PATIENT DEMOGRAPHICS

PATIENT INFORMATION:

Patient Name:____

Address:_________________________________City:________________________State:_________Zip:______________

Home Number:____________________Cell Number:_____________________ Work Number:___________________

Date of Birth:_______________ Sex: *Male Female* Marital Status: *Married Single Divorced Widowed* SS#:________________

Employer (if applicable):____Occupation:______________________________

Employment Status: full-time part-time housewife unemployed retired Student Status (if applicable): 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 Number:____________________Cell Number:____________________ Work Number:_____________________

EMERGENCY CONTACT: (someone NOT in your household)

NAME::___________________________________Relation:___________ *Home Number:*____________________

*Cell Number:*_____________________ *Work Number:*_____________________

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 CARDS(S) AND DRIVERS LICENSE TO FRONT DESK FOR SCANNING!!

INSURANCE AUTHORIZATION & ASSIGNMENT:

I authorize Charles J. Rodman, MD PA to furnish information to insurance carriers concerning my medical condition and care. I assign to Charles J. Rodman, MD PA 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 Charles J. Rodman, MD PA.

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.

____ ______________________________

Signature *Date*

The signature is of the: ____Patient ____Parent of Minor ____Legal Guardian ____Patient's Power of Attorney

Health Assessment & History

Name: ____ Date: ______________
DOB: _____________________ Age: ______ Male Female 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: (medicines, latex, chemical products, 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 / Type of Treatment

Surgical / Invasive History:

Procedure	Date	Hospital	Type of Anesthesia

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		

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		

Musculoskeletal	Yes	No
Arthritis		
Muscle Disease		
Physical limitation Cane/ Walker/ Wheelchair/ Prosthesis Amputations/ Shoe Inserts		

Skin	Yes	No
Rash		
Wounds		
Bruises		
Lesions		
Physical Trauma		

Pain	Yes	No
Having Pain?		
What Relieves It?		

Infectious Disease	Yes	No
HIV/AIDS		

Respiratory	Yes	No
Asthma		
Wheezing		
Shortness Of Breath		
TB - History		
Emphysema		
Collapsed Lung		

Speech/Hearing	Yes	No
Language Problem		
Voice Problem		
Ringing In Ears		
Frequent Ear Infection		
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		

Neurological	Yes	No
Numbness/Tingling		
Paralysis		
Weakness		
Loss Of Memory		
Seizures		
CVA/Stroke		
Headaches		

Cardiovascular	Yes	No
Chest Pain		
Shortness of Breath		
Pacemaker		
Congestive Heart Failure		
Angina		
Myocardial Infarction		
Bleeding/ Clotting Disorders		
Phlebitis		
Peripheral Vascular Disease		
Blood Transfusions		

Social History	Yes	No
Alcohol Amount:		
Tobacco Amount:		
Drugs Type: Amount:		
Chemical /Environmental Exposure		

Please explain any "Yes" answers from the above questions:

____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

Venous Health History Form

1. Have you ever had vein stripping surgery? _____ If yes, which leg(s)? _____
2. Have you ever had vein injections? ____ If yes, which leg(s)? ____
3. Have you ever had a blood clot? ____ If yes, which leg(s)? ____ When? _______
4. Have you ever had phlebitis? ____ If yes, which leg(s)? ____ When? _________

Family History

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

	Yes	No
Father		
Mother		
Brother(s)		
Sister(s)		
Other		

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

	Yes	No	Left	Right	Both
Aching/ Pain?					
Heaviness?					
Tiredness/Fatigue?					
Itching/Burning?					
Swollen Ankles?					
Leg Cramps?					
Restless Legs?					
Throbbing?					
Other?					

2. Have your symptoms 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 do you take and how many time/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. What kind of exercise? _____ 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, who prescribed the compression stockings, and when were they prescribed? ___________
7. Do you wear support hose (i.e., Sheer Energy)? __ Yes __No Do they provide relief? __Yes__ No
8. Do you have any problems walking? __ Yes __No If yes, describe how it interferes with your activities of daily living, which activities? _______________________________________
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 interfering with your essential job functions of your specific occupation, which activities? _____________________
   ____
10. Have you ever had any tests done on your veins? __Yes __No If yes, which leg(s) ____ which tests? ____
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? ____
13. Other health concerns:

____ hypertension | ____Congestive heart failure | ____clotting disorders
____Myocardial infarction | ____Peripheral vascular disease | ____ breathing difficulties
____ cirrhosis | ____ Kidney dysfunction | ____ diabetes mellitus

Do you smoke? ______ PPD ______

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 you please with the care you are receiving? __ Yes __ No

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 Lowers (full, partial)
__ Glasses or contact __ 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/min
__ Bi-PAP/ C-PAP __ Other:______________________

Advanced Directives – *Please Bring with you*	Yes	No	Explanation
Durable Power of Attorney			
Health Care Representative			
Do Not Resuscitate Document			
Living Will			
Life-Prolonging Procedures			
Do you have any of the above documentation?			
Where is the COPY of the document?			

_________________________________ ____________________ _________________
Questionnaire completed by Relationship Date

Consent to Photograph for Communication with Insurance Company

Patient Name: ____________________________ Date: _________________________

The undersigned authorizes the veins centers of Texas 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 the Vein Centers of Texas 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 Guardian' Signature if patient is under 18: ________________________________
Witness' Signature: ______________________________________ Date: ____________

I, _______________________________have read and understand the HIPAA Notice of Privacy Practices of Dr. Charles J. Rodman's office.

____ 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 Dr. Charles J. Rodman to discuss my medical history/condition with the following person(s):

Name: _______________________________ ____ Limited Time
_______________________________ ____Until rescinded
____

Patient Signature: __________________________________ Date: __________________

Patient Payment Policy

Thank you for choosing Vein Centers of Texas! 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, Discover and Care Credit.

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 it sent over via fax 409-832-4881 Attn: Billing. <u>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.</u>

What is my Responsibilities for Services?

- <u>If services you receive are covered by your insurance plan:</u> You will be responsible for all applicable co-pays, deductible & out of pocket amounts at time of service.
- <u>If services your receive are not covered by your insurance plan:</u> You will be responsible for full payment at time of service.

Our practice bases your costs off of 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 VNUS Closures (CPT codes 36475, 36476, 36471) all done in the specialist's office.

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

<u>Vein Centers of Texas will not be held responsible for any misquotes in benefits.</u>

VNUS Closure Surgery in the office:

If your physician recommends surgery an inner office referral will be created and sent on to the Surgery Coordinator. When the surgery coordinator receives the inner office referral a request for predetermination / preauthorization will be sent in to your insurance company with all required documentation. You will not be scheduled for your surgeries until this process is done and it may take up to 30 days to get a predetermination from your insurance. Once our office receives the predetermination / preauthorization from your insurance an Estimated Surgical Cost Analysis will be generated and mailed to you with the amount you will owe for your procedure(s). Once this is done then the surgery scheduler will contact you to schedule your 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 route you to the appropriate department.

The Estimated Surgical Cost Analysis is done as a courtesy to you and will show you your estimated financial responsibilities, based on the benefit levels and coverage of 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 minors, 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 charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to Charles J Rodman, MD PA.

I authorize Charles J Rodman MD PA to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

__________	______________________________	________________________
Date	**Signature**	**Printed Name**