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

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