

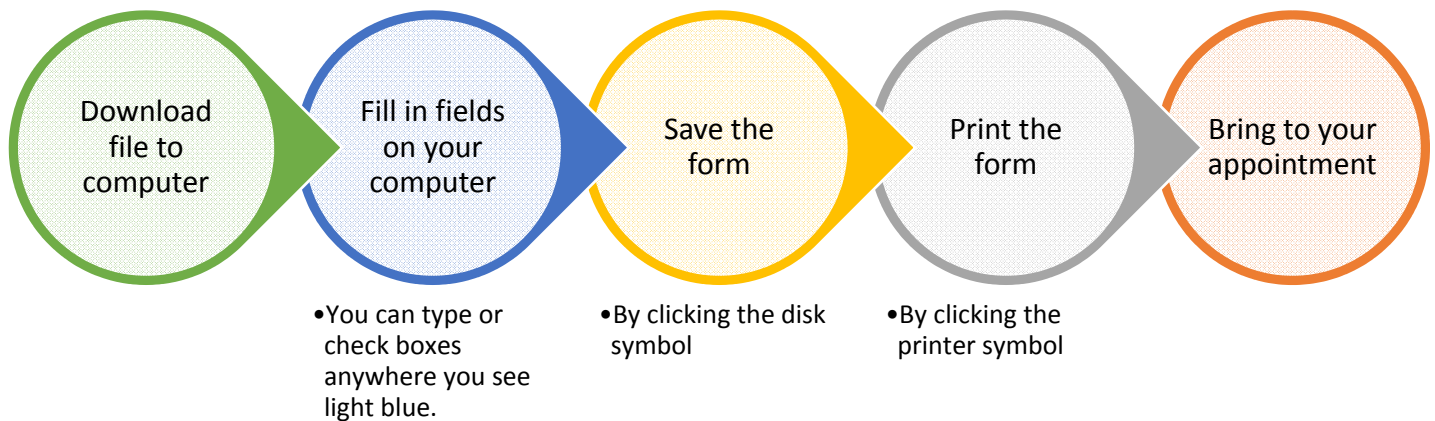
Thank you for choosing VasCare. Completing this form before your appointment will accelerate your first appointment. If you have questions, please do not hesitate to call our office.

Thank you,

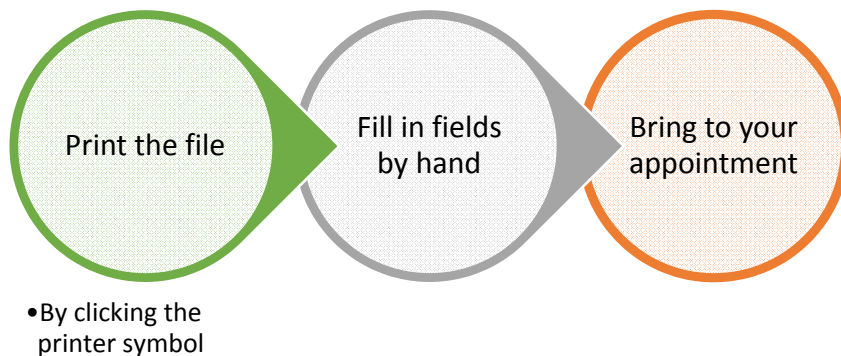
VasCare Clinics

Do not complete this form in your internet browser, you will not be able to save your work.

Option 1: Computer + Printer



Option 2: Printer + Pen





Patient Demographics

PATIENT INFORMATION:

Patient Name: _____ **SS#** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Date of Birth: ___/___/_____ **Sex:** Male Female **Marital Status:** Married Single Divorced Widowed

Race: American Indian or Alaskan Native, Asian, Black or African American, Caucasian, Chinese, Filipino, Hispanic, Japanese, Multi-racial, Native, Hawaiian, Pacific Islander, Other, Undetermined, Patient Declines

Language: English, French, German, Japanese, Korean, Latin, Spanish, Vietnamese, Patient Declines

Ethnicity: Hispanic or Latino, Not Hispanic or Latino, Patient Declines to State

Employer (if applicable): _____ **Occupation:** _____

Employment Status: Full-time, Part-time, Housewife, Unemployed, Retired

Student Status: Full-time, Part-time

Pharmacy Name / Location: _____ **Patient Email Address:** _____

RESPONSIBLE PARTY INFORMATION: (complete only if different from patient)

Guarantor: _____ **Date of Birth:** ___/___/_____ **SS#** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Emergency Contact: (someone not in your household)

Name: _____ **Relation:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

INSURANCE INFORMATION:

Primary Insurance Name: _____

Policy #: _____ **Group:** _____

Name of Insured: _____ **Date of Birth of Insured:** ___/___/_____

Secondary Insurance Name: (complete only if Medicare is the primary insurance) _____

Policy #: _____ **Group:** _____

Please Give Insurance Card(s) and Drivers License to Front Desk For Scanning!

Insurance Authorization and Assignment:

I authorize East Texas Surgical Associates, P.A., to furnish information to insurance carriers concerning my medical condition and care. I assign to East Texas Surgical Associates, P.A., all payments for medical services rendered to me or my dependents. I also request payment of government benefits either to myself or to the party who accepts assignment. This authorization is valid as long as I am a patient of East Texas Surgical Associates, P.A.. Any Person signing below guarantees payment of the health care costs incurred on behalf of patient and in the event of such costs are not incurred on below and in the event such costs are not timely paid further guarantee payment of the cost of collection of such bills including attorney fee's.

Signature

Date

The signature is of the: Patient Parent of Minor Legal Guardian Patient's power of attorney



Health Assessment and History

Name: _____ Date: ____/____/____
DOB: ____/____/____ Age: _____ Sex: _____ Height _____ Weight _____

CHIEF COMPLAINT:

Primary Care Physician: _____ Phone: _____
Home Health Agency: _____ Phone: _____
Pharmacy: _____ Phone: _____

Current Medications: (Please list prescriptions, over the counter, vitamins, herbs, etc)

Medication / Dosage	Medication / Dosage

Allergies: (medication, latex, chemical, food, x-ray dye, etc)

Have you taken steroids / cortisone / prednisone? Yes No

If yes, last date taken: _____ Reason: _____

Have you, or a blood relative, had a reaction to anesthetic? Yes No

If yes, please explain: _____

CURRENT MEDICAL HISTORY: (Please list all previous hospitalizations or operations)

Illness / Condition	Date	Hospital	Doctor / Treatment

SURGICAL / INVASIVE HISTORY:

Illness / Condition	Date	Hospital	Type of Anesthesia



Patient: _____

Charles J. Rodman, MD
East Texas Surgical Associates, P.A.
Vascular Surgery and Phlebology

Hepatic/Renal	Yes	No
Yellow Jaundice		
Hepatitis		
Cirrhosis		
Kidney Problems		
Blood in Urine		
Urinary Frequency		
Difficulty Urinating		
Mental	Yes	No
Anxiety		
Depression		
Agitation		
Excitability		
Forgetfulness		
Confusion		
Infectious Disease	Yes	No
HIV/AIDS		
Speech/Hearing	Yes	No
Language Problem		
Voice Problem		
ringing In Ears		
Frequent Ear Inf.		
Hard Of Hearing		
Deaf		
Dizziness		
Vision	Yes	No
Blind		
Cataracts		
Glaucoma		
Double Vision		
Blurring		
Pain (Eye)		
Low Vision		
Endocrine	Yes	No
Insulin Dependent Diabetes Mellitus		
Non-Insulin Dependent Diabetes		
Thyroid Disease		
Adrenal Disease		

Respiratory	Yes	No
Asthma		
Wheezing		
Shortness Of Breath		
TB – History		
Emphysema		
Collapsed Lung		
Cardiovascular	Yes	No
Chest Pain		
Shortness of Breath		
Pacemaker		
Congestive Heart Failure		
Angina		
Myocardial Infarction		
Bleeding/ Clotting Disorders		
Phlebitis		
Peripheral Vascular Disease		
Blood Transfusions		
Gastrointestinal	Yes	No
Ulcers or Gastritis		
Diverticular Disease		
Blood In Stools		
Frequent Diarrhea Or Constipation		
Heartburn/ Sour Taste In Mouth		
Nausea/Vomiting		
Difficulty Chewing		
Difficulty Swallowing		
Ostomy: Type;		
Feeding Tube		
Special Diet		
Recent Weight Loss Amount Of Loss?		
Laxative Use		
Musculoskeletal	Yes	No
Arthritis		
Muscle Disease		
Physical limitation		
Cane/Walker Wheelchair/ Prosthesis Amputations/ Shoe Inserts		
Skin	Yes	No
Rash		
Wounds		
Bruises		
Lesions		
Physical Trauma		

Neurological	Yes	No
Numbness/Tingling		
Paralysis		
Weakness		
Loss Of Memory		
Seizures		
CVA/Stroke		
Headaches		
Pain	Yes	No
Having Pain?		
What Relieves It?		
Social History	Yes	No
Alcohol Amount:		
Tobacco Amount:		
Drug Use		
Drug Type:		

Drug Amount:		

Chemical /Environmental Exposure		
Last Flu Shot:		
Last Pneumonia Vaccination:		
Please explain any "Yes" answers from the above questions:		
Would you like for us to send your reports to your specialists?		
Please List your Specialists:		
Cardiologist(heart):		
Neurologist(nerve):		
Hematologist(blood):		
Rheumatologist(arthritis):		
Podiatrist(foot):		
Dermatologist(skin):		
Endocrinologist(hormone):		
Pulmonologist(lung):		
Pain Specialist:		
Wound Care:		



Patient Name: _____

Special Needs: Cultural Communication Literate Developmental Religious
 Financial Foreign Language

Learning Style: Verbal Written Demonstration

PRESENT LIVING ARRANGEMENTS

- Home Alone
- Home with Family / Caregiver (who)_____ Part-Time Full-Time
- Nursing Home (name) _____ Group Home (name) _____
- Other, Explain: _____ Are pleased with the care you are receiving: Y N

PERSONAL CARE NEEDS (Based on Health Status)

Do you currently need or will you need, help with the following (check all that apply):

- Standing Walking Toileting Eating Wound Care Cooking
- Dressing Bathing Preparing Medications Transportation for health care needs

Explain: _____

DO YOU USE ANY OF THE FOLLOWING? (Check all that apply)

- Dentures Uppers (Full / Partial) Dentures Lower (Full / Partial)
- Glasses / Contacts Braces or retainers
- Loose, chipped or cracked teeth Hearing Aids (R L Both)
- Capped teeth or bridge work Prosthesis / Implant
- Hospital Bed IV Therapy
- Respiratory treatments / Inhalers Oxygen ___L/minute
- Bi-Pap / C-Pap Other: _____

Advanced Directives – Please Bring with you	Yes	No	Explanation
Durable Power of Attorney	<input type="checkbox"/>	<input type="checkbox"/>	
Health Care Representative	<input type="checkbox"/>	<input type="checkbox"/>	
Do Not Resuscitate Document	<input type="checkbox"/>	<input type="checkbox"/>	
Living Will	<input type="checkbox"/>	<input type="checkbox"/>	
Life-Prolonging Procedures	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any of the above documentation?	<input type="checkbox"/>	<input type="checkbox"/>	
Where is the copy of the document	<input type="checkbox"/>	<input type="checkbox"/>	

Questionnaire completed by

Relationship

Date



Venous Health History

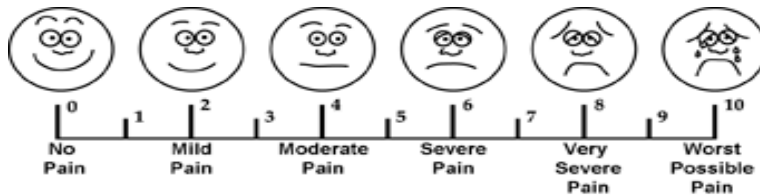
Patient Name: _____ **DOB:** ____/____/____

Do you experience any of the following in your legs?

	Left	Right	Comments (optional)
Aching / Pain	<input type="checkbox"/>	<input type="checkbox"/>	
Heaviness	<input type="checkbox"/>	<input type="checkbox"/>	
Tiredness / Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	
Itching / Burning	<input type="checkbox"/>	<input type="checkbox"/>	
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	
Leg Cramps	<input type="checkbox"/>	<input type="checkbox"/>	
Restless Legs	<input type="checkbox"/>	<input type="checkbox"/>	
Throbbing	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

Activities Affected by Legs: Walking, Shopping, Exercising, Cleaning, Cooking, Showering, Job Functions

What is the pain level in your legs? (select one)



Have you ever had the following?

	No	Left	Right	Date	Comments (optional)
Vein Stripping or Ablation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Vein Injections (Cosmetic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Leg Ulcerations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

- Do you have a family history of varicose veins? Yes No Who? _____
- Have your symptoms worsened in recent months? Yes No
- Do you take any medication for pain in your legs? Yes No
- Do you elevate your legs for discomfort? Yes No How long? _____
- Do you exercise? Yes No How often? _____
- Do you wear / have you worn compression stockings? Yes No How Long? _____
- Do you have difficulty walking? Yes No
- Does your occupation require prolonged standing? Yes No
- Does your occupation require prolonged sitting? Yes No
- What is the name of your referring physician? _____

Patient Signature

Date



Consent to Photograph for Communication with Insurance Companies / HIPAA Privacy Policy Acknowledgement

Patient Name: _____ **Date:** ____/____/____

The undersigned authorizes East Texas Surgical Associates, P.A., to take and reproduce photographs of the above named person in communication with diagnosis, care and treatment. Use of such materials and the person's name is also authorized for use in dealing with the named person's insurance company, including filing claims, medical necessity and appeals with said insurance company.

____ Initial to indicate that you have read, understand and approve authorization as stated above.

I release East Texas Surgical Associates, P.A. and its physicians, employees and consultants from any liability in connection with the use of such materials. I understand that this authorization will remain effective unless revoked in writing.

Patient's Signature: _____ Date: ____/____/____

Phone Number: _____

Legal Guardians' Signature if patient is under 18: _____

Witness' Signature: _____ Date: ____/____/____

I, _____ have been given the opportunity to read the HIPAA Notice of Privacy Practices of East Texas Surgical Associates, P.A..

- I want a copy of the HIPAA Privacy Policy
- I **do not** want a copy of the HIPAA Privacy Policy

I have given permission for the office of East Texas Surgical Associates, P.A., to discuss my medical history / condition with the following person(s):

Name: _____

- Limited Time
- Until Rescinded

Patient's Signature: _____ **Date:** ____/____/____



Patient Payment Policy

Thank you for choosing East Texas Surgical Associates, P.A.! We are committed to the success of your medical treatment and care. Please understand that payment for your services is part of your treatment and care.

For your convenience, we have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a billing specialist or the Practice Manager.

How May I Pay?

We accept payment by cash, check, VISA, MasterCard, American Express, and Discover.

Do I Need a Referral and / or Authorization?

If you have an HMO plan with which we are contracted, you need a referral and / or authorization from your primary care physician prior to your first visit. If we have not received a referral and / or authorization prior to your arrival at the office you will need to call your primary care physician and have a referral faxed to our office at Attn: Billing. If you are unable to obtain the referral and/or authorization at the time of service, you will be rescheduled to a later date to allow ample time for us to receive this in the office. We will not see you without this referral and/or authorization on file.

What is My Responsibility for Services?

- If services you receive are covered by your insurance plan: you will be responsible for all applicable co-pays, deductibles and out of pocket amounts at the time of service. VasCare offers a variety of payment plans.
- If services you receive are not covered by you insurance plan: You will be responsible for the full payment at the time of service. VasCare offers a variety of payment plans.
- We offer durable medical equipment (DME) products for sale (compression stockings, lotion, etc.) but we do not bill private insurance companies. If you would like to purchase any DME product, you will be expected to pay in full at the time of service and an itemized receipt will be given upon your request so you can bill your own insurance.

Our practice bases your costs off what is quoted to our Insurance Specialist by your insurance company. When verifying benefits our Insurance Specialist will ask how your insurance covers specialist office visits, Venous Doppler (CPT codes 93970, 93971) and Venefit Closure Procedures (CPT codes 36475, 36476, 36471).

We recommend that you call your insurance company as well and check on those services and CPT codes mentioned above. You may also see what medical policy guidelines you must follow for these procedures.

East Texas Surgical Associates, P.A. will not be held responsible for any misquotes in benefits.



Patient Payment Policy, Cont'd

Venefit Closure Procedures in the Office

If your physician recommends surgery, an inner office referral will be created and sent to the Surgery Coordinator. When the Surgery Coordinator receives the inner office referral, a request for predetermination / preauthorization will be sent to your insurance company with all required documentation. You will not be scheduled for surgeries until this process is done and it may take up to 30 days to get a predetermination from your insurance. Once our office has received the predetermination / preauthorization from your insurance company, an Estimated Surgical Cost Analysis will be generated and mailed to you with the amount you will owe for the procedure(s). Once this is done, the Surgery Scheduler will contact you to schedule the surgeries. At that time, if you have any questions regarding the surgeries, the scheduler will be happy to assist you or if unable to he / she will direct you to the appropriate department.

The Estimated Surgical Cost Analysis is done as a courtesy to you and will show you your final estimated financial responsibilities, based on the benefit levels and coverage quoted by your insurance plan. This estimated amount will be expected to be paid in full at the initial surgery.

What if my Child Needs to See the Physician?

A parent or legal guardian must accompany patients who are minor, under the age of 18. This accompanying adult is responsible for payment of the account, according to the policy outlined above.

I have read, understand and agree to the above financial policy. I understand that the charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to East Texas Surgical Associates MD.

I authorize East Texas Surgical Associates, P.A. to release pertinent medical information to my insurance company when request, or to facilitate payment of a claim.

Walk-In Appointments:

East Texas Surgical Associates, P.A. actively encourages every patient to schedule an appointment for every episode of care. Patients in need of urgent care are asked to call ahead for an appointment even if they are only able to give minimal notice of their impending arrival. If your insurance requires referrals for office visits and there is not one on file, you will be expected to pay in full in advance of being seen.



VASCARE[®]

Charles J. Rodman, MD
East Texas Surgical Associates, P.A.
Vascular Surgery and Phlebology

Patient Payment Policy, Cont'd

No Show or Cancelled Appointments:

If you are unable to keep your scheduled appointment, please call our office 24 hours before your appointment to reschedule. This will allow time to provide that time slot to another patient. We reserve the right to charge \$25.00 for appointments that are not canceled at least 24 hours in advance.

Signature

Printed Name

Date

___/___/___