

The Vein Centre

At Vascular Surgical Associates

Richard A. Murbach, M.D.

Welcome to our office and thank you for choosing The Vein Centre at Vascular Surgical Associates.

Our office is located on the third floor of the Cheek-Powell Heart and Vascular Pavilion at **455 Pinellas St. Suite 325**, near Morton Plant Hospital in Clearwater (at the corner of Ft. Harrison and Pinellas St). Our phone number is **(727) 442-8172**.

Please complete the enclosed forms in ink and bring them with you on the day of your appointment along with your insurance card(s), if applicable. Please do not mail your completed forms. Any referrals necessary will be coordinated by our office, but please bring any referrals provided to you with you to your appointment.

It is likely that Dr. Murbach will order an ultrasound to be performed during your new patient consultation to check on the health of the veins in your legs. Therefore, it is best to wear comfortable and suitable undergarments or bathing suit bottoms if you prefer.

If a surgical procedure is proposed for treatment, you will meet with one of our Vein Centre Coordinators to schedule a procedure date. Your insurance, the type of procedure being performed, your schedule and your physician's schedule are all taken into consideration when choosing a procedure date. Please keep in mind that your insurance (if applicable) and any prior authorization steps necessary according to your insurance plan may affect how soon you can schedule your procedure. You also have the option of paying with cash, personal check, credit card (Visa or Mastercard), or with Care Credit, a financing plan we accept that is a separate line of credit with flexible financing options to cover your healthcare needs *(including no interest for those eligible and no annual fees)*. Please call us for more information or visit www.carecredit.com.

If you have any questions regarding your appointment or any of the forms, please feel free to contact our office. Again, welcome to our practice.

Sincerely,



Colette McCormick
Vein Centre Coordinator



The Vein Centre

At Vascular Surgical Associates
Richard A. Murbach, M.D.

Patient Personal Information Sheet

PLEASE PRINT

Name _____
Address _____
City _____ State _____ Zip _____
Alternate Address _____
City _____ State _____ Zip _____
Phone # Home _____ Work _____ Cell _____
Date of Birth _____ S.S.# _____
E-mail _____

Employer Name _____
Employer Address _____ Phone # _____

Name of Spouse _____
Spouse's Work # _____

Please list name of Physician (if applicable):

Referring Physician _____ Phone# _____
Primary/Family Physician _____ Phone# _____
Cardiologist _____ Phone# _____
OB/GYN _____ Phone# _____

In Case of Emergency Contact

In case of Emergency please notify (Please list someone other than spouse)

Name _____
Relation to patient _____ Phone # _____
Address _____
City _____ State _____ Zip _____

Today's Date _____



The Vein Centre

At Vascular Surgical Associates
Richard A. Murbach, M.D.

Insurance Information (Please provide card to front desk for photocopy)

Primary Insurance Company _____
Subscriber's Name _____ DOB _____
Insurance Policy or Subscriber ID # _____
Group # _____ Phone# _____

Secondary Insurance Company (if applicable) _____
Subscriber's Name _____ DOB _____
Insurance Policy or Subscriber ID # _____
Group # _____ Phone# _____

Guarantee of Payment: For services rendered, the undersigned does hereby agree to guarantee and promise to pay to Cardiac/Vascular Surgical Associates all charges incurred in the treatment of the named patient, including the expenses not covered by any insurance policy presently in force. If any action at law or inequity is brought to enforce this agreement, Cardiac/Vascular Surgical Associates shall be entitled to reasonable attorney's fees, court costs, and any other costs of collection incurred. I understand that all bills are payable and become due upon presentation.

Receipt of Notice of Privacy Practices: By my signature on this document, I acknowledge receipt of a Notice of Privacy Practices.

Patient's or authorized person's signature: I authorize the release of any medical or other information requested by myself, any medical facility, or insurance company. I also request payment of Medicare/insurance benefits to myself or to the party that accepts assignment.

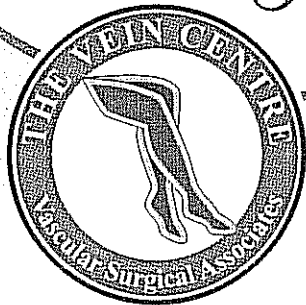
Print name _____ **Date** _____

Patient Signature _____

POA/Other authorized signature _____

(Please allow us to copy POA/Authorization)





Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled to Cardiac Surgical Associates. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Cardiac Surgical Associates for medical services rendered to myself and/or my dependents.

Authorization to Release Information

I hereby authorize Cardiac Surgical Associates to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of treatment. This order will remain in effect until revoked by me in writing.

I have requested medical services from Cardiac Surgical Associates on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment.

I further understand that co pays / fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature _____ Date _____

Witness _____ Date _____

The Vein Centre

At Vascular Surgical Associates
Richard A. Murbach, M.D.

Release of Information

X Patient Name: _____ X Patient Birth Date: _____

X Patient Social Security Number: _____

I am requesting Protected Health Information from:

(Name, Address, Phone / Fax)

THE SPECIFIC INFORMATION TO BE RELEASED IS AS FOLLOWS: _____

I am requesting Protected Health Information to be released to:

(Name, Address, Phone / Fax)

I would like a **copy** of my protected health information to be:

Mailed to 455 Pinellas Street, Suite 325, Clearwater, FL 33756

Faxed to (727) 441-9375

The Vein Centre at Vascular Surgical Associates or other named facility has permission to release any and all information which the named facility may possess in regard to the patient's examinations and treatments, including but not limited to, alcohol abuse or drug abuse information, HIV antibody testing information, psychiatric and/or psychological information, communicable disease information, or any other information related at any time and must do so in writing. I understand that the revocation will not apply to protected health information (PHI) that has already been disclosed in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I must present my written revocation to the Medical Record Department at Vascular Surgical Associates. I understand that the disclosure of my protected health information (PHI) carries with it the potential for re-disclosure by the recipient and the PHI may not be protected by the federal privacy rules. Vascular Surgical Associates may not condition treatment, payment, or enrollment or eligibility for benefits on this signed authorization.

X _____
Signature of Patient

X _____
Date signed

Relationship: Patient Natural Guardian Legal Guardian Authorized Representative

Information regarding HIV, AIDS, alcohol, drug abuse, psychiatric and/or psychological information, is protected by state/federal law. You shall make no further disclosure of this information without the specific written and informed release of the individual to whom it pertains, or as otherwise permitted by state/federal law.



The Vein Centre

At Vascular Surgical Associates
Richard A. Murbach, M.D.

Release of Information

I, _____, request that the following people are able to receive information on my medical treatment and care. They are also allowed to pick up any prescriptions, ordered, medical records with proof of identification and a written notice from myself.

Name _____
Relation to patient _____ Phone # _____
Address _____
City _____ State _____ Zip _____

Name _____
Relation to patient _____ Phone # _____
Address _____
City _____ State _____ Zip _____

Name _____
Relation to patient _____ Phone # _____
Address _____
City _____ State _____ Zip _____

Name _____
Relation to patient _____ Phone # _____
Address _____
City _____ State _____ Zip _____

This authorization is good for one year from date.

Signature of Patient

Date signed



The Vein Centre

Medical Questionnaire

Name: _____ Date: _____
(First) (Middle) (Last)

Age: _____ Sex: _____ Height: _____ Weight: _____

Current/Previous Occupation (circle one): _____

Who referred you, or how did you learn of the Vein Center? Dr. _____

Internet Brochure Walk-In Word of Mouth Other _____

1. How long have you been having problems with your veins? _____ months / years (circle one)

2. Please circle the type of symptoms that you are having:

Tired/heavy sensations

Bleeding

Pain in legs during exercise

Aching Legs

Numbness

Phlebitis

Throbbing or cramping pain

Tingling

Swelling (legs or ankles)

Skin Ulcers

Burning pain

Skin discoloration

Skin changes

Itching

Pain in legs while resting

3. Have your veins become worse in the past several months? Yes No

4. How have your daily activities been affected or limited by your leg problems? _____

5. Have you worn support hose before? Yes No If so, for how long? _____ months / years (circle one)

**Some insurance plans require that compression hose be worn 3-6 months prior to request coverage for treatment*

6. Have you taken any analgesic medication for the pain? Yes No If yes, please list _____

7. Have you been treated for vein problems before? Yes No If yes, by whom? _____

What treatment? _____ How long ago? _____

8. Do you have a family history of vein symptoms (varicose veins, spider veins, leg ulcers, blood clots, or swollen legs)? _____

If yes, who? _____

9. Do you have a history of the following?

Blood clots/phlebitis

Hepatitis

Heart Disease

Diabetes

Thyroid

Migraines/headaches

Stroke

High Blood Pressure

Asthma

Seizures

Vascular Disease

Fainting/Dizziness

10. Please list all allergies: _____

Are you allergic to local anesthesia? _____

11. List all medications that you are currently taking: (since when? Please include birth control pills/hormones or blood thinners)

12. If you are a female, when was your last menstrual period? _____ Number of pregnancies _____

13. Do you use tobacco? Yes No If yes, how much and how often? _____

14. Do you have a family history of blood clots or phlebitis? _____

15. Please list all previous surgeries: _____

Patient signature _____ Date _____

Doctor Signature _____ Date _____