

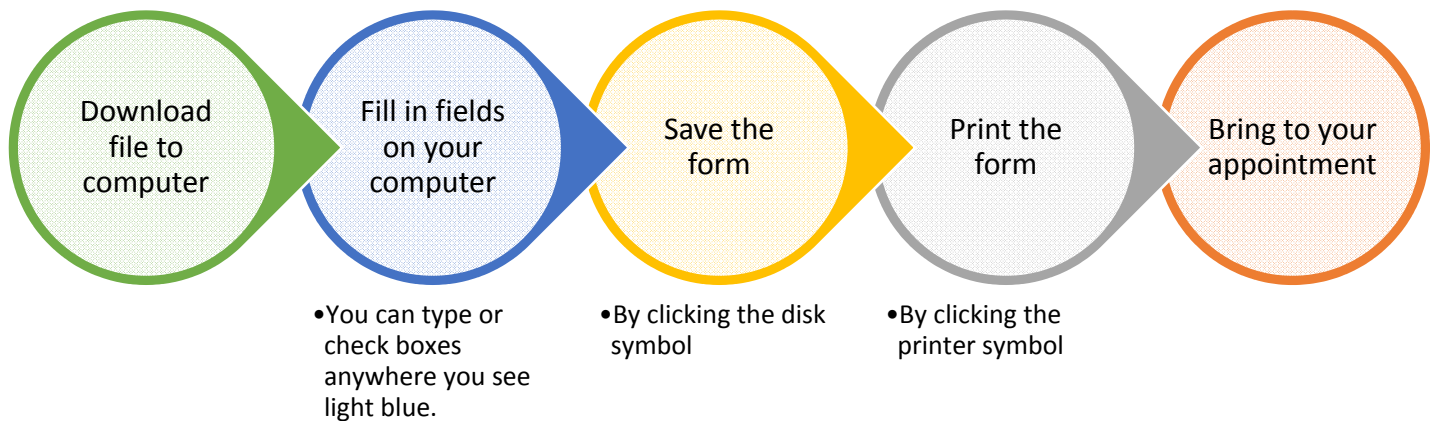
Thank you for choosing VasCare. Completing this form before your appointment will accelerate your first appointment. If you have questions, please do not hesitate to call our office.

Thank you,

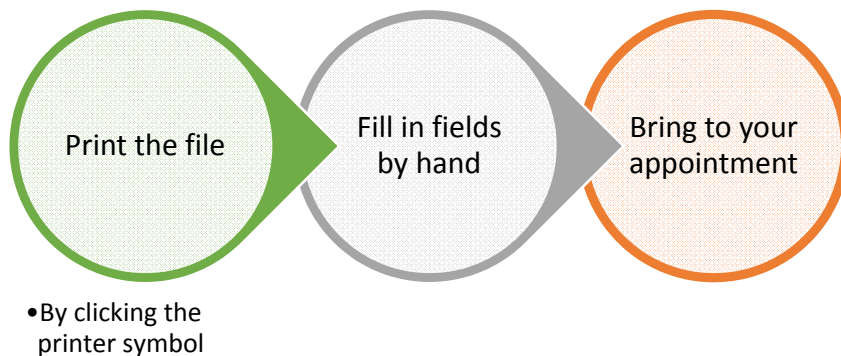
VasCare Clinics

**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 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: \_\_\_\_\_

<b>Advanced Directives – Please Bring with you</b>	<b>Yes</b>	<b>No</b>	<b>Explanation</b>
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

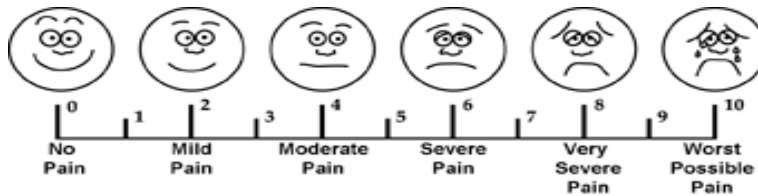
**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_

### 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**

### **Venfit 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**<sup>®</sup>

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

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### **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**

\_\_\_\_/\_\_\_\_/\_\_\_\_