VEIN & SURGERY CENTER

Name (Last, First, Middle)		Soc. Sec. Number	Birth Date	Sex
Local Address		City State Zip		
Secondary/ Billing Address - (If Applicable)		City State Zip		
Home Phone	Cell Phone	Email		
Race/Ethnicity	Languages	Work Phone	Occupation	
Employer Name (□Retired/□Disabled/□None)		Employer Address City State Zip		
Referred By? □Physician↓ □Self-Referred→		How did you hear about TVS?		
Referring Physician - Name & Specialty:		Office Address City State Zip		
Emergency Contact Name	Relationship	Best Contact Phone	Email	

Responsible Party Information - (Please complete if different than patient information above)

Name (Last, First, Middle)		Soc.Sec.Number	Birth Date	Sex
Local Address		City State Zip		
Secondary/ Billing Address - (If Applicable)		City State Zip		
Home Phone	Work Phone	Relationship to Patient: □Self □Spouse □Parent □Guardian □Other		

ASSIGNMENT AND RELEASE: I hereby authorize payment directly to Ganesh Ramaswami, M.D. for all insurance benefits otherwise payable to me for service rendered. I understand that I am financially responsible for all charges, whether or not paid by insurances, and for all services rendered on my behalf or my dependents. I authorize any provider and/or supplier of services in this office to release any information required in securing the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand I will be subjected to a $30 service fee if my check is returned unpaid or if 24 hrs prior to my scheduled appointment. I fail to notify the office I will not be keeping my scheduled appointment.

Signature:____Date:____

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PATIENT MEDICAL INFORMATION

Date _________________

Patient Name: ________________________Birthdate: ___________ Age: ______

Chief complaint/reason for visit: ____

Date of first symptoms (required by insurance): _______________________________________

Symptoms: Describe ____

Family History: Varicose Veins? No Yes (please circle one)

Other Cardiac Conditions? ____

Medications – include dosage
1.____
2.____
3.____
4.____
5.____
6.____
7.____
8.____

Allergies – include reaction
Latex allergy: No Yes
____
____
____
____
____

Over the counter medications/supplements: ____________________________________

Bleeding/Clotting History

DVT/Blood clot _________When_______________

Aspirin Daily	☐No		☐Yes	
Plavix	☐No		☐Yes	
Coumadin	☐No		☐Yes	
Do you smoke?	☐No	☐Yes	# Per Day	Years	Date Quit
Alcohol use	☐No	☐Yes	☐Occasionally	☐Daily
Employed	☐No	☐Yes	Retired job	Years

Previous surgeries: ____
____

Other hospitalizations: ____
____

TVS Staff ONLY – Reviewed By (initial): RN: ________ Physician: _______

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	NO	YES	Comment		NO	YES	Comment
Arthritis				Asthma			
Cancer				Hypertension			
Diabetes				Depression/Anxiety			
Stroke				COPD			
STDs				Bleeding Disorder			
Ulcers				Other			

Heart Disease: Atrial fibrillation CAD Stents _______________________________________

History of MI / Heart Attack: When: _____________________________ Other: _________________________

Pregnant? No Yes Children: ___________________________ Ages: __________________________

Height: __________ Weight: ___________

Your Referring Physician:

_______________________________ ____ _________________

Doctors Name Address Phone

Your Primary Physician:

_______________________________ ____ _________________

Doctors Name Address Phone

Others Physicians Involved In Your Care:

_______________________________ ____ _________________

Doctors Name Address Phone

_______________________________ ____ _________________

Doctors Name Address Phone

Pharmacy Preference:

_______________________________ ____ _________________

Pharmacy Name Address Phone/Fax

Patient Signature:____ **Date**:______________________________

TVS Staff ONLY – Reviewed By (initial): RN: ________ Physician: _______

VEIN & SURGERY CENTER

NOTICE OF PATIENT PRIVACY AND HIPAA FORM

Taylor Vein Solutions and Ganesh Ramaswami, M.D., P.C. is not in any way affiliated with VeinSolutions, LLC of Carmel, IN.

This policy describes how medical information can be used and disclosed. It also explains how you can get access to this information. Please review carefully.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

Without your consent, we may use your health information:
To obtain payment for your treatment
To continue or coordinate your treatment
For Administrative purposes such as evaluation/quality of care

Subject to certain requirements, we may give out health information without your authorization for public health purpose, abuse and neglect reporting, health planning, auditing purposes, research studies, funeral arrangement and organ donation, worker compensation purposes and emergencies. We may provide information required by law, such as for law enforcement in specific circumstances, In any other situation, we will ask for your written authorization or require a written authorization from any other entity requesting your medical records and/or personal health We may use or disclose identifiable health information about you without your authorization for several other reasons. Information i.e. Record copy services, attorneys etc. You may later revoke any signed written authorization form and stop any future uses and disclosure.

INDIVIDUAL RIGHTS

In most cases, you have the right to look at or obtain a copy of your medical records and/or personal health information our office has pertaining to you. If you request records, our office has a three day waiting period for these records to be produced. These records are to be picked up at our office. We will not mail them to your home or another address since this information is personal in nature. You also have the right to receive a list of instances where we have disclosed health information about you for any reason.

You may request in writing, for us not to use or disclose your information for any reason except when specifically authorized by you, when required by law or in emergency circumstances. We will consider your request but are not legally required to accept it.

OUR LEGAL DUTY

We are required by law to protect the privacy of your medical information, provide this notice about our information practices and follow them as described in this notice. All employees of Ganesh Ramaswami, M.D.P.C are fully trained on this policy and the confidentiality practices of our office. If you have further concern or questions regarding this notice please ask to speak to the office manager.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised Notice effective for the health information we already have about you as well as any information we receive in the future. Our office will always have a copy of this NOTICE posted in our office for your review.

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Communication Preferences and Message Consent:

Patient Authorization to Receive Communications by Alternative Means

Patient Name:____________________________ **DOB**:__________________________

The HIPAA Privacy Law gives patients the right to request and receive provider communications that may contain their protected health information (PHI) through alternative methods or locations. The law also allows TVS to send communications to patients about appointments, treatment and healthcare operations, and the products and services we offer. The ability to communicate with patients and coordinate their care is important to their overall health care experience and outcome success.

To support your rights and ensure TVS can contact you, please define your communication and message preferences using this form.

Directions:

Please circle either "Yes" or "No" to the questions below and provide the requested contact numbers and information to inform TVS how best to communicate with you.

Yes / No 1. You may call my **home phone** (______-_______-_________) and leave a voice message.

Yes / No 2. You may leave a **message with anyone** answering my **home phone**

Yes / No 3. You may call and leave a message on my **cell phone** (_______-_______-___________)

Yes / No 4. You may send **text messages** to my **cell phone**

Yes / No 5. You may leave a message on my **work voice mail** (______-_______-_________)

Yes / No 6. You may send email to my **email address____________________________________**

Yes / No 7. Please direct written communications to my **home address**. (If No, please define address below):

Alternative Address: □ Other Residence □ Work □ Other:______________________________________

____

Patient Communication Consent:
By my signature below, I give express written consent and authorize TVS to contact me using the alternative methods listed above, and I will hold TVS harmless from any liability that may arise from the release of information. I understand it is my responsibility to notify TVS in writing of any changes in my contact preferences indicated above. I also understand that I may 'opt-out' of any communication(s) at any time, and that the consent will remain enforce unless otherwise revoked in writing by me and submitted to TVS.

_______________________________________ _________________
Signature of Patient or Guardian Date

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Patient Consent, Assignment of Benefits and Acknowledgement Form

Patient Name: ______________________________________ DOB: ______________________

Consent for Treatment

I hereby authorize Taylor Vein Solutions, through its appropriate personnel, to perform or have performed upon me appropriate assessment and treatment procedures. I hereby agree and give my consent to the providers/staff of TVS to order, prescribe and provide diagnostic medical and surgical treatment to me that they judge is appropriate in diagnosing and/or treating my medical condition(s)
Patient/Guarantor Signature ___________________________Date ___________________________

Assignment of Insurance Benefits & Financial Agreement

The following is our Financial Policy, which will help you with your concerns regarding our billing and payment procedures. Payment for services is due at the time service is rendered. We accept cash, checks, money orders, debit cards, MasterCard, Visa and Discover. We will submit an insurance claim on your behalf. If your carrier is not contracted with our practice, we will courtesy bill them with the understanding that whatever the insurance does not pay; the balance is then your responsibility to pay within 30 days of your first billing statement. **IF YOU HAVE A CO-PAY, IT WILL BE COLLECTED AT THE TIME OF SERVICE.** You are responsible for knowing your insurance/auto/work comp benefits. What are covered services in your plan? Does your insurance require a Primary Care Physician (PCP) referral? Does your physician participate in the plan? If you are an HMO member, you are responsible for KNOWING your PCP and/or carrier. Patients are responsible for deductible balances, co-insurance and non-covered amounts at the time of service**.** Any billed balances are due within 30 days of the statement date. .

Remember that insurance authorizations/referrals for services do NOT guarantee payment. If your insurance does not pay in full within 60 days, we ask that you contact them as charges will then be transferred to you. We require you to pay the balance due even though your insurance carrier may eventually process your claim. A refund will then be mailed to you. Interest on past due balances will accrue at a rate of 1.5% monthly. There will be a $30.00 fee for all returned check items. Should your account become delinquent and be referred to a collection agency, you shall be financially responsible for the costs of collection and/or legal fees. Collection costs are calculated by adding to the principle the greater of $25 or an amount 35% in excess of the balance owed.

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment. I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care. The Practice will notify you in writing, via certified mail, if you are discharged from care. I have read and understand the above information, and I agree to the terms described:
Patient/Guarantor Signature ___________________________ Date ___________________________

I request that payment of authorized Medicare/or any third party benefits be made to the Ganesh Ramaswami, M.D, P.C on my behalf for any services rendered to me. I authorize any holder of medical information about me to release to the Center for Medicare/Medicaid Services and its agents or any third party payor any information to determine these benefits or the benefits payable for related service.

In the event that you are unable to meet your payment obligation, we will be happy to enter into a payment plan with you.

____________________________________ ____________________________________
Printed Name of Patient/Responsible Party Signature of Patient/Responsible Party

____ ______________________________
Patient Date of Birth Date

VEIN & SURGERY CENTER

Tobacco Usage Form

Name: ______________________________ **Date**: ______________________________

Are you a:

- ☐ current smoker
- ☐ former smoker
- ☐ nonsmoker
- ☐ light tobacco smoker
- ☐ heavy tobacco smoker

If 'current smoker': How often do you smoke cigarettes?

- ☐ every day
- ☐ some days, but not every day

If 'current smoker': How many cigarettes a day do you smoke?

- ☐ 5 or less
- ☐ 6-10
- ☐ 11-20
- ☐ 21-30
- ☐ 31 or more

If 'current smoker': How soon after you wake up do you smoke your first cigarette?

- ☐ within 5 minutes
- ☐ 6-30 minutes
- ☐ 31-60 minutes
- ☐ after 60 minutes

If 'current smoker': Are you interested in quitting?

- ☐ Ready to quit
- ☐ Thinking about quitting
- ☐ Not ready to quit

If 'nonsmoker', select all that apply:

- ☐ Aggressive non-smoker
- ☐ Current non-smoker
- ☐ Current non-smoker, but past smoking history unknown
- ☐ Does not use moist powdered tobacco
- ☐ Ex-cigar smoker
- ☐ Ex-cigarette smoker
- ☐ Ex-cigarette smoker amount unknown
- ☐ Ex-heavy cigarette smoker (20-30/day)
- ☐ Ex-light cigarette smoker (1-9/day)
- ☐ Ex-moderate cigarette smoker (10-19/day)
- ☐ Ex-pipe smoker
- ☐ Ex-trivial cigarette smoker (<1/day)
- ☐ Ex-user of moist powdered tobacco
- ☐ Ex-very heavy cigarette smoker (40+/day)
- ☐ Intolerant ex-smoker
- ☐ Intolerant non-smoker
- ☐ Never chewed tobacco
- ☐ Never used moist powdered tobacco
- ☐ Non-smoker for medical reasons
- ☐ Non-smoker for personal reasons
- ☐ Non-smoker for religious reasons
- ☐ Tolerant ex-smoker
- ☐ Tolerant non-smoker

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Alcohol Usage Form

Name: ________________________________

Gender: ______________________________

Date: ________________________________

Did you have a drink containing alcohol in the past year?

- ☐ Yes
- ☐ No

If 'Yes': How often did you have a drink containing alcohol in the past year?

- ☐ Never
- ☐ Monthly or less
- ☐ 2 to 4 times a month
- ☐ 2 to 3 times a week
- ☐ 4 or more times a week

If 'Yes': How many drinks did you have on a typical day when you were drinking in the past year?

- ☐ 1 or 2 drinks
- ☐ 3 or 4 drinks
- ☐ 5 or 6 drinks
- ☐ 7 to 9 drinks
- ☐ 10 or more drinks

If 'Yes': How often did you have 6 or more drinks on one occasion in the past year?

- ☐ Never
- ☐ Less than monthly
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

Media Consent

I hereby give my permission to **Taylor Vein Solutions** for use of photographs and videos taken of my procedures while in the office. I authorize them to use the aforementioned pictures and videos in print, online and video-based marketing materials as well as all other means of publication.

I release **Taylor Vein Solutions** from any reasonable expectation of privacy or confidentiality associated with the images specified above. I agree that my name and likeness will not be mentioned in any marketing materials going forward.

I acknowledge that my participation is voluntary and that I will not receive financial compensation of any type. I acknowledge and agree that publication of said photos confers no rights of ownership or royalties whatsoever.

Authorization

Patient Name:____

Signature:____

Date:____

Witness:____