# VICTORIA VEIN & SURGERY CLINIC
# PATIENT INFORMATION FORM

## PATIENT INFORMATION

Patient Name: _____
Sex: M [ ] F [ ] *First* *Middle Initial* *Last*

Email address:_____

Patient's SS#:_____Date of Birth:____/____/____Race:_____

Address:_____City:_____State _____

Zip_____-____ Home #(  )_____-_____ Cell #(  )_____-_____ Work #(  )_____-_____

## RESPONSIBLE PARTY (*If Minor /Responsible Party*)

Responsible Party Name (if different than patient)_____
Sex: M [ ] F [ ] *First* *Middle Initial* *Last*

Name:_____DOB____/____/_____SS#_____-_____-_____

***Emergency Contact:***_____Home #(  )_____-_____
Relationship_____

## INSURANCE INFORMATION

***Primary Insurance Name:***_____Name of Insured: _____
ID or Policy Number:_____Group Number: _____
Insurance Phone #_____Effective Date:_____

***Secondary Insurance Name:***_____Name of Insured: _____
Id or Policy Number:_____Group Number: _____
Insurance Phone #_____Effective Date:_____

## INSURANCE AUTHORIZATION & ASSIGNMENT:

*I authorize Sean M. Hamilton, MD with Victoria Vein & Surgery Clinic to furnish information to insurance carriers concerning my medical condition and care. I assign to Sean M. Hamilton, MD all payments for medical services rendered to me or my dependents. I also request payment of government benefits to the party who accepts assignment. This authorization is valid as long as I am a patient of Sean M. Hamilton M.D.*

*Any person signing below guarantees payment of the health care costs incurred on behalf of patient and in the event such costs are not incurred on behalf of patient and in the even such costs are not timely paid further guarantee payment of the cost of collection of such bills including attorney fee's. collection agencies and interest.*

_____ _____
***Signature*** ***Signature Date***
The signature is of the:____Patient____Parent of Minor____Legal Guardian____Patient's Power of Attorney

**We reserve the right to charge a no-show fee of $10.00 if you fail to notify our office of your cancellation within 24 hours of your appointment. Insurance will not cover this fee.**

# Victoria Vein & Surgery Clinic
# Patient Medical History

**Name**:_____ **Date of Birth**: _____

**Patient Referred by**:_____ **Reason for Referral**: _____

**Race:** Check the appropriate box
White(Non-Hispanic)___ Hispanic___Black___ Asian___ American Indian___ Pacific Islander___Other___

**Primary Care Physician**_____ **Pharmacy**_____ **Phone:**_____

**Past Medical History:** Please list any medical problems you have:
1. _____ 2. _____ 3 ._____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____

**Surgical History/ Trauma History:** List any operations or injuries along with month, year and hospital
1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

**Have you or any family members ever had a reaction to anesthesia?**_____ **Bleeding Problems?** _____

**Medications:** List the medications you are currently taking along with the dosages, include nonprescription items such as St. John's Wort, dietary supplements, diet pills, cold and flu medications, etc.
1. _____ 2._____ 3._____
4. _____ 5._____ 6._____
7. _____ 8. _____ 9. _____

**Have you taken the following in the last month?** Prednisone____Coumadin_____Aspirin/ Motrin/ Naprosyn ____

**What meds are you ALLERGIC to?** _____

**Review of Systems:** Check the appropriate box if you have had these symptoms recently

| Yes No | Yes No | Yes No | Yes No |
|---|---|---|---|
| _____ Fevers | _____Calf Pain | _____Upper Abdominal Pain | _____Nipple discharge |
| _____ Night Sweats | _____Short of breath (SOB) | _____Lower Abdominal Pain | _____Headache or migraine |
| _____ Fatigue | _____SOB with ex | _____Painful urination | _____Room spinning |
| _____ Vision changes | _____SOB at night | _____Blood in urine | _____Seizures |
| _____ Double vision | _____Wheezing | _____Straining on urination | _____Passing out |
| _____ Hearing loss | _____Cough, sputum | _____Kidney stones | _____Numbness or tingling |
| _____ Ringing in ears | _____Coughing blood | _____Pelvic pain | _____Memory loss |
| _____ Ear pain or drainage | _____Diarrhea | _____Vaginal discharge/bleeding | _____Anxiety |
| _____ Bloody nose | _____Constipation | _____Joint or muscle pain | _____Depression |
| _____ Nasal discharge | _____Stool incontinence | _____Decreased mobility, weakness | _____Suicidal thoughts |
| _____ Sinusitis | _____Black tar-like stools | _____Joint swelling | _____Excessive hair growth |
| _____ Sore throat | _____Bloody stools | _____Skin rash | _____Excessive thirst |
| _____ Hoarseness | _____Difficulty swallowing | _____Itching | _____Excessive urination |
| _____ Oral ulcers | _____Heartburn | _____Mole changes | _____Easy bruising |
| _____ Chest pain | _____Nausea | _____Loss of hair | _____Bleeding tendency |
| _____ Palpitations | _____Vomiting | _____Difficulty w/ nails | _____Swollen nodes |
| _____ Ankle swelling | _____Irregular Pulse | _____Vomiting blood | _____Breast lumps, pain |

**Menstrual History**: Are you pregnant?____Number of Pregnancies_____Live births ____
Miscarriages____Age of first pregnancy_____Do you take birth control pills?____Age of Menopause _____

**Social History:** Marital status:_____Number of children_____International travel? _____
Occupation:_____Do you do heavy lifting on a daily basis? _____
Cigarette Smoking: I have smoked_____packs per day for_____years. Quit smoking in_____Drug use? ____
Please describe your alcohol intake:_____None____Occasional_____1-2 drinks per day_____>2 drinks per day
**Family History:** Check the box if you have first degree relatives with the following cancers (Ca) or diseases:
Breast Ca____Ovarian Ca____Colon Ca____Skin Ca____Lymphoma____Leukemia Inflam. Bowel Disease _____
Brain tumors____Heart disease____Thyroid Disease____Parathyroid disease____Other _____

VICTORIA VEIN & SURGERY CLINIC

# Patient Medical Photography Consent

Patient Name:_____

I authorize Victoria Vein & Surgery Clinic to take and reproduce photographs of the above named person in communication with other caregivers and physicians for use in diagnosis, care, and treatment. Use of such materials with the patient's insurance company is also authorized for all necessary communication regarding filing claims or appeals, confirming medical necessity, or any other requested documentation needs regarding the patient's medical care.

_____ _____

Patient Signature Date

## Additional Authorized Medical Photograph Uses

By consenting to the following medical photograph uses, I understand that I will not receive payment from any party. Although these photographs will be used without identifying information such as my name or entire face, I understand that it is possible that someone may recognize me. Refusal to consent to photographs will in no way affect the medical care I will receive. I release Victoria Vein & Surgery Clinic and Sean M Hamilton, MD, employees, and consultants from any liability regarding use of the authorized photographs and understand that I may withdraw my consent at any time with a written request. **I authorize the use of these images: (Please initial indicating YES or NO below)**

For demonstration purposes including an office photo album
**YES____**
**NO ____**

On our website for prospective patients
**YES____**
**NO____**

In print advertisements and/or professional journals
**YES____**
**NO____**

By signing this form below I confirm that this consent has been explained to me in terms which I understand.

Patient's Signature:_____ Date:_____

Legal Guardian's Signature if patient is under 18:_____

# Victoria Vein & Surgery Clinic

**Patient please complete questions 1-12**

**Patient Name:**_____ **Date of Birth:** _____

**Directions: Please answer the following questions. Provide estimates for date of occurrence.**

**Past Medical History**

1. Have you ever had vein stripping surgery ☐ Yes ☐ No
   If yes, when and which leg? _____
2. Have you ever had vein injections? ☐ Yes ☐ No
   If yes, which leg and where on the leg? _____
3. Have you ever had a blood clot? ☐ Yes ☐ No
   If yes, which leg and when? _____
4. Have you ever had phlebitis? ☐ Yes ☐ No
   If yes, which leg and when? _____

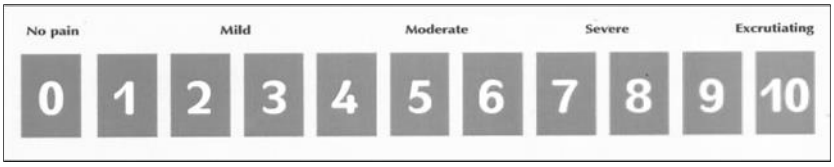
**Family History**

Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers or swollen legs?

| | | |
|---|---|---|
| Father | ☐ Yes | ☐ No |
| Mother | ☐ Yes | ☐ No |
| Brother(s) | ☐ Yes | ☐ No |
| Sister(s) | ☐ Yes | ☐ No |
| Other | ☐ Yes | ☐ No |

1. Do you experience any of the following in your legs?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Aching/pain? | ☐ Yes | During activity or prolong standing | ☐ Yes | ☐ No | ☐ LT / RT leg | ☐ Both legs |
| Heaviness? | ☐ Yes | During activity or prolong standing | ☐ Yes | ☐ No | ☐ LT / RT leg | ☐ Both legs |
| Tiredness/fatigue? | ☐ Yes | During activity or prolong standing | ☐ Yes | ☐ No | ☐ LT / RT leg | ☐ Both legs |
| Itching/burning? | ☐ Yes | During activity or prolong standing | ☐ Yes | ☐ No | ☐ LT / RT leg | ☐ Both legs |
| Swollen ankles? | ☐ Yes | During activity or prolong standing | ☐ Yes | ☐ No | ☐ LT / RT leg | ☐ Both legs |
| Leg cramps? | ☐ Yes | During activity or prolong standing | ☐ Yes | ☐ No | ☐ LT / RT leg | ☐ Both legs |
| Restless legs? | ☐ Yes | During activity or prolong standing | ☐ Yes | ☐ No | ☐ LT / RT leg | ☐ Both legs |
| Throbbing? | ☐ Yes | During activity or prolong standing | ☐ Yes | ☐ No | ☐ LT / RT leg | ☐ Both legs |




**VAS Scale** -Rate the intensity of pain_____Persistent ☐ Yes ☐ No

2. Have your veins gotten worse in recent months? ☐ Yes ☐ No
   Describe: _____

3. Do you take any medication for pain (i.e., Advil, Motrin) ☐ Yes ☐ No
   If yes, what medication(s) do you take and how many times/mgs per day? _____
   _____

4. Do you elevate your legs to relieve discomfort? ☐ Yes ☐ No
   If yes, how long per day do you elevate and does it provide relief?_____

5. Do you exercise? ☐ Yes ☐ No
   If yes, what kind of exercise and how often? _____

6. Do you wear prescription compression stockings? ☐ Yes ☐ No
   If yes, what type and gradient? How long have you worn them? _____
   _____

   If yes, what is the name of the physician who prescribed your compression stockings and when were they prescribed? _____

7. Do you wear light support hose (i.e., Sheer Energy)?
   If yes, do they provide relief? ☐ Yes ☐ No

8. Do you have any problem walking? ☐ Yes ☐ No
   If yes, describe how it interferes with your activities of daily living, which activities? (worse at night, after standing/sitting long periods or after exercise) _____
   _____

9. What type of work do you do? _____
   How long do you stand (hours per day) at work?_____At home? _____
   Describe how your symptoms are/ if interfering with your essential job function of your specific occupation, which activities: (inability to walk or stand for long hours)_____
   _____

10. Have you ever had any test(s) done on your veins? ☐ Yes ☐ No
    If yes, when and what type of test and where on the leg? _____
    _____

11. Were you diagnosed with saphenous vein reflux? ☐ Yes ☐ No

12. Name of referring Physician and how long have you been under his care for treatment of this condition?
    _____

Patient Signature:_____Date:_____

VICTORIA VEIN & SURGERY CLINIC

# HIPAA NOTICE CONFIRMATION

I, _____ have read and understand the HIPAA Notice of Privacy Practices of Dr. Sean M. Hamilton's office Victoria Vein & Surgery Clinic.
_____ I WANT a copy of the HIPAA Privacy Practice
_____ I DO NOT want a copy of the HIPAA Privacy Practice

**PLEASE LIST ANY INDIVIDUALS YOU WOULD LIKE TO HAVE PERMISSION FOR US TO DISCUSS YOUR MEDICAL RECORDS WITH. OTHERWISE, WE WILL ONLY DISCUSS ANY MEDICAL INFORMATION WITH YOU, THE PATIENT.**
I have given permission for Dr. Sean M. Hamilton's office Victoria Vein & Surgery Clinic to discuss my medical history/condition with the following person(s):
Name:_____ { } Until Rescinded In Written Notification **OR**
{ } Limited Time Period Ending Date_____

Name:_____ { } Until Rescinded In Written Notification **OR**
{ } Limited Time Period Ending Date_____

Patient Signature:_____ Date:_____

# Victoria Vein & Surgery Clinic Financial Policy

We recognize the need for definite understanding between patients and physicians regarding financial arrangements for medical care. We have established the following financial policy in response to this need. It is our hope that you will understand that these payment collection practices are a necessary part of assuring the financial resources required to provide the best medical care possible to our patients and community. We bill all insurances as a courtesy to our patients. You, the patient or responsible party, should facilitate the payment process by providing our office with current insurance information including the correct insurance responsible for payment at the time service is rendered, billing address, phone numbers, member ID numbers, employer information, and effective dates for all insurances. ***Please bring your insurance cards with you to each visit, and remember to notify staff at time of check in to any changes to insurances.*** You should also cooperate fully with our office and/or your insurance company in providing additional information as needed for reimbursement. **Ultimately, the patient or responsible party is responsible for payment when insurances fail to pay clean claims, or when accurate insurance information was not provided at time of service.** We will allow a reasonable amount of time for claim processing by insurance; (**no longer than 90 days**), once this time has passed, payment will be expected from the patient.
**Copays:** Your copay is determined by your contract with your insurance company. This is a requirement of your insurance company, and is due at the time of services rendered. **Copays not paid at time of service will be subject to an additional $10 statement preparation and mailing fee for each statement the patient receives per 28 day billing cycle.**

**Deductibles & Allowed Amounts:** We will also collect any deductible or allowable amount the patient is determined to be responsible for according to their insurance contract at the time of services rendered. A summary of these charges will be given for each visit and/or service which should be kept by patient for their records. ***Payment plans may be arranged for deductible or allowed amounts, and will NOT be subject to interest charges. These payments may be made up to a maximum of 6 months, and there will be a one-time $50 statement preparation and mailing fee added to total charges for payment plan arrangements.*** A contract must be signed for any payment plan arrangements, and a copy will be given to patient for their records.

**Self -Pay Patients:** We offer discounted fees on many services to our self-pay patients. Please inquire with staff regarding discounted rates. ***A down payment is required before all elective procedures. This down payment is to be at least half the fee for the anticipated service, and may increase or decrease if the actual service performed is more or less extensive than anticipated. The remaining balance is to be paid in monthly installments as arranged by contract at time of service, and not to exceed 6 months. Evaluation and management, or office visit fees are due in full at the time of service, and unpaid fees will be subject to a $10 statement preparation and mailing fee for each statement received in a 28 day billing cycle.*** Cosmetic procedures are required to be paid in full at time of service.

**Unpaid Charges:** Additional charges determined to be owed after filing claims with a patient's insurance company will be billed in a statement sent to patient. Unpaid balances will be subject to a $10 statement preparation and mailing fee for each additional statement sent after the first statement unless other arrangements are made with our office. Once our efforts to collect unpaid balances are exhausted, we will refer these accounts to the collection agency of our choice for collection of payment and reporting to credit agencies. ***A collections preparation and submission fee of $200 will be added to the patient balance at the time the account is turned over to the collection agency. In addition, an interest charge of 6% per year from the time of service will be added to the total balance to be collected by the collection agency.*** From this point, unpaid accounts will be referred to court mediation.

**Miscellaneous Fees:**
**Returned Checks:** $35
**Medical Records:** $25 for first 25 pages, then $1.00 per page
**Family Medical Leave Act or Disability Paperwork:** $25
**Itemized Statements/Multi Appointment:** $15 (a copy of your receipt will be given at time of each service or payment in office, please save these for your records in order to avoid this fee at a later date)
**Shipping Fees:** $14.50 to your address, $11.50 to office
**Ordered Products Not Picked Up within 1 Month:** $15
**Missed Office Visit Appointments** (when office is not notified of before-hand): $25
**Missed Surgical/Procedure Appointments** (when office is not notified before-hand): $75

**Workman's Compensation:** We will provide treatment for work related injuries using Workman's Compensation ***for emergency situations only.*** We do require all appropriate paperwork and authorizations needed to process these claims. Without required information and authorizations, the patient will be treated as a self-pay patient.

**Referrals and Prior-Authorizations:** If your insurance requires referral from a primary care physician (PCP), you are required to have prior authorization from your PCP and insurance company prior to your visit. If this authorization is not provided, you will be asked to reschedule your appointment or otherwise be responsible for exam fee payment. We will be happy to assist you in obtaining this

authorization if we are notified prior to exam, and make an effort to determine if your insurance requires referral prior to your exam.
**We reserve the right to refuse treatment to any person who does not adhere to our financial policy**

I have read and understand Victoria Vein & Surgery Clinic's Financial Policy. I agree to comply and accept responsibility for any payment that becomes due as outlined previously.

Patient Name:_____

Patient Signature:_____

Date:_____

_____ _____
Responsible Party Member's Name Relationship to patient

_____
Responsible Party Member's Signature