Madison Vein Center
Shoals Vein Center
A Division of Shoals Surgical Group, LLC

ACCOUNT #_____ DATE_____

## PLEASE PRINT

**PATIENT INFORMATION:**

PATIENT NAME_____

ADDRESS_____

CITY/STATE/ZIP_____CELLULAR PHONE_____

HOME PHONE (  )_____SOCIAL SECURITY_____

SEX M F BIRTHDATE_____AGE____MARITAL STATUS S M W D

EMPLOYER_____WORK PHONE (  )_____

EMPLOYER ADDRESS_____

SPOUSES NAME_____

DATE OF BIRTH_____SOCIAL SECURITY_____

EMPLOYER_____

EMPLOYER ADDRESS_____

**IN AN EMERGENCY CALL_____RELATIONSHIP_____**
TELEPHONE (  )_____
**PATIENT'S NEAREST RELATIVE_____RELATIONSHIP_____**
(not living with patient)
ADDRESS_____PHONE (  )_____

**PHARMACY NAME_____PHONE (  )_____**

**REFERRED BY:**
DOCTOR'S NAME_____
**FAMILY DOCTOR:**
DOCTOR'S NAME_____

**PERSON RESPONSIBLE FOR BILL IF OTHER THAN PATIENT:**
GUARANTOR'S NAME_____
ADDRESS_____PHONE (  )_____
EMPLOYER_____ADDRESS_____

**INSURANCE INFORMATION:**

**PRIMARY INSURANCE COMPANY**_____

INSURED NAME_____RELATIONSHIP_____

**POLICY NUMBER_____GROUP NUMBER_____**

**SECONDARY INSURANCE COMPANY**_____

INSURED NAME_____RELATIONSHIP_____

**POLICY NUMBER_____GROUP NUMBER_____**

**PLEASE ALLOW THE RECEPTIONIST TO COPY YOUR INSURANCE CARD(S). A COPY OF OUR FINANCIAL POLICY IS ATTACHED. PLEASE READ AND SIGN.**

MADISON VEIN CENTER
SHOALS VEIN CENTER
A DIVISION OF SHOALS SURGICAL GROUP, LLC
PERSONAL HISTORY

Patient's Name_____ DOB_____ Date_____

Referring Physician _____

Reason for Visit _____

Location_____ Severity (Scale 1-10) ____ Duration (How long)_____ Timing(When it Occurs)_____

**SYMPTOMS/LEGS**

__Aching / Pain
__Heaviness
__Tiredness/Fatigue
__Burning
__Itching
__Swelling
__Cramps
__Restless Legs
__Skin Changes
__Throbbing
__Ulcers
__Spider Veins
__Other_____

**VASCULAR HISTORY**

Do you have or have you ever been diagnosed with:
__Phlebitis(vein redness.tenderness)
__Blood Clots
__DVT
__Saphenous Vein Reflux
__Varicose vein problems

**PAST SURGERIES**

__Heart Surgery
__Vein Stripping
__Sclerotherapy
__Laser on Legs
__Electrosurgical

**MEDICATIONS**

1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

Drug **ALLERGIES**_____
_____

Food **ALLERGIES**_____

PAST MEDICAL HISTORY

| | | | | |
|---|---|---|---|---|
| __Arthritis | __COPD/Emphysema | __Gout | __Phelbitis | __Thyroid Disorder |
| __Asthma | __Diabetes | __Heart Failure | __Seizure Disorder | __Valvular Heart Disease |
| __Bleeding Disorder | __Dialysis | __High Blood Pressure | __Sinusitis | __Other_____ |
| __Blood Clots | __DVT | __Migraines | __Stroke | _____ |

**FAMILY HISTORY**

__Bleeding Disorder
__Varicose Veins
__Blood Clots
__Stroke
__Heart Disease
__DVT
__Pulmonary Emboli
__Phlebitis

**SOCIAL HISTORY**

Tobacco: Cigarettes____/Day Cigars___/Day Quit Y N
Snuff_____ Chew_____ Quit Y N
Alcohol: Type_____Amount_____Years_____

Occupation_____

**REVIEW OF SYSTEMS (Please Check All Symptoms You are Experiencing Now)**

| | |
|---|---|
| Constitutional | __Black Out Spell __Dizziness __Fatigue __Fever __Loss of Appetite __Weakness |
| HEENT | __Blurred Vision __Hearing Loss __Hoarseness __Ringing in Ears __Sore Throat __Vision Loss |
| Respiratory | __Bloody Phlegm/Sputum __Cough __Shortness of Breathing ___Wheezing |
| Cardiovascular | __Ankle Swelling __Chest Pain __Irregular Heartbeat __Leg Pain with Walking __Palpitations |
| Urinary Tract | __Blood in Urine __Burning on Urination __Frequency __Hesitation __Urgency/Incontinence |
| Male Only | __Prostate Problems __Impotence |
| Female Only | __Menstrual Problems __Abnormal Vaginal Bleeding __Menopausal Symptoms __Breast Lumps/Discharge |
| Musculoskeletal | __Joint Pain/Swelling __Joint Stiffness __Back Pain __Muscle Pain __Neck Problems |
| Skin | __Skin Lesions __Rash __Sores __Itching |
| Neurology | __Headaches __Muscle Weakness __Numbness |
| Psychiatric | __Agitation __Anxiety __Confusion __Depression __Difficulty Sleeping __Memory Loss |
| Endocrine | __Heat/Cold Intolerance __Excessive Thirst or Urination |
| Hematology/Lymph | __Excessive Bruising __Free Bleeding __Swollen Glands |

_____ _____ _____Reviewed history recorded by patient
Patient Signature Date

Physician Signature_____

**Madison Vein Center** **Dr. Bailey**
**Shoals Vein Center** **Dr. Collignon**
**A Division of Shoals Surgical Group, LLC**

Patient's Name_____

## Assignments of Benefits

I AUTHORIZE Shoals Surgical Group, LLC to perform medical treatment. I certify that the signature below shall serve as **Signature on File** for Medicare, Medicaid, and all insurance companies for claims filed on my behalf by Shoals Surgical Group, LLC. I assign the benefit payable for physician services to Shoals Surgical Group, LLC and authorize Shoals Surgical Group, LLC to submit a claim to Medicare, Medicaid, and all insurance companies for payment.

I understand that by signing this agreement, I am authorizing the provision of therapy for varicose veins which may include the following; Consultation, VNUS® ClosureFast® procedure, Ambulatory Phlebectomy, Sclerotherapy (non cosmetic), and Venous Duplex Ultrasound while under the care and supervision of my attending physician.

I authorize direct payment of any insurance benefits for Consultation, VNUS® ClosureFast® procedure, Ambulatory Phlebectomy, Sclerotherapy (non cosmetic), and Venous Duplex Ultrasound, to be made directly to Shoals Surgical Group, LLC, their billing agent, or to any provider of these services. I also authorize my insurance company to furnish to Shoals Surgical Group, LLC any and all information pertaining to my insurance benefits and status of claims submitted for therapy rendered.

## Agreement to Pay

**Madison Vein Center and Shoals Vein Center, a division of Shoals Surgical Group, LLC participates with many insurance plans as a convenience to our patients. Your co-payment and / or deductibles are determined by your insurance company. We are required to collect these fees, to ensure the insurance policy is enforced. Please understand that payment of your bill is considered in part the responsibility of the patient. Payment, according to the policies below, is due at the time of service. We accept cash, checks, MasterCard or VISA**. "Bounced Checks" **will be charged a** $30.00 fee **and if not paid within 10 days will be referred to Colbert County Court or Madison County Court for Legal Action-** it is your responsibility to contact us as soon as you are aware that your check has been rejected for payment. **Also if you write a bad check you will be required to pay via cash or credit card.** All co-pays and / or deductibles, and services not covered by insurance will be collected up front on the day services are rendered.

I acknowledge that reasonable efforts will be made to have my insurance pay for this therapy. In the event that my insurance will not cover this therapy, I agree to be responsible for the full amount of the charges or any remaining balances due after insurance has paid, including any costs or expenses incurred, including a reasonable attorney's fee in collecting such payment.

I consent to the release of my medical information to any insurance company for use in determining payment for VNUS® ClosureFast® procedure, Ambulatory Phlebectomy, Sclerotherapy (non cosmetic), and Venous Duplex Ultrasound. This consent shall be valid for whatever period of time is reasonable, necessary, or until I revoke this consent in writing.

PATIENT WITHOUT INSURANCE: Payment in full is due at the time of service. We will not do any procedures/surgeries without having full payment.

**Sclerotherapy and VeinWave, (treatment of spider veins) that is cosmetic is not covered by insurance companies and a claim will not be file with your insurance company. Payment in full will be collected prior to any treatment being rendered.**

The undersigned certifies the following: that the foregoing text has been read, and that the undersigned is the patient or a duly authorized representative of the patient and as such as is responsible to execute the above and accept its items.

_____ _____
Patient's Signature Date

# SHOALS SURGICAL GROUP, LLC
# AUTHORIZATION

Patient Name_____

I AUTHORIZE Shoals Surgical Group, LLC to perform medical treatment. I certify that the signature below shall serve as **Signature on File** for Medicare, Medicaid, and all insurance companies for claims filed on my behalf by Shoals Surgical Group, LLC. I assign the benefit payable for physician services to Shoals Surgical Group, LLC and authorize Shoals Surgical Group, LLC to submit a claim to Medicare, Medicaid, and all insurance companies for payment.

I AUTHORIZE any physician, medical practitioner, hospital, clinic or other medical or medically related facility, peer review organization, insurance or reinsuring company, the Healthcare Financing Administration, the Medical Information Bureau, Inc. consumer reporting agency, employer or third party administrator having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, and/or Acquired Immunodeficiency Syndrome (AIDS) and/or tests for or infection with Human Immunodeficiency Virus (HIV), and/or treatment of me or my dependents to give to the group policyholder, my employer, third party administrator, my third party carrier or its legal representative, any and all such information.

I UNDERSTAND the information obtained by this authorization will be used to determine eligibility for insurance, and eligibility for benefits under my insurance coverage. Any information will not be released except to persons or organizations performing business or legal service in connection with the claim, or as may be otherwise lawfully required or as I may further authorize. I UNDERSTAND that information disclosed pursuant to this release may be redisclosed by the authorized recipient and not longer protected by the privacy rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I AGREE that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

I UNDERSTAND that my medical history is strictly confidential. Absolutely NO information will be released without proper legal consent, unless so deemed by laws of this state.

**PAYMENT OF BENEFITS**

I AUTHORIZE payment of medical benefits be made to Shoals Surgical Group, LLC.

I UNDERSTAND that I am financially responsible to Shoals Surgical Group, LLC for charges not covered by this authorization and for any portion of charges not covered by this authorization and for any portion of charges for my care not covered by my insurance. Your co-payment and / or deductibles are determined by you insurance company. We are required to collect these fees, to ensure the insurance policy is enforced. Please understand that payment of your bill is considered in part the responsibility of the patient. In the event of nonpayment of charges for medical service rendered, I agree to pay all cost of collection, including a reasonable attorney's fee and court costs and hereby waive all rights of exemption under the Constitutional Laws of the State of Alabama. I further understand that there will be a $30.00 fee for each returned check. I have read this contract and understand its provisions.

**AUTHORIZATION TO LEAVE MESSAGES**

I authorize Shoals Surgical Group, LLC physicians and staff to leave messages regarding my medical condition, such as lab reports, other test results, medications, and appointment reminders on my home answering machine. This authorization will be in effect until I have given written notice to Shoals Surgical Group, LLC.
Agreed____ Disagree___

**AUTHORIZATION TO REVEAL MEDICAL INFORMATION**

I authorize Shoals Surgical Group, LLC physicians and staff to reveal to the following individuals, as needed, information regarding my protected health information. I understand that once this information is disclosed to those individuals that Shoals Surgical Group, LLC will not have control over to whom these individuals may reveal this information. I may revoke this authorization by giving written notice to Shoals Surgical Group, LLC.

1) Name_____Relationship_____

2) Name_____Relationship_____

Signed_____Date_____
(Patient, or Parent if Minor)

Insured or Guardian's Signature_____Date_____