# Initial Clinical History Intake Form

Date: _____

**Patient Information** English/Spanish

Name:_____ Date of Birth: ___ / ___ / ____

**Reason For Visit**:_____ **Referring Doctor:**_____

**HEIGHT** _____ **WEIGHT**_____

**Your Medical Team**

| | | |
|---|---|---|
| Primary Doctor: | Nephrologist/Kidney Doctor: | Podiatrist/foot Doctor: |
| Cardiologist/Heart Doctor: | Wound Care: | Other: |

**Past Medical History (Please check all that apply)**

- ☐ None
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Stroke/TIA/Mini stroke
- ☐ Heart Attack
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Obstructive Sleep Apnea
- ☐ Other: _____
- ☐ Anxiety
- ☐ Bleeding Difficulties
- ☐ Hepatitis A B or C
- ☐ HIV
- ☐ PAD
- ☐ VENOUS INSUFFICIENCY
- ☐ Diabetes
- ☐ Cancer:_____
- ☐ High Cholesterol
- ☐ Seizures
- ☐ Loss of consciousness
- ☐ Arthritis (type)_____
- ☐ Asthma
- ☐ Emphysema
- ☐ Osteoporosis
- ☐ TB
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Kidney Disease
- ☐ Dialysis (type)_____

**Past Surgical History (type and year)**

1._____ 4._____

2._____ 5._____

3._____ 6._____

**Prescription Medications (Name and Dose/Number per day)**

1._____ 4._____

2._____ 5._____

3._____ 6._____

7._____ 8.

# Initial Clinical History Intake Form

9._____ 10._____

**NAME:**_____

**Non-Prescription Medications (Name and Dose/Number per day)**

1._____ 4._____

2._____ 5._____

3._____ 6._____

**Do you have:**

☐ Fever/Chills ☐ Shortness of Breath ☐ Chest Pain

**Drug Allergies and Type of Reaction**

☐ No Known Drug Allergies 1._____ 3._____

☐ Latex ☐ Shellfish 2._____ 4._____

☐ Tape ☐ Iodine/Contrast Other:_____

**Social History (Please check appropriate listings)**

| **Tobacco Use** | **Alcohol Use** | **Drug use** |
|---|---|---|
| Never | None | None |
| Quit/When?_____ | Socially | Marijuana |
| Cigarettes/Pack per day?_____ | Daily | Amphetamines |
| Pipe | Heavy | Other_____ |
| Cigars | | |
| Chewing Tobacco | Have you ever been treated for alcoholism? | Have you ever been treated for drug use? |
| How many years?_____ | Yes_____ No_____ If yes, when?_____ | Yes_____ No_____ If yes, when?_____ |

**Family History**

| | | | | |
|---|---|---|---|---|
| Father | Living Deceased | Age:_____ | Medical History or cause of death | ___Blood pressure ____Diabetes ____Cholesterol ____Cancer/Type_____ ____Other_____ |
| Mother | Living Deceased | Age:_____ | Medical History or cause of death | ___Blood pressure ____Diabetes ____Cholesterol ____Cancer/Type_____ ____Other_____ |

# PATIENT DEMOGRAPHICS

Date: _____

**Patient Information** English/Spanish E-mail: _____

Name:_____ Age:_____ Date of Birth: ___ / ___ / ____

Address By: ☐ He/Him/Mr. ☐ She/Her/Ms./Mrs.

**Race:** ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ Multi-Racial

☐ Other:_____

**Sex:** ☐ Male ☐ Female

**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ #Children: _____

Primary Doctor Full Name/Number:_____ Referring Doctor Name:_____

**PHARMACY PHONE #: _____**

**EMERGENCY CONTACT**

Name:_____ Relationship:_____

Phone:_____

# Espada Vascular

Print Name:_____

## Consent and Disclosure

**Consent to Treat:** I understand that as a patient I have the right to make all decisions regarding my care. I voluntarily request Dr. Jeffrey Martinez, as my treating Physician, and associates of Espada Vascular, such as, a Physician Assistant/Nurse Practitioner, RN/LVN, technical assistants and other health care providers as deemed necessary, to treat my condition. I also understand that no warranty or guarantee has been made to me as to results or cure. I understand that my Physician and/or Physician Assistant may discover other or different conditions which require additional or different procedures than those planned. I authorize my Physician and/or Physician Assistant to perform such other procedures which are advisable in their professional judgment.

**Risk and Emergency:** Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the treatment.

**Electronic Communication/Messaging:** I authorize Espada Vascular to send communication via text message and/or by email.

**Ambient AI Listening**: To support accurate documentation and allow your clinician to focus on your care, our practice may use ambient AI technology during your visits. This technology listens to the conversation between you and your clinician and assists with creating medical notes. In accordance with Texas law, you are informed of this audio technology and consent. The audio is used only for clinical documentation purposes and is maintained in compliance with HIPAA and applicable Texas privacy laws. Your clinician reviews and approves all documentation before it becomes part of your medical record. I acknowledge and consent to the use of ambient AI listening for documentation purposes.

**Authorization to Release Information:** I authorize Jeffrey Martinez, MD to release any and all healthcare information as necessary to (a) obtain payment from my Payers for my healthcare, (b) to conduct utilization review, peer review, and quality assurance, and (c) to other healthcare providers that will assist with my care. I understand that this information will identify me and may relate to my history, diagnosis, treatment, or prognosis; it will also include, where applicable, psychiatric, alcohol abuse, drug abuse, specific laboratory results of HIV, or the diagnosis of AIDS. I understand that in the event of a healthcare worker being exposed to my blood or bodily fluids, my blood may be tested for the HIV antibody and other communicable diseases.

**Financial Authorizations:** I authorize all payers to directly pay Jeffrey Martinez, MD for services provided. I assign to Jeffrey Martinez, MD my right to receive payment from third-party payers. Third-Party payers include anyone from whom benefits are or may become payable to me for services provided.

**Receipt of Information:** I acknowledge that I have received the "Notice of Privacy Practices" and a copy of "Patients' Rights, Responsibilities and Healthcare Choices" from Jeffrey Martinez, MD. I certify this has been fully presented and explained to me, that I have read it or have had it read to me, and that I understand its contents.

**Financial Responsibilities:** I understand and agree that I am responsible for payment of all charges that result from the care provided to me. I agree to pay these charges including payments not paid by my insurance company payers within 120 days. I understand that it is my responsibility to submit accurate insurance information on all dates of service and to comply with all requests of my insurance company within a timely manner to ensure payment is made within 120 days. I understand that if I am covered by Medicare/Medicaid, my obligation under this section may be limited by law. All payments, including co-payments, co-insurance, and deductibles, are due at the time services are rendered. I understand if balances on my account are not paid in a timely manner, they may be transferred to a third party for collections or further actions.

**Medication History:** I authorize Medication History Retrieval from the National database.

**Property:** I understand that Jeffrey Martinez, MD, does not assume responsibility for any personal property.

**No Show/Late Appointment Policy:** I understand that 24 hours' notice is required for appointment cancellations and that cancellations can and must be left on voicemail after hours. I understand and agree to a $50 standard appointment no-show fee, and/or a $100 procedure no-show fee. All no-show fees are to be collected prior to the next scheduled appointment or before services are rendered. Workers' Compensation patients will be personally responsible for these amounts. After 3 No Shows on record, we reserve the right to conclude our relationship for noncompliance with the stated office policy. If you are more than 15 minutes late for your scheduled appointment, you may need to reschedule your appointment.

**Request forms:** Due to the quantity and complexity of the forms requested, there will be a $10 charge, payable in advance, for the completion of each of the first two forms requested. There will be a $25 charge for all additional forms.

**Sunshine ACT Disclosure:** In compliance with the Sunshine Act, a provision of the Affordable Care Act, we wish to disclose that our office occasionally receives food and beverages, sample drugs and patient coupons, and promotional material from pharmaceutical vendors and/or manufacturers in conjunction with product education. We do not receive direct financial compensation from any of our vendors. By initialing here, you acknowledge this disclosure.

**PATIENT/ OTHER LEGALLY RESPONSIBLE PERSON (signature required): By signing, you certify that this form has been fully explained to you, that you have been given the opportunity to ask questions, and that you fully understand its contents.**

Signature: _____Date: _____


**Jeffrey M. Martinez, M.D.**
7500 Barlite Blvd., Ste. 107
San Antonio, TX 78224
P: 210-540-6766 F: 210-903-8044

## Authorization to Release or Obtain Medical Records

I, _____ DOB: _____Authorize:
**Patient's Name (Please Print)**

☐ **Jeffrey M. Martinez, MD, PA**
**7500 Barlite Blvd., Ste. 107**
**San Antonio, TX 78224**
**(P) 210-540-6766 (F) 210-903-8044**

**Or Other (specify below)**

☐ Name of Person or Facility: _____
Address: _____
City: _____ State: _____ Zip: _____

☐ **To release information to:** ☐ **To Obtain information from:**

Name of Person of Facility: _____
Address: _____
City: _____ State: _____ Zip: _____

Purpose of this Authorization: _____
I authorize the release of the following protected health information:
(Place an "X" in the box(es) that apply to this information you want released or want to obtain)
For personal copies of your medical records the cost will be $25.00 for the first 25 pages and .25 cents for each page thereafter. Please allow 15 business days from day of request to process your request for medical records.

☐ Entire record ☐ Consultation notes/report ☐ Lab reports ☐ X-Ray reports ☐ Surgical reports

☐ Medical History, Examination reports ☐ Treatment or Test ☐ Hospital records including reports

☐ Other: _____

Patient Signature: _____ Date: _____

Witnessed by: _____Date: _____

JEFFREY M. MARTINEZ, MD
ESPADA VASCULAR

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**DESIGNATION OF AUTHORIZED REPRESENTATIVE**
**ASSIGNMENT OF BENEFITS & RIGHTS**
**(ERISA / MA / COMMERCIAL / GOVERNMENT PLANS)**

I, _____ ("Patient"), hereby:

**Designation of Authorized Representative (DAR)**

Pursuant to:

- **29 C.F.R § 2560.503-1(b)(4)**
- **29 C.F.R § 2560.503-1(h)**
- **42 C.F.R §§ 422.566-422.574**
- And all other applicable federal and state regulations

I, designate _____ ("Provider") as my **Authorized Representative** for all purposes relating to my health plan benefits. This designation includes, but is not limited to:

- Requesting and receiving claim determinations
- Filing and pursuing all appeals (internal and external)
- Requesting reconsiderations, redetermination, and review
- Participating in Independent Review / IRE processes
- Communicating with plan administrators and fiduciaries
- Filing complaints with CMS, DOL, EBSA, OCR, or state regulators
- Receiving all correspondence, EOBs, ERAs, and notices
- Acting wholly in my stead in administrative proceedings

The plan shall communicate directly with my Authorized Representative.

**Assignment of Benefits**

I, hereby assign and transfer to Provider:

- All insurance benefits payable for services rendered
- All rights to payment under my plan
- All rights to pursue payment, appeals, administrative review, and litigation relating to services rendered.

Payment shall be made directly to Provider.

**Assignment of Rights & Causes of Action (ERISA)**

To the extent permitted by law, I assign to Provider:

- All rights under ERISA §502(a)
- All rights to pursue breach of fiduciary duty
- All rights to enforce plan terms
- All rights to challenge denials, reductions, bundling, downcoding, recoupments, or improper offsets

**Anti-Assignment Savings Clause**

If my health plan contains an anti-assignment provision:

- This document should remain fully valid as a Designation of Authorized Representative for all administrative and appeal purposes.
- The Plan may not refuse to process an appeal submitted by my Authorized Representative pursuant to 29 C.F.R § 2560.503-1(b)(4).
- Any anti-assignment clause shall not impair Provider's ability to obtain the full administrative record or act on my behalf in pre-litigation proceedings.

**Administrative Record Demand**

I request and authorize my Provider to obtain:

- The complete administrative claim file
- All internal notes, guidelines, coverage criteria
- Medical Policies Relied upon
- Communications relating to claims decisions
- Financial methodologies related to allowed amounts
- Any documents required under 29 C.F.R § 2560.503-1(h)(2)(iii)

Failure to produce these materials shall be considered a violation of federal claims procedure regulations.

**HIPAA Authorization**

I authorize the release of all protected health information, claim information, plan documents, and related materials to Provider for purpose of:

- Obtaining payment
- Filing appeals
- Filing complaints
- Pursuing administrative or legal remedies

This authorization complies with HIPAA, 45 C.F.R § 164.508.

**No Contractual Conditioning**

The Plan may not require Provider to sign a network participating agreement or other contract as condition of processing appeals or honoring this designation.

**Duration**

This designation and assignment:

- Is effective immediately
- Remains in effect until revoked in writing
- Applies to all past, present, and future claims related services rendered

A photocopy or electronic copy shall be as valid as original.

Patient Signature: _____ Date: _____

Printed Name: _____