Vein Center Houston
Medical and Cosmetic Specialists

How did you hear about us?

Email add: _____

Physician Referral	Ad	TV	Website	Billboard	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**

Mario O. Kapusta M.D.
PO Box 6730 Houston, Texas 77265 Phone 713-349-8346, Fax 713-218-8346
www.veincenterhouston.com

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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, Discover, Cash-App ($veincenterhouston) and Pay-pal https://www.paypal.me/veincenterhouston

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 $75.00 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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Telemedicine Consent Form

Patient Name: _____ Date of Birth: _____

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following: · Patient medical records · Medical images · Live two-way audio and video · Output data from medical devices and sound and video files. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of each patient identification and imaging data.

Possible Risks:

· In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
· Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
· In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee of $35.00.
4. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
5. I understand and authorize direct payment to **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 for telemedicine care.
6. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
7. I understand that if I do not keep my Telemedicine appointment or are more than 15 minutes late it will result in a no-show fee of $75.00.

Patient Consent to the Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or assistants as may be designated, and all of my questions have been answered to my satisfaction.
I hereby give my informed consent for the use of telemedicine in my medical care.
I hereby authorize **VEIN CENTER HOUSTON** to use telemedicine in the course of my diagnosis and treatment.

_____ _____
Patient's/parent/guardian signature Date

_____ _____
Witness/Office Personnel signature Date

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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

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(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

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

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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:**
☐Swelling in the right leg	☐Itching	☐Intense	☐Varicose Veins in the right leg
☐Swelling in the left leg	☐Burning	☐Severe	☐Varicose Veins in the left leg
☐Ankle Swelling	☐Swelling	☐Dull	☐Reticular Veins
☐Restlessness	☐Heaviness	☐Aching	☐Spider Veins
☐Tenderness	☐Bleeding	☐Cramping	☐Cellulitis
☐Tiredness	☐Tingling	☐Sharp	☐Varicocele
☐Discoloration	☐Awareness	☐Throbbing	
☐Numbness		☐Tight	**How long have you had this problem?**

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 _____

Habits:

Do you drink Alcohol?
☐ Yes ☐ No_____

Exercise:
☐ Yes ☐ No_____

Tobacco Use:
☐ Yes ☐ No_____

Venous History:

☐Phlebitis	☐Sclerotherapy	☐IV drug use
☐DVT	☐Sonogram	☐AIDS/HIV/HEPATITIS
☐Pulmonary Embolism	☐Prior Vein Surgery	☐Previous Trauma to the legs
☐Bleeding from Veins	☐Hemorrhoids	☐Clotting Disorder

Current Medications:

_____ _____ _____

_____ _____ _____

Allergic to any medication? _____

SURGICAL HISTORY:

_____ _____ _____

_____ _____ _____

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Name: _____Date:_____DOB:_____

Referring Physician: _____

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

REVIEW OF SYSTEMS: Check if yes.

General:	**Skin:**	**Eyes**:	**ENMT**:	**Neurological:**	
☐Fevers	☐Abnormal Moles	☐Decreased Vision	☐Sore Throat	☐Paralysis	☐Seizure
☐Hypertension	☐Skin Changes	☐Double Vision	☐Sinus Drainage	☐Weakness	☐Fainting
☐High Cholesterol	☐Discoloration	☐Temporary Blindness	☐Hoarseness	☐Headache	☐Migraine
☐Fatigue	☐ Itching	☐Blurred Vision	☐Discharge from ears	☐Stroke	
☐Cancer	☐Dry Skin	☐ Detached Retina	☐Nose Bleeds	☐Dysphasia	
☐Decreased Memory	☐Decreased Appetite	☐Chronic Skin Problems		☐Temporal Arteries	
☐Hearing Deficit	☐Changes in Weight	☐Rash	☐Ringing in Ears		

Gastrointestinal:		**Cardiac:**	**Respiratory:**	**Genitourinary:**
☐Painful Swallowing	☐Constipation	☐Pedal Edema	☐Cough	☐Unable to urinate
☐Heartburn-GERD	☐Abdominal Pain	☐Atrial Fibrillation	☐COPD	☐Painful Urination
☐Vomiting	☐Bloody Stools	☐Dyspnea on exertion	☐Unspecified SOB	☐ Prostate Problems
☐Vomit Blood	☐Change in Stool Color	☐Dizziness	☐Production of Sputum	☐Kidney/Bladder Disease
☐Gall Bladder Dis.	☐Change in Bowel Mov.	☐Congenital Heart Dis.	☐Coughing of Blood	☐Decreased Urine Stream
☐Liver Disease	☐Jaundice	☐Syncope	☐Apnea	☐Renal Insuf/Failure
☐Hemorrhoids	☐Diarrhea	☐Palpitations	☐Wheezing	☐Blood in Urine
		☐Heart Attack	☐Bronchitis	☐Polyuria
		☐Chest Discomfort	☐Pneumonia	

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

_____

_____

Pharmacy Name/Phone #:_____

Patients/Representative Signature **Date**

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