VERO VASCULAR SURGERY, P.A.

W. Clark Beckett, M.D., F.A.C.S.

Board Certified Vascular Surgeon

3770 7th Terrace, Suite 101 * Vero Beach, Florida 32960 * 772.567.6602 * Fax 772.567.7754

DATE:_____

SECTION A: PATIENT INFORMATION AGE_____

NAME: LAST_____FIRST_____INITIAL_____

MAILING ADDRESS_____

CITY_____STATE_____ZIP CODE_____

HOME PHONE_____CELL PHONE_____DATE OF BIRTH_____

SECONDARY ADDRESS_____

CITY_____ ST_____ZIP_____PHONE_____

PATIENT SOCIAL SECURITY #_____MARITAL STATUS_____

PERSON RESPONSIBLE FOR BILL_____REFERRED BY_____

EMPLOYER_____OCCUPATION_____

STREET ADDRESS_____CITY_____ST_____ZIP_____

PHONE #_____

PATIENT EMAIL:_____ (TO ACCESS PATIENT PORTAL)

SECTION B: SPOUSE INFORMATION

NAME_____DATE OF BIRTH_____SOC.SEC.#_____

EMPLOYER_____OCCUPATION_____

STREET ADDRESS_____CITY_____ST_____ZIP_____

HOME PHONE_____CELL PHONE_____

SECTION C: IN CASE OF EMERGENCY, PLEASE NOTIFY:

NAME_____RELATIONSHIP_____PHONE_____

NAME_____RELATIONSHIP_____PHONE_____

How did you hear about us? (Circle one) Friend Press Journal Physician VB Magazine

Other_____

SECTION E: **PLEASE BRING YOUR PHOTO ID & INSURANCE CARDS**

PRIMARY INSURANCE	**SECONDARY INSURANCE**
INS.CO.NAME_____	INS.CO.NAME_____
ID#_____GROUP#_____	ID#_____GROUP#_____

We request the following information to better treat medical conditions which may be related to these items and to ensure communication is clear. Please take a moment to answer each of these.

1. Race: _____

2. Ethnicity: (Circle one) Hispanic or Non-Hispanic Or Other_____

3. Preferred Language: _____

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AUTHORIZATION FOR PAYMENT AND/ OR INSURANCE BENEFITS

Patient's Name_____DOB_____

SELF PAY:

I understand that I will be ultimately responsible for any unpaid balance after medical/surgery services and will not hold Vero Vascular Surgery, PA responsible.

Patient/Guardian's Signature_____Date_____

NON MEDICARE:

I hereby assign to Vero Vascular Surgery, PA the medical/surgical benefits to which I or my dependents are entitled under my health insurance plan. I understand that I will be responsible for all unpaid balance, and will not hold Vero Vascular, PA responsible if the insurance benefits are denied for any reason.

Patient/Guardian's Signature_____Date_____

TRADITIONAL MEDICARE:

I certify that the information given in applying for payment under Title XVIII, of the Social Security Act is correct. I request payment of authorized Medicare benefits be made either to me or on my behalf to Vero Vascular Surgery, PA or individually to any physician provider or its staff for any services furnished me by that organization or physician. I authorize the holder of medical/surgical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that I will be responsible for all unpaid balance, and will not hold Vero Vascular, PA responsible if the insurance benefits are denied for any reason.

Patient/Guardian's Signature_____Date_____

MEDICARE ADVANTAGE PLANS:

Insurance plans that work as a replacement for Medicare have co-pays, deductibles and co-insurances that may differ from Traditional Medicare. We are not contracted with most advantage plans. This means that we are considered out-of-network and therefore you may be responsible for a higher deductible, co-insurance or co-pays as applied by your insurance carrier. By signing this you acknowledge that you are aware of these differences are in agreement to adhere to the terms of you your insurance carrier. Regardless of the contract status, we will still see you as a patient and file insurance as a courtesy.

Patient/Guardian's Signature_____Date_____

MEDIGAP:

I request that payment of authorized MEDIGAP benefits be made on my behalf to Vero Vascular Surgery, PA for any services furnished me by the employees of Vero Vascular Surgery, PA to authorized any holder of medical/surgical information about me to release to my MEDIGAP insurer any information needed to determine these benefits or the benefits payable for related services. I understand that I will be responsible for any unpaid balance, and will not hold Vero Vascular, PA responsible if the insurance benefits are denied for any reason.

Patient/Guardian's Signature_____Date_____

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PATIENT HISTORY FORM

Name_____**D.O.B.**_____

Date of visit_____ **Telephone (H)** _____**(C)** _____**Age**_____

Referring Physician_____**Height**_____**Weight**_____

Other Physicians_____

Chief Complaint_____

_____

Prior Vein Treatment No_____**Yes**_____**Explain**_____

(Nurse will record BP) Blood Pressure Left_____ **Right**_____ **Pulse**_____

PERSONAL HABITS:

1. Tobacco Use: No_____**Yes**_____**How Much**_____**Quit**_____**How Long Ago**_____

2. Alcohol Use: No_____**Yes**_____**How Much**_____**Quit**_____**How Long Ago**_____

3. Caffeine Use: No_____**Yes**_____**How Much**_____**Quit**_____**How Long Ago**_____

4. Exercise Program: No_____ **Yes**_____ **Describe:** _____

5. Nursing Mother: No_____ **Yes**_____

FAMILY HISTORY:

Any history of varicose veins or venous disorder in your family? Yes or No (circle one)

_____

GENERAL INFORMATION:

1. Allergies: _____

2. Current Medications: **Please include dosage and instructions for taking your medications**

_____ _____

_____ _____

_____ _____

_____ _____

3. Surgeries: (Include Dates)

_____

_____

(Nurse will record) Stocking Size: _____**Ankle** _____**Calf** _____**Thigh** _____**Length** _____

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MEDICAL HISTORY: (Please check all that apply)

GENERAL:	**Yes**	**No**
Headaches	____	____
Dizziness	____	____
Blurred/Double Vision	____	____
Cataracts	____	____
Dentures	____	____

NEUROLOGICAL:		
Seizures	____	____
Paralysis	____	____
Tremors	____	____
TIA's	____	____
Stroke	____	____
Parkinson's	____	____
Alzheimer's	____	____

CARDIOVASCULAR:		
Chest Pain	____	____
Murmur	____	____
High Blood Pressure	____	____
High Cholesterol	____	____
Irregular Heart Beat	____	____
Congestive Heart Failure	____	____
Heart Attack	____	____
Pacemaker	____	____

PVS:		
Varicose Veins	____	____
Spider Veins	____	____
Leg Pain-----at rest	____	____
Walking	____	____
Deep Vein Clot	____	____
Superficial Phlebitis	____	____

RESPIRATORY:	**Yes**	**No**
Difficulty Breathing	____	____
Chronic Cough	____	____
Asthma	____	____
Emphysema	____	____

DIGESTIVE:		
Heart Burn	____	____
Nausea/Vomiting	____	____
Constipation	____	____
Ulcer Disease	____	____

KIDNEY/BLADDER:		
Frequent Urination	____	____
Incontinence	____	____
Difficulty Urination	____	____
Kidney Disease	____	____

MUSCLES/BONES/JOINTS:		
Back Pain	____	____
Muscle Weakness	____	____
Arthritis	____	____
Osteoporosis	____	____

HEMAT/LYMPH/IMMUNO:		
Anemia	____	____
Bleeding Tendency	____	____
Hepatitis, Type_____	____	____
Cancer, Type_____	____	____
Peripheral Neuropathy	____	____
Liver Disease	____	____
Diabetes, Type _____	____	____

Do you have any other Health care concerns not mentioned previously_____

_____

_____

Patient Name: _____ **DOB:**_____

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MEDICATION ACCESS AUTHORIZATION

□ **I authorize VVS to obtain/download medication information from my pharmacy.**

□ **DO NOT authorize VVS to obtain/download medication information from my pharmacy. I acknowledge by choosing this option, I may be limiting my quality of care.**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1966, in order for your physician or the staff of **Vero Vascular Surgery, PA (VVS)** to give copies of and/or discuss your condition, exams, procedures, x-rays with members of your family or other individuals that you designate other that your primary care doctor or specialist, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

□ **I DO NOT authorize VVS to release any information concerning my care to any individual.**

□ **I authorize VVS to release any/all information including verbal information, copies of x-rays, and medical paperwork concerning my medical care to the following individuals.**

Name: _____Relationship: _____Phone#: _____
Name: _____Relationship: _____Phone#: _____

AUTHORIZATION TO DISCUSS FINANCIAL INFORMATION

In accordance with federal government privacy implemented through the Health Insurance Portability and Accountability Act of 1966, we must obtain your authorization to discuss financial information with members of your family or other individuals that you designate other than insurance companies or third party payers and their agents.

□ **I DO NOT authorize VVS to release any information concerning my care to any individual.**

□ **I authorize VVS to release to discuss financial information with financial information with the following individuals.**

Name: _____Relationship: _____Phone#: _____
Name: _____Relationship: _____Phone#: _____

AUTHORIZATION TO LEAVE PHONE MESSAGE

□ **I authorize VVS to leave detailed messages at □Home phone □Cell phone**

□ **I DO NOT authorize VVS leave a detailed message on my answering machine or voicemail. I acknowledge in choosing this option that I, the patient/Guardian, assume full responsibility for contacting VVS regarding any/all testing results.**

E-MAIL AUTHORIZTAION

Please provide your email address if you would like to receive healthcare updates and information from VVS. VVS will not share or sell your e-mail.

_____ @ _____ . _____

RECEIPT OF HIPAA PRIVACY NOTICE

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how VVS may use and disclose my protected health information. I understand that VVS reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

Print Patient Name: _____DOB: _____/_____/_____

Signature of Patient/Guardian: _____Date: _____/_____/_____