SURGICAL SPECIALISTS of Ocala

THE VEIN CENTER of North Florida

SURGICAL SPECIALISTS OF OCALA, PA
1920 SW 20th Place, Ocala, Florida 34471

Name:_____ DOB:_____
(Last) (First) (MI)

___Male ___Female Social Security Number:_____ Age:_____

Email Address:_____

Permanent Address:_____
(If you have a secondary address, please let the receptionist know)

City:_____ State:_____ Zip:_____

Primary Phone:_____ Secondary Phone:_____

Employer:_____ Work Phone:_____

****

___Married ___Single ___Divorced ___Widowed

Race: ___African American ___Asian ___Caucasian ___Native American ___Other _____

Ethnicity: ___Latino/Hispanic ____ Not Latino/Hispanic ___Other_____

****

Spouse or Guardian:_____ Date of Birth:_____

Contact Phone:_____ SSN:_____

****

In Case of Emergency, Notify:_____

Relationship to Patient:_____ Phone:_____

****

POWER OF ATTORNEY

If you have a ___Medical and/or ___Financial POA – Name:_____

Phone:_____ Relationship to Patient:_____

Please provide our office with a copy of your POA, so we have it on file.

****

Primary Insurance_____ Policy #_____ Group #_____
Secondary Insurance_____ Policy #_____ Group #_____
Tertiary Insurance_____ Policy #_____ Group #_____

BRING TO YOUR APPOINTMENT: Driver's license or legal identification AND all of your insurance cards.
AUTHORIZATION FOR YOUR VISIT: If your insurance requires an authorization and we do not have one, your appointment may need to be rescheduled.

SURGICAL SPECIALISTS of Ocala

THE VEIN CENTER of North Florida

SURGICAL SPECIALISTS OF OCALA, PA

Patient Information and Medical History

Patient Name:_____ DOB:_____

Referring Physician:_____

Reason for Referral:_____

Primary Care Physician:_____ Cardiologist:_____

Hematologist:_____ Gastroenterologist:_____

Oncologist:_____ Pulmonologist:_____

Preferred Pharmacy:_____ Phone:_____

Medical History of:

Shortness of Breath	_____	Hypothyroidism	_____
Dizziness	_____	Hyperthyroidism	_____
Nausea	_____	Neuropathy	_____
Vomiting	_____	Liver Disease	_____
Leg Swelling	_____	Kidney Disease	_____
Asthma	_____	Gastrointestinal Bleed	_____
Bronchitis	_____	Ulcers (Peptic or skin)	_____
COPD	_____	Gastric Reflux (GERD)	_____
Emphysema	_____	Inflammatory Bowel Disease	_____
High Blood Pressure	_____	Anemia / Bleeding Disorders	_____
Irregular Heartbeats	_____	Arthritis	_____
Heart Attack	_____	Back Problems	_____
Coronary artery disease	_____	Hepatitis B or Hepatitis C	_____
A-FIB	_____	High Cholesterol	_____
Stroke / TIA	_____	Hiatal Hernia	_____
Vascular Disease	_____	Blood Clots (DVT or PE)	_____
Congestive Heart Failure	_____	Venous Insufficiency	_____
Diabetes	_____	Varicose Veins	_____
Cancer	_____	Other	_____

Date of Last Mammogram: _____ **Date of Last Colonoscopy:** _____

Family History of:

	Mother	Father	Sister	Brother	Other/Comment
Cancer	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____
Aneurysm	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
Varicose Veins	_____	_____	_____	_____	_____

Do you currently smoke? _____Y _____N _____Packs per day x_____Years

Are you an ex-smoker? _____Y _____N Quit _____ Years Ago

Do you drink beer / wine / alcohol?_____Y _____N Amount per day:_____

Drug use? ____ Marijuana _____ Cocaine _____ Heroin _____ Other

Do you exercise? ____ Y _____N # Days Per Week: _____

SURGICAL SPECIALISTS OF OCALA, PA
1920 SW 20th Place, Ocala, Florida 34471

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of Surgical Specialists of Ocala, PA's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and if I have a request for restriction(s) concerning the use of my personal medical information, I will submit my request in writing to the Privacy Officer of Surgical Specialists of Ocala, PA.

Print Name:_____ DOB:_____

Signed:_____ Date:_____

If not signed by the patient, please indicate your relationship to the patient (i.e. spouse)

Relationship:_____
Witnessed By:_____

IF PATIENT REFUSES TO SIGN, DOCUMENT YOUR ATTEMPT TO OBTAIN A SIGNATURE.

[ ] Patient refused to sign this Acknowledgement
[ ] Other_____

Date:_____ Time:_____ Employee Name:_____

****

MEDICAL/FINANCIAL RELEASE OF INFORMATION AUTHORIZATION

I, _____, hereby authorize
(Patient Name)
Surgical Specialists of Ocala, PA to release information about my medical and financial records if requested by:

_____
Name Relationship Daytime Phone Number

_____
Name Relationship Daytime Phone Number

_____ _____
Signature of Patient or Legal Guardian Date

SURGICAL SPECIALISTS of Ocala

THE VEIN CENTER of North Florida

SURGICAL SPECIALISTS OF OCALA, PA

1920 SW 20th Place, Ocala, Florida 34471

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

RELEASE OF INFORMATION – I, the patient named below, do hereby authorize Surgical Specialists of Ocala, PA to release to any third party provider (such as an insurance company, government agency, physician(s), or hospital(s) any medical information concerning my treatment, for its use in connection with determining a claim for payment for such treatment and/or diagnosis and continuation of care for such treatment.

MEDICARE – I certify the information given by me in applying payment under title XVII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration/Division of Family Services or its intermediaries or carriers any information needed for this or related MEDICARE claim. I hereby certify all MEDICARE benefits shall be assigned to Surgical Specialists of Ocala, PA.

We are a participating provider of Medicare, and we will file your claim on your behalf. You will be expected to sign an Advance Beneficiary Notice and pay for any services considered non-covered by Medicare at the time of service. We also will file any secondary and tertiary insurance as a courtesy to you and if that insurance information is supplied to us in full.

It is not the policy of the office to accept Medicaid, except where Medicare is the primary insurance.

INSURANCES – We will honor the terms of our contract, if one is in effect. You will be expected to pay all copays, deductables, and non-covered charges at the time of service.

SELF-PAY – Full payment for office visits and testing is expected at the time of service. If surgery is deemed medically necessary, you are required to pay seventy-five percent (75%) of the physician's fee at prior to scheduling surgery. Payment arrangements for the balance will be made at that time with our Billing Department. If surgery was done on an emergency basis, payment is expected within sixty (60) days of the date of service unless payment arrangements have been made.

We accept personal checks, cash, Mastercard, Visa, Discover, American Express, money orders, cashier checks, and Care Credit.

AUTHORIZATION FOR SERVICES – I understand my insurance company may require an authorization for services. If, for any reason, my insurance company does not give authorization for services incurred by me, I may be responsible for any and all charges in full. In addition, I understand my appointment and/or surgery may have to be rescheduled until an authorization is obtained.

FEES FOR SERVICES – Costs of services (office visits, testing, surgery) can only be determined after services are rendered. I understand any fees explained to me prior to service are estimated fees only. In addition, I understand I am responsible for any deductibles, copays, and coinsurances that my insurance company requires. All payments are due at the time of service. I also understand I will be charged a "no-show" fee of $25 (office and ultrasound appointments) and $75 (procedure appointments) if my appointment(s) are cancelled within 24 hours or not at all.

AGREEMENT – I agree that should the amount of the insurance benefit be insufficient to cover the expenses, I will be responsible for payment of the difference. I will be responsible for the entire amount due for services rendered if the expense is not covered under my insurance policy. I will not involve Surgical Specialists of Ocala, PA if disputes between me and my insurance company regarding deductibles, copays, covered charges or usual or customary charges other than to supply factual information as necessary. I agree to pay all costs including collection fees and/or reasonable attorney fees incurred by Surgical Specialists of Ocala, PA in the collection of this obligation.

I understand situations may arise where an overpayment may result from billing or payment errors. In these cases, I understand any amount owed to me will be refunded promptly. If, however, there is an overpayment at the time there is a balance due from previous services with Surgical Specialists of Ocala, PA, then I consent to the application of the funds be put towards owed balances for previous services.

PATIENT/GUARANTOR PRINTED NAME	PATIENT/GUARANTOR SIGNATURE	DATE

PATIENT NAME: _____ DATE: _____

MEDICATION LIST

MEDICATION NAME	DOSE	FREQUENCY

SURGICAL PROCEDURES

PROCEDURE	DATE	PHYSICIAN

ALLERGIES

MEDICATION	SIDE EFFECT

SURGICAL SPECIALISTS of Ocala

1920 SW 20th Place Bldg. 100
Ocala, FL 34471
P: 352-237-1212 F: 352-237-0066

MEDICAL RELEASE AUTHORIZATION

I hereby authorize my medical records to be released to:

_____ Surgical Specialists of Ocala, P.A.
(Dr. Ravi Chandra Patricia Hurst, ARNP Bhumi Patel, PA Amelia Labonte, PA)

_____ Other: _____

_____

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

FOR OFFICE USE ONLY:

Records Requested:

- ❑ **ALL** medical records
- ❑ Imaging Reports: _____
- ❑ Imaging Disc: _____
- ❑ Office Notes: _____
- ❑ Other: _____

THE VEIN CENTER of North Florida

Patient Name: _____

Date of Birth: _____

Date: _____

Quality of Life Questionnaire

1. How often do you experience the following leg symptoms?

Symptoms	Circle Leg R / L / Both	Everyday	Intermittently	Never
Heaviness	R / L / Both			
Achiness	R / L / Both			
Swelling	R / L / Both			
Burning sensation	R / L / Both			
Restless legs	R / L / Both			
Throbbing	R / L / Both			
Itching	R / L / Both			
Tingling sensation (pins and needles)	R / L / Both			
Cramping	R / L / Both			
Varicose vein hemorrhage/bleeding	R / L / Both			

2. Have you previously tried any relief measures to help with your symptoms?

Relief Measures	CURRENTLY (GREATER THAN 3 MONTHS)	NOT CURRENTLY OR LESS THAN 3 MONTHS	NEVER TRIED
Compression therapy (20-30mm stockings/socks, ace-wraps, etc.)			
Leg elevation			
Exercise (such as, walking, house/yard work)			
Weight management (such as, diet or nutrition management/tracking)			
OTC medications (such as, ibuprofen, Aleve, Tylenol)			

3. Do your symptoms interfere with any of the following?

How Symptoms Affect Daily Life	Often	Sometimes	Never
Difficulty walking, due to symptoms			
Difficulty dressing yourself, due to symptoms			
Difficulty standing after sitting for prolonged periods, due to symptoms			
Legs feeling fatigued at the end of the day			
Difficulty doing house work or yard work, due to symptoms			
Difficulty crossing legs or sitting in specific positions			

4. Have you had previous vein treatments? ☐ YES ☐ NO

Date	Procedure (such as, stripping, ablation, phlebectomy or sclerotherapy)	Doctor/Location

5. Have you been previously diagnosed with an autoimmune disease; such as: Diabetes Type 1, thyroid disease, COPD or rheumatoid arthritis? ☐ YES ☐ NO

6. Have you ever had an allergic reaction to adhesives, tape or glue? ☐ YES ☐ NO

7. Have you ever had an allergic reaction to iodine or shellfish? ☐ YES ☐ NO