# 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: _____*

# VEIN & SURGERY CENTER

| | 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: _____

# 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.

# 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 provide the requested contact numbers and information to inform TVS how best to communicate with you. Please circle either "Yes" or "No" regarding email communication preference.

Home phone: (_____-_____-_____)

Cell phone: (_____-_____-_____)

You may send email to my email address: _____ Yes / No (circle one)

Are you okay receiving mail at your home address: Yes / No

_____

**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

# Patient Consent, Assignment of Benefits and Cancellation Policy 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).

## 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.

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

(continued on next page)

**Cancellation / No Show Policy**

**No-show and Same Day Cancellation Policy for Patients at Taylor Vein Solutions**
Here at Taylor Vein Solutions, we enforce policies regarding no-shows and same day cancellations to ensure efficient and quality health care for our patients. No-shows and same day cancellations increase wait time for our patients who are at the office and need to be seen. All fees are subject to physician/manager. In order to avoid a fee, we require at least *24-hour notice* for all appointment changes or cancellations and *7 days' notice* per procedure.

**No-Show/Less than 24 Hour Cancellation Policy:**

- **1st Occurrence:** You will be forgiven with no charge.

- **2nd Occurrence:** You will be assessed a fee of twenty-five dollars ($25.00) for an office visit and seventy-five ($75) for procedure. This is also a warning that upon your third missed appointment it is subject for approval to schedule any further appointments.

- **3rd Occurrence:** You are now subject for approval to schedule any future appointments and assess a fee of twenty-five dollars ($25.00) per office visit and or seventy-five ($75) for procedure.

- Any fees accrued are due prior to scheduling your next appointment, or when you receive your statement.

Taylor Vein Solutions firmly believes that a good physician/patient relationship is based upon understanding and good communication. If you have any questions, we are here to help you.

By signing below, you agree to the terms of this policy and acknowledge that you have received a copy if requested.

**I have read and understand the above information pertaining to the Consent for Treatment, Assignment of Insurance Benefits & Financial Agreement, and Cancellation/No Show Policy, and I agree to the terms described above.**

_____ _____

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

_____

Patient Date of Birth Date

# 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:_____

# 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

# Alcohol Usage Form

**Name**: _____

**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