



# Vein Center Houston

Medical and Cosmetic Specialists

How did you hear about us?

Physician Referral

Ad

TV

Website

Billboard

Email add: \_\_\_\_\_

Bldg sign

Cell

#: \_\_\_\_\_

**Patient Information**

Last Name:		First:	MI:
Date of Birth:	Referring Physician name & address:		
Social Security No:			
Pt. Address:	Gender:		
	Male	Female	
City:	State:	Zip:	Marital Status:
Employer Name & Address:			
Home Phone:	Work Phone:	Emergency Contact Name and Telephone:	

**Insurance Information**

Insurance name:	Member Number:	Group Number:	
Insurance Address:	City:	State:	Zip:
Insurance Telephone Number:	Insurance Fax Number:		

**Policy Holder and relationship to Insured:(Guarantor)**

Insured's Last name:	First:	MI:
Insured's Address:	City:	State: Zip:
Insured's Employer Name:	Address:	City: State:
Zip:	Home Phone:	Work Phone:
Employer Phone:	Social Security:	Date of Birth:

**SERVICES RENDERED ARE TO BE PAID AT TIME OF VISIT AND NON-REFUNDABLE**

X

\_\_\_\_\_  
Patient's or Personal Representative's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Insured's Signature

\_\_\_\_\_  
Date



# Vein Center Houston

## Medical and Cosmetic Specialists

Welcome to Vein Center Houston! This office is committed to you and your well-being.

### Payment and Insurance Information

This office requests payment at the time services are rendered. This includes co-pays and insurance deductible. Insurance companies occasionally apply services other than office visits towards a calendar year deductible. Please be prepared to pay today. If you have any questions regarding your insurance benefits, please contact your insurance company. If you have an HMO or POS policy and require a referral please be sure that our office has this on file, otherwise, full payment will be due from you today. Please be sure that your account is current prior to scheduling your next appointment. This office accepts cash, checks, and the following major credit cards: Visa, MasterCard, American Express and Discover.

### Patient Services

We do our best to schedule in a manner to minimize your wait. Occasionally, emergencies occur, making it difficult for us to see you at your scheduled appointment time. Please be assured that this office devotes itself toward serving you as promptly as possible. If you arrive 15 minutes late we may reschedule your appointment to avoid delaying other appointments.

**Please note:** This office reserves the right to charge a cancellation fee of \$55.00 for appointments/\$250.00 for surgeries cancelled without a 24-hour notice. In addition, please be sure to notify our office if any of your information has recently changed. This includes personal and insurance information. This helps us to stay in contact with you and ensures that your insurance claims are processed accurately.

Thank you for choosing our office for your health care needs.

I have read and fully understand the policies of this office and agree to the terms.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## Authorization and Consent for Billing

Subscriber employer: \_\_\_\_\_ Employer Phone#: \_\_\_\_\_

Patient Name: \_\_\_\_\_

### ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize and request my insurance to pay the Doctor the amount(s) due on my claim for services rendered to my dependent or me. I further agree that should the amount be insufficient to cover the entire medical and surgical expense, I will be responsible for payment of the difference; and if the nature of the disability were such that it is not covered by the policy, I will be responsible for payment of the entire bill. Furthermore, "I request that payment of authorized Medicare benefits be made to me or on my behalf to Dr. Mario Kapusta for any services furnished to me by that physician. I authorize any holder of medical information about to me to release to the Healthcare Financing Administration (HCFA) and its agents any information needed to determine these benefits or the benefits payable for related services." **INITIALS**

### Financial Agreement/ Billing Authorization

1. All services are to be paid at the time of service. HMO, PPO'S and Managed Care members are billable only if we are contracted with the carrier at the time services are rendered and have a valid authorization. **ALL DIAGNOSTIC AND THERAPUTIC PROCEDURES which are classified AS COSMETIC are payable at the time services are rendered.**
2. In consideration of the services to be rendered to me/patient, **I HEREBY INDIVIDUALLY OBLIGATE MYSELF/GUARANTOR TO PAY THE ACCOUNT OF THE VEIN CENTER HOUSTON IN ACCORDANCE WITH THE RATES AND TERMS FOR THE CENTER/PHYSICIAN.** Should the account be referred to an attorney or collection agency for collection, I shall pay reasonable attorneys and collection expenses. All delinquent accounts referred to an attorney and/or collection agency shall bear interests at the legal rate.
3. I hereby authorize direct payment to the **VEIN CENTER HOUSTON** and/or Physician of any insurance benefits otherwise payable to me for their services rendered to me at a rate not to exceed the **VEIN CENTER HOUSTON/Physician's** regular charges.
4. I certify that I am the patient or am duly authorized by the patient and/or guarantor to execute this document and accept its term.
5. If my insurance is Medicare, I certify that the information given to me is applying for payment under Title XVIII of the Social Security Administration Act is correct.
6. I give **VEIN CENTER HOUSTON** the right to appeal any claims not processed correctly in my behalf.

I hereby authorize **VEIN CENTER HOUSTON** and/or Aggregate to act as an agent in the billing of Medicare or any health insurance covering services rendered by the physician and/or **VEIN CENTER HOUSTON.**

HIPAA acknowledgement of review of Notice of Privacy Practice: I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

**INITIALS**

**SERVICES RENDERED ARE TO BE PAID AT TIME OF VISIT AND NON-REFUNDABLE**

X \_\_\_\_\_  
Patient/Guarantor Signature Date:

Print Name: \_\_\_\_\_ Relationship (If Not Patient): \_\_\_\_\_



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## HIPAA CONSENT

### Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of their home.

#### I wish to be contacted in the following manner (check all that applies):

- Home Telephone \_\_\_\_\_
- OK to leave a message with details
- Leave message with call-back number only
- Work Telephone \_\_\_\_\_
- OK to leave a message with details
- Leave message with call-back number only
- Written Communication \_\_\_\_\_
- OK to mail to my home address
- OK to mail to my work/office address
- OK to fax to this number \_\_\_\_\_
- I give authorization for VCH to leave a message in my absence with \_\_\_\_\_, \_\_\_\_\_ (indicate relation to patient) for matter regarding:
  - my appointment reminders
  - my account such as billing and amount due
  - my treatment/test results

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Birthdate

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep record of PHI disclosures. Information provided below, if completed properly, will constitute and adequate record

**Note: Uses and disclosures for Treatment Records, Payment Information and Healthcare Operations may be permitted without prior consent in an emergency.**

### Record of Disclosures of Protected Health Information

Date	Disclosed to whom Address or Fax number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

- (1) Check this box if the disclosure is authorized
- (2) Type key: T=Treatment Records; P=Payment Information; O=Healthcare Operations
- (3) Enter How disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other



# *Vein Center Houston*

Medical and Cosmetic Specialists

## **Consent to Photograph**

I, \_\_\_\_\_, hereby authorize Dr. Mario O. Kapusta/and staff to photograph my legs while I am under his care. I agree that he may use or permit other persons to use the negatives or prints prepared for insurance purposes. Dr. Mario O. Kapusta may utilize the pictures for publication in the medical literature or education (without identifying the patient.)

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Name: \_\_\_\_\_ Date: \_\_\_\_\_ DOB: \_\_\_\_\_

What is the reason for your visit today?  
\_\_\_\_\_

Where are the veins you are seeking a medical opinion for located?  Face  Leg(s), Right/Left / Both

CHECK IF IT APPLIES?		
Chief Complaints:	Type of Pain:	Venous Problems:
<input type="checkbox"/> Swelling in the right leg	<input type="checkbox"/> Intense	<input type="checkbox"/> Varicose Veins in the right leg
<input type="checkbox"/> Swelling in the left leg	<input type="checkbox"/> Severe	<input type="checkbox"/> Varicose Veins in the left leg
<input type="checkbox"/> Ankle Swelling	<input type="checkbox"/> Dull	<input type="checkbox"/> Reticular Veins
<input type="checkbox"/> Restlessness	<input type="checkbox"/> Aching	<input type="checkbox"/> Spider Veins
<input type="checkbox"/> Tenderness	<input type="checkbox"/> Cramping	<input type="checkbox"/> Cellulitis
<input type="checkbox"/> Tiredness	<input type="checkbox"/> Sharp	<input type="checkbox"/> Varicocele
<input type="checkbox"/> Discoloration	<input type="checkbox"/> Throbbing	
<input type="checkbox"/> Numbness	<input type="checkbox"/> Tight	<b>How long have you had this problem?</b>

Are symptoms getting worse over time?  Yes  No Do your symptoms affect your daily living?  Yes  No

Please Explain: \_\_\_\_\_

**Do you have any of these Functional Impairments?**

Bleeding from veins due to erosion of/or trauma to the skin  Skin ulcerations  Superficial Thrombophlebitis  Venous Stasis Dermatitis  
 Moderate to Severe pain causing Functional/Impairment:  when standing  pain with motion  at rest  while walking  while sitting

Have you ever worn prescription grade compression stockings?  Yes  No How Long: \_\_\_\_\_

Do you elevate your legs:  Yes  No Do you take any pain medications for this problem?  Yes  No \_\_\_\_\_

Is there a family history of Varicose Veins?  Yes  No \_\_\_\_\_

**Venous History:**

<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Sclerotherapy	<input type="checkbox"/> IV drug use
<input type="checkbox"/> DVT	<input type="checkbox"/> Sonogram	<input type="checkbox"/> AIDS/HIV/HEPATITIS
<input type="checkbox"/> Pulmonary Embolism	<input type="checkbox"/> Prior Vein Surgery	<input type="checkbox"/> Previous Trauma to the legs
<input type="checkbox"/> Bleeding from Veins	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Clotting Disorder

**Do you drink Alcohol?**

Yes  No \_\_\_\_\_

**Habits:**

**Exercise:**

Yes  No \_\_\_\_\_

**Tobacco Use:**

Yes  No \_\_\_\_\_

**Current Medications:**

\_\_\_\_\_  
\_\_\_\_\_

**Allergic to any medications?** \_\_\_\_\_

**SURGICAL HISTORY:**

\_\_\_\_\_  
\_\_\_\_\_

Referring Physician: \_\_\_\_\_

Would you like for us to forward your medical records to this office?  Yes  No

Name: \_\_\_\_\_ Date: \_\_\_\_\_ DOB: \_\_\_\_\_

PAST MEDICAL HISTORY: Have you ever had any of the following? Check if yes.			
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Blood transfusions	<input type="checkbox"/> Heart Problems
<input type="checkbox"/> Psychological illness	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Stroke
<input type="checkbox"/> Blood disease	<input type="checkbox"/> Prolonged Bleeding	<input type="checkbox"/> Nervous Breakdown	<input type="checkbox"/> Seizures or convulsions
<input type="checkbox"/> Difficult skin healing or abnormal scarring		<input type="checkbox"/> Frequent infection or boils	<input type="checkbox"/> Diabetes

**REVIEW OF SYSTEMS: Check if yes.**

General:	Skin:	Eyes:	ENMT:	Neurological:
<input type="checkbox"/> Fevers	<input type="checkbox"/> Abnormal Moles	<input type="checkbox"/> Decreased Vision	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Paralysis
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Skin Changes	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Sinus Drainage	<input type="checkbox"/> Weakness
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Discoloration	<input type="checkbox"/> Temporary Blindness	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Headache
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Itching	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Discharge from ears	<input type="checkbox"/> Migraine
<input type="checkbox"/> Cancer	<input type="checkbox"/> Dry Skin	<input type="checkbox"/> Detached Retina	<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Stroke
<input type="checkbox"/> Decreased Appetite	<input type="checkbox"/> Chronic Skin Problems	<input type="checkbox"/> Temporal Arteries	<input type="checkbox"/> Hearing Deficit	<input type="checkbox"/> Dysphasia
<input type="checkbox"/> Changes in Weight	<input type="checkbox"/> Rash		<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Decr. Memory

Gastrointestinal:	Cardiac:	Respiratory:	Genitourinary:
<input type="checkbox"/> Painful Swallowing	<input type="checkbox"/> Pedal Edema	<input type="checkbox"/> Cough	<input type="checkbox"/> Unable to urinate
<input type="checkbox"/> Heartburn-GERD	<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> COPD	<input type="checkbox"/> Painful Urination
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Dyspnea on exertion	<input type="checkbox"/> Unspecified SOB	<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Vomit Blood	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Production of Sputum	<input type="checkbox"/> Kidney/Bladder Disease
<input type="checkbox"/> Gall Bladder Dis.	<input type="checkbox"/> Congenital Heart Dis.	<input type="checkbox"/> Coughing of Blood	<input type="checkbox"/> Decreased Urine Stream
<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Syncope	<input type="checkbox"/> Apnea	<input type="checkbox"/> Renal Insuf/Failure
<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Blood in Urine
	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Polyuria
	<input type="checkbox"/> Chest Discomfort	<input type="checkbox"/> Pneumonia	

Musc/Skeletal:	Psychology:	Immunology:	Endocrine:	Hematology:
<input type="checkbox"/> Bone/joint deformity	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Lupus	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Easy Bruising
<input type="checkbox"/> Joint swelling	<input type="checkbox"/> Confusion	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Insulin dep. Diabetes	<input type="checkbox"/> Anemia
<input type="checkbox"/> Leg pain	<input type="checkbox"/> Depression		<input type="checkbox"/> Non-Insulin dep. Diabetes	<input type="checkbox"/> Clotting Disorder
<input type="checkbox"/> Back pain	<input type="checkbox"/> Delusions	<b>Art/Vasc:</b>	<input type="checkbox"/> Polyphagia	<input type="checkbox"/> Bleeding Disorder
<input type="checkbox"/> Muscle aches		<input type="checkbox"/> Rest pain	<input type="checkbox"/> Polydipsia	
<input type="checkbox"/> Limited motion		<input type="checkbox"/> Sensitivity to cold		
<input type="checkbox"/> Leg cramps		<input type="checkbox"/> Hx of gangrene		
<input type="checkbox"/> Knee replacement		<input type="checkbox"/> Claudication		
<input type="checkbox"/> Spinal Problems		<input type="checkbox"/> Slow healing wound		
		<input type="checkbox"/> PAD		
		<input type="checkbox"/> Vascular surgery date: _____		

Pharmacy Name/Phone #: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patients/Representative Signature \_\_\_\_\_ Date \_\_\_\_\_