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 #( ) _____-_____

Emergency Contact: _____ Home #( )_____-_____
Relationship_____

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

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

ADVANCE CARE DIRECTIVE

Do you have an Advance Care Directive? Y N
Does the Advance Care Directive indicate "Do Not Resuscitate"? Y N
Have you chosen a surrogate decision maker? Y N Name:_____
****Please supply our office with your advance care directive if you would like us to have this on file****

INSURANCE AUTHORIZATION AND 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 fees, collection agencies, and interest.

_____ _____ ***Signature***
Signature Date

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

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 __ Inflammatory Bowel Disease
___ Brain tumors ___ Heart disease ___ Thyroid Disease ___ Parathyroid disease ___ Other _____

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? _____

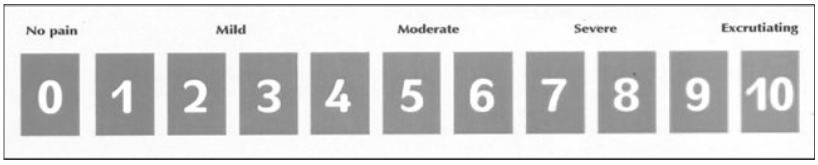
Family History

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 leg / 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



Rate the intensity of pain_____ Persistent? ☐ Yes ☐ No

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

☐ Yes ☐ No

3. Do you take any medication for pain (i.e., Advil, Motrin)
   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 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 excellent medical care to our patients and the community. We bill all insurances as a courtesy to our patients. You, the patient or responsible party, may 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.*** We will allow a reasonable amount of time for claim processing; (**no longer than 90 days**), once this time has passed, payment will be expected from the patient.

Referrals and Prior Authorizations: If your insurance requires a 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 pay for your visit at time of service.** It is the responsibility of the patient and/or responsible party to maintain these referrals.

Co-pays, Co-Insurance, and Deductibles: Co-pay, co-insurance, and deductible amounts are determined by your individual contract with the insurance company you have chosen, and are due at the time of service. We will contact your insurance provider for you prior to each visit in order to obtain an estimated amount you will owe based on expected services. This amount will be collected prior to each visit. After the completed exam or procedure is billed to the insurance, any additional charges to the patient will be itemized in the explanation of benefits mailed to you by your insurance.

Refunds: Occasionally an overpayment is made, and a refund is due to the patient. This refund will be made if the credit amount is one dollar or more and there are no outstanding insurance claims and no outstanding patient balances on the account. If a refund is due to insurance, the insurance company is notified and our office proceeds as instructed in returning overpayments. If an account has a credit balance owed to insurance, this will not change the amount due from the patient for the "patient responsibility" portion of the bill.

Unpaid Charges: Additional amounts owed by the patient, as determined by the insurance provider after a claim is processed, will be billed in a statement provided to the patient. Unpaid balances will be subject to a $10 statement preparation and mailing fee for each additional statement mailed 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 an account is turned over to the collection agency. In addition, an interest charge of 6% per year from the time of the service will be added to the total balance to be collected by the collection agency.* We require that past accounts be satisfied prior to agreeing to treat any patient for a new problem, even if this balance has been "written off" of our books due to exhaustion of collection efforts.

Self Pays: We offer discounted fees and payment plans on most surgical services as a courtesy to our self-pay patients. A down payment is required before all elective surgeries. Evaluation and Management, or office visit fees, are predetermined and are due at time of service.

Miscellaneous Fees:

Returned Checks: $35
Family Medical Leave Act, Complete Medical Records Printed, and Disability Paperwork: $25
Missed Office Visit Appointments (without minimum 24 business hours prior notification): $25
Missed Surgical/Procedure Appointments (without minimum 72 business hours notification): $75

Workman's Compensation:

We will provide treatment for work related injuries ***only, if they are emergencies.*** If Dr. Hamilton is called out to the hospital for a trauma and it is a workman's compensation patient, then we are obligated to take care of that patient. We do require all appropriate paperwork and authorizations needed to process our claims and without the required information and authorizations, the patient will be treated as a self-pay patient. Once we are provided with all necessary information to process the claim, we will refund their money.

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

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

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:_____