will make a reasonable attempt to inform me.
- I understand that I have the right to request restrictions in the use or disclosure of my health information for treatment of healthcare operations and that Vascular Solutions of North Carolina is not required to agree to the restrictions requested.
- I understand that I may revoke this acknowledgement in writing except to the extent that Vascular Solutions of North Carolina has already taken action on it.

Authorization to Use and Disclose Protected Health Information

Please note: If the patient is physically or mentally unable to sign, a representative may sign on the patient's behalf. In this event, the signature line must indicate the patients name, followed by the representatives name, address and relationship to the patient, along with the reason the patient cannot sign for themselves. The authorization is effective indefinitely unless patient or patients representative revoke this arrangement.

With my consent, Vascular Solutions of North Carolina may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment, and health care operations. Please refer to Vascular Solutions of North Carolinas Note of Privacy Practices for a more complete description of such use and disclosure. I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that Vascular Solutions of North Carolina reserves the right to revise its Notice of Privacy Practices in accordance with Section 164.520 of the Code of Federal Regulations. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer, Vascular Solutions of North Carolina. As a patient you have a right to inspect a copy, amend, request a restriction, or revoke a prior restriction on the use and disclosure of your Protected Health Information. You may also request a copy of an accounting of disclosure, which will detail all disclosures made for reasons other than treatment, payment, or heath care operation purposes. I hereby am consenting Vascular Solutions of North Carolina to use and disclose my PHI for typical healthcare operations. I am also acknowledging that I have been presented with the Vascular Solutions of North Carolina Notice of Privacy Practices. If I do not sign this consent, Vascular Solutions may decline to provide treatment to me.

Consent to Medical Care

I hereby agree and give consent for Vascular Solutions of North Carolina to furnish medical care and treatment considered necessary and proper in diagnosing or treating my physical condition.

Initials: _____

DNR Policy

It is the policy of Vascular Solutions of North Carolina to always preform CPR when indicated. If you have a DNR order in place and you wish to have this DNR order honored, you will need to have your procedure scheduled at a different facility.

Release of Information for Billing Purposes

I hereby authorize the designated physician to release any information acquired during my treatment to my insurance company for completion of claims, in consideration of the medical services to be rendered. I assign all payments made from my insurance provider(s) to Vascular Solutions of North Carolina, and not myself, for all services provided. If these benefits or payments are sent to me in error, I recognize these benefits or payments are owed to Vascular Solutions of North Carolina and I will immediately forward the benefit payment to the practice. I agree to pay for all charges not paid by insurance. If applicable, I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize Vascular Solutions of North Carolina to use my information for a range of purposes including but not limited to:

insurance/payment, eligibility/benefit verification, billing and collecting money due from payor or their agents including insurance companies, managed care entities, certification, quality of care assessment and improvement activities, evaluation of the performance or qualifications of physicians and health care workers, conducting healthcare staff training and educational programs, ensuring compliance with legal, regulatory and accreditation requirements, and public health activities. I authorize Vascular Solutions of North Carolina to utilize or release my health information. whether written, verbal, or electronic, to such employees, billing companies, agents or third parties necessary for these purposes. I certify that I have read the above or had it explained to me, and I agree to all terms.

Policy Regarding Financial Responsibility

We have contracts with many insurance companies and we will bill them as a service to you. We will let you know in advance if we are not in network with your policy. If you wish to be seen at Vascular Solutions of North Carolina, you are responsible for payment of co-pays and/or deductible charges at the time of service. If you are uninsured, or we are not in network with your insurance policy, we are happy to provide services to you at a self-pay rate. As the responsible party, you are financially responsible if your insurance company declines to pay for any reason. If you are in need of a payment plan, you are expected to reach out to our financial department before your procedure to make arrangements. We accept payment in the form of credit card, cash or check. Any checks returned to us due to insufficient funds, or any other reason, will result in a fee of $25.00 each.

The person signing on behalf of the patient as the Responsible Party must:

- Inform Vascular Solutions of North Carolina of the current address and phone number for the patient and the responsible party.
- Present all current insurance cards prior to each visit and verify at each visit that it is current.
- Pay any required co-pay/deductible amounts at the time of service, then agree to pay any additional amounts due within 30 days of receiving a statement from our office.

I have read this financial policy and understand that I am responsible for payment of medical services provided by Vascular Solutions of North Carolina, and hereby assume and guarantee payment of all expenses incurred during my visit. Should legal action be required to secure payment, I agree to pay the legal expenses incurred by this office.

Signature: _____ **Date:**_____

Vascular Solutions of North Carolina

Authorization for Release of Medical Records

Patient Information

Name:		
Date of Birth:		Social Security:
Street Address:		
City:	State:	Zip:
Phone: ( )		

Physician's Office Information

Name:		
Address:		
City:	State:	Zip:
Phone: ( )		

I REQUEST MY MEDICAL RECORDS TO BE RELEASED TO:
VASCULAR SOLUTIONS OF NORTH CAROLINA
1000 CRESCENT GREEN, SUITE 102
CARY, NC 27518

PHONE : (919) 897 – 5999
FAX : (919) 897 – 5980

By my signature, I authorize release of my medical records.

Signature: _____ **Date**: _____