VASCARE®

East Texas Surgical Associates, PA
Llewellyn Lee, MD
Jennifer Mike-Mayer, MD, FACS

Patient Demographics

PATIENT INFORMATION:

Patient Name: _____ **SS#** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Date of Birth: ___/___/_____ Sex**:** □Male □Female **Marital Status:** □Married □Single □Divorced □Widowed

Race: □American Indian or Alaskan Native, □Asian, □Black or African American, □Caucasian, □Chinese, □Filipino, □Hispanic, □Japanese, □Multi-racial, □Native, □Hawaiian, □Pacific Islander, □Other, □Undetermined, □Pt Declines

Language: □English, □French, □German, □Japanese, □Korean, □Latin, □Spanish, □Vietnamese, □Patient Declines

Ethnicity: □Hispanic or Latino, □Not Hispanic or Latino, □Patient Declines to State

Employer (if applicable): _____ **Occupation:** _____

Employment Status: □Full-time, □Part-time, □Housewife, □Unemployed, □Retired

Student Status: □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 Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Emergency Contact: (someone not in your household)

Name: _____ **Relation:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

INSURANCE INFORMATION:

Primary Insurance Name: _____

Policy #: _____ **Group:** _____

Name of Insured: _____ **Date of Birth of Insured:** ____/____/_____

Secondary Insurance Name: _____

Policy #: _____ **Group:** _____

Please Give Insurance Card(s) and Driver License to Front Desk

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Health Assessment and History

Name: _____ **Date:** ____/____/_____
DOB: _____/_____/_____ **Age:** _____ **Sex:** _____ **Height**_____ **Weight**_____

REASON FOR TODAY'S VISIT (PLEASE BE SPECIFIC):

_____

_____

Primary Care Physician: _____ Phone: _____
Home Health Agency: _____ Phone: _____
Pharmacy: _____ Phone: _____

CURRENT MEDICAL CONDITIONS: (example: High blood pressure, Diabetes)

Illness / Condition	Date	Illness / Condition	Date

SURGICAL HISTORY: (example: Hysterectomy, Appendectomy, Stent, Angiogram?)

Surgery	Date	Surgery	Date

HOSPITALIZATIONS: (Have you ever had a serious illness requiring a hospital stay other than surgery?)

Reason	Year	Hospital	Reason	Year	Hospital

Current Medications: (Please list prescriptions, over the counter, vitamins, herbs, etc.)

Medication	Dose	How Often	Medication	Dose	How often

Allergies: Are you allergic to any medications, food, environmental, IODINE, SHELLFISH, LATEX or other substances? Please specify allergy and reaction

□ No Known Allergies

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Allergy	Reaction

Allergy	Reaction

Patient:_____

Have you, or a blood relative, had a reaction to anesthetic? □Yes □No
If yes, please explain: _____

Social History:

Occupation: _____

(please check one) □ Full-time, □ Part-time, □ Retired, □ Homemaker, □ Unemployed, □ Disabled

Patient Name: _____ **DOB:** ____/____/_____

Alcohol Use Screening:

□ No	□ Yes
	How often did you have a drink containing alcohol in the past year? □ Monthly or less □ 2-4 times a month □ 2-3 times a week □ 4 or more times a week
	How many drinks did you have on a typical day when you were drinking in the past year? □ 1 or 2 □ 3 or 4 □ 5 or 6 □ 7 to 9 □ 10 or more
	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

Tobacco Use Screening:

□Nonsmoker	□ Former Smoker	□ Current Smoker
	How long has been since you last smoked? □ 1-3 months □ 3-6 months □ 6-12 months □ 1-5 years □ 5-10 years □ > 10 years	How often do you smoke cigarettes? □ everyday □ some days
		How many cigarettes a day do you smoke? □ 5 or less □ 6-10 □ 11-20 □ 21-30 □ 31 or more
		soon after you wake up do you smoke your first cigarette? □ within 5 minutes □ 6-30 minutes □ 31-60 minutes □ after 60 minutes
		Are you interested in quitting? □ Ready to quit □ Thinking about quitting □ Not ready to quit

Family History: Relationship (Mother / Father / Brother / etc.)

□ Diabetes: _____ □ Aneurysms: _____ □ Varicose veins: _____

□ Hypertension: _____ □ Bleeding problems: _____ □ Leg swelling: _____

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□ Heart Attack: _____ □ DVT (Blood Clots): _____ □ Cancer: _____

□ Stroke / TIA: _____ □ Lupus: _____ □ Other: _____

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Patient:_____

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		
Infectious Disease	**Yes**	**No**
HIV/AIDS		
Speech/Hearing	**Yes**	**No**
Language Problem		
Voice Problem		
Ringing in Ears		
Frequent Ear Inf.		
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		

Respiratory	Yes	No
Asthma		
Wheezing		
Shortness of Breath		
TB – History		
Emphysema		
Collapsed Lung		
Cardiovascular	**Yes**	**No**
Chest Pain		
Shortness of Breath		
Pacemaker		
Congestive Heart Failure		
Angina		
Heart Attack		
Bleeding Disorders		
Blood Clots (DVT/PE)		
Phlebitis		
Peripheral Vascular Disease		
Blood Transfusions		
Gastrointestinal	**Yes**	**No**
Abdominal Pain		
Diverticular Disease		
Blood in Stools		
Frequent Diarrhea		
Frequent Constipation		
Heartburn / Indigestion		
Nausea / Vomiting		
Special Diet		
Recent Weight Loss Amount of Loss?		
Musculoskeletal	**Yes**	**No**
Arthritis		
Muscle Disease		
Physical limitation Cane/Walker Wheelchair/ Prosthesis Amputations/ Shoe Inserts		
Skin	**Yes**	**No**
Change in skin color		

Neurological	Yes	No
Numbness / Tingling		
Paralysis		
Weakness		
Loss of Memory		
Seizures		
CVA / Stroke		
Headaches		
Pain	**Yes**	**No**
Having Pain?		
What Relieves It?		

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

Occupation:

Last Flu Shot:

Last Pneumonia Vaccination:

Would you like for us to send your reports to your specialists?

Please List your Specialists:

Cardiologist(heart):
Neurologist(nerve):
Hematologist(blood):
Rheumatologist(arthritis):
Podiatrist(foot):

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Wounds		
Bruises		
Lesions		
Rash		

Dermatologist(skin):
Endocrinologist(hormone):
Pulmonologist(lung):
Pain Specialist:
Wound Care:

Venous Health History

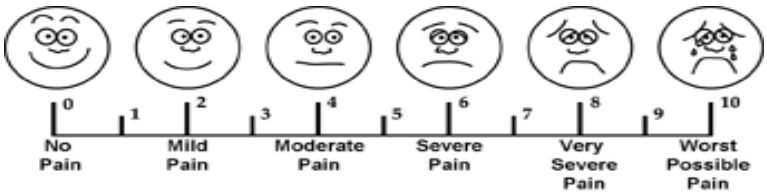
Patient Name: _____ **DOB:** ____/____/_____

Do You have any symptoms? Be specific, your insurance requires this information for approval!

	Left	Right	Comments (optional)
Aching / Pain	☐	☐	
Heaviness	☐	☐	
Tiredness / Fatigue	☐	☐	
Itching / Burning	☐	☐	
Swollen Ankles	☐	☐	
Leg Cramps	☐	☐	
Restless Legs	☐	☐	
Throbbing	☐	☐	
Other	☐	☐	

Activities Affected: **(Circle all that apply)** Walking, Shopping, Exercising, Cleaning, Cooking, Showering, Work

What is the pain level in your legs? (select one)



Have you ever had the following?

	No	Left	Right	Date	Comments (optional)
Vein Stripping or Ablation	☐	☐	☐		
Vein Injections (Cosmetic)	☐	☐	☐		
Leg Ulcerations	☐	☐	☐		
Blood Clots (DVT / PE)	☐	☐	☐		
Phlebitis	☐	☐	☐		

Do you have a family history of varicose veins?	☐Yes	☐No	Who? _____
Have your symptoms worsened in recent months?	☐Yes	☐No	
Do you take any medication for pain in your legs?	☐Yes	☐No	What?_____ For how long?_____
Do you elevate your legs for discomfort?	☐Yes	☐No	How long? _____

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Do you exercise?	□Yes	□No	How often? _____Type? _____
Do you wear / have you worn compression stockings?	□Yes	□No	**When did you start?_____**
Do you have difficulty walking?	□Yes	□No	
Does your occupation require prolonged standing?	□Yes	□No	
Does your occupation require prolonged sitting?	□Yes	□No	

What is the name of your referring physician? _____

Patient Signature **Date**

Arterial Health History

Patient Name: _____ **DOB:** ____/____/_____

How long can you walk before developing leg pain?
□ 1 city block □ 2 city blocks □ 3 city blocks □ indefinitely □ Other:

Where does the pain occur? □ Foot, □ Leg Below Knee, □ Thigh, □ Other:

What relieves the pain? □ Resting leg in down position □ Resting leg in elevated position
□ Exercise: □ Medication: □ Other:

What makes the pain worse?

Have you ever had wounds on your: □ Foot □ Toe □ Leg □ Other: How long?
Did the wounds heal and return? □ Yes □ No

Do you have any prosthetics or implants? □ Yes, specify: □ No

Do you have a pacemaker? □Yes □No

Have you ever had the following tests?
Stress Test on the heart? □Yes □No When / Where? _____
MRI or CT scan? □Yes □No When / Where? _____
Angiogram of blood vessels? □Yes □No When / Where? _____
Lung function test / pulmonary function test? □Yes □No When / Where? _____
Heart catheterization / angiogram? □Yes □No When / Where? _____

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Uterine Health History (if applicable)

Menstrual History

Length (Days #): _____ Heavy (Days #): _____ □ Pads □ Tampons □ Both

Frequency of change: _____ LMP: _____ 1st Menses (Age): _____

Pregnancies: _____ Live Births: _____ Miscarriages: _____ Elective Abortions: _____

□ Anemia □ Transfusions □ Blood Clots □ Frequency Constipation

□ Urinary Frequency □ Pelvic Pressure □ Pelvic Pain □ Other _____

□ Birth Control Pills: ____/____/____ □ Lupron / Depo-Provera: ____/____/____

Ob/Gyn: _____ **Last Pap Smear**: _____ **Uterine Biopsy**: Y / N Date**:** _____

Comments: _____

Patient Name: _____ **DOB:** ____/____/_____

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 pleased with the care you are receiving: ☐Y ☐N

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)

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☐ Dentures Uppers (☐Full / ☐Partial)
☐ Glasses / Contacts
☐ Loose, chipped or cracked teeth
☐ Capped teeth or bridge work
☐ Hospital Bed
☐ Respiratory treatments / Inhalers
☐ Bi-Pap / C-Pap

☐ Dentures Lowers (☐Full / ☐Partial)
☐ Braces or retainers
☐ Hearing Aids (☐R ☐L ☐Both)
☐ Prosthesis / Implant
☐ IV Therapy
☐ Oxygen ___L/minute
☐ 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	☐	☐	

Patient Payment Policy

Insurance Authorization and Assignment:

I authorize East Texas Surgical Associates, P.A., to furnish information to insurance carriers concerning my medical condition and care. I assign to East Texas Surgical Associates, P.A., 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 East Texas Surgical Associates, P.A.. Any Person signing below guarantees payment of the health care costs incurred on behalf of patient and in the event of such costs are not incurred on below and in the event such costs are not timely paid further guarantee payment of the cost of collection of such bills including attorney fee's.

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Thank you for choosing East Texas Surgical Associates, P.A.! 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, Care Credit, VISA, MasterCard, American Express, and Discover.

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 a referral faxed to our office at Attn: Billing. 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.

What is My Responsibility for Services?

- If services you receive are covered by your insurance plan: you will be responsible for all applicable co-pays, deductibles and out of pocket amounts at the time of service.
- If services you receive are not covered by you insurance plan: You will be responsible for the full payment at the time of service.
- We offer durable medical equipment (DME) products for sale (compression stockings, lotion, etc.) but we do not bill private insurance companies. If you would like to purchase any DME product, you will be expected to pay in full at the time of service and an itemized receipt will be given upon your request so you can bill your own insurance.

_____ _____ ____/____/____
Signature **Printed Name** **Date**

The signature is of the: □Patient □Parent of Minor □Legal Guardian □Patient's power of attorney
Our practice bases your costs off 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.
We recommend that you call your insurance company as well and check on those services. CPT codes can be provided upon request. You may also see what medical policy guidelines you must follow for these procedures.

East Texas Surgical Associates, P.A. will not be held responsible for any misquotes in benefits.

Procedures in the Office
If your physician recommends surgery, an inner office referral will be created and sent to the Surgery Coordinator. When the Surgery Coordinator receives the inner office referral, a request for predetermination /

preauthorization will be sent to your insurance company with all required documentation. You will not be scheduled for surgeries until this process is done and it may take up to 30 days to get a predetermination from your insurance. Once our office has received the predetermination / preauthorization from your insurance company, an Estimated Surgical Cost Analysis will be generated and mailed to you with the amount you will owe for the procedure(s). Once this is done, the Surgery Scheduler will contact you to schedule the 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 direct you to the appropriate department.

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

I authorize my insurance benefits be paid directly to East Texas Surgical Associates, P.A.

I authorize East Texas Surgical Associates, P.A. to release pertinent medical information to my insurance company when request, or to facilitate payment of a claim.

Walk-In Appointments:
East Texas Surgical Associates, P.A. actively encourages every patient to schedule an appointment for every episode of care. Patients in need of urgent care are asked to call ahead for an appointment even if they are only able to give minimal notice of their impeding arrival. If your insurance requires referrals for office visits and there is not one on file, you will be expected to pay in full in advance of being seen.

No Show or Cancelled Appointments: If you are unable to keep your scheduled appointment, please call our office 24 hours before your appointment to reschedule. This will allow time to provide that time slot to another patient. We reserve the right to charge $25.00 for appointments that are not canceled at least 24 hours in advance.

_____ _____ ____/____/____

Signature **Printed Name** **Date**

Consent to Photograph for Communication with Insurance Companies / HIPAA Privacy Policy Acknowledgement

The undersigned authorizes East Texas Surgical Associates, P.A., 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 East Texas Surgical Associates, P.A., 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.

I, _____ have been given the opportunity to read the HIPAA Notice of Privacy Practices of East Texas Surgical Associates, P.A..

☐ 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 East Texas Surgical Associates, P.A., to discuss my medical history / condition with the following person(s):

Name: _____ ☐ Limited Time

_____ ☐ Until Rescinded

_____

By providing your email address and cellphone at any time, you consent to receiving unsecure healthcare communications at the email, cellphone, or text messaging address you have provided. These communications may include, but are not limited to, information regarding your treatment or condition (for example, post-procedure instructions, prescription information, etc.), appointment reminders, billing information, or educational information. The health care communications that we send to you will be unencrypted, which means that there is a risk that an unauthorized third party can access the information outside of our control. Please Note: You may opt out of these communications at any time. We do not charge for these services, but standard text messaging rates or cellphone minutes may apply (please contact your cellular plan carrier for any rates, minutes or details that may apply to you).

_____ _____ ____/____/____

Signature **Printed Name** **Date**