valley SURGICAL, AESTHETICS & VEIN CARE
BRAD A. CASE, MD

New Patient Medical and Surgical History

Patient Name: _____ Age: _____

Who referred you to our office? _____

Chief Complaint/Reason for visit: _____

Arthritis/Gout	No	Yes
Bleeding disorder	No	Yes
Cancer	No	Yes
Coronary Artery Disease	No	Yes
Deep Venous Thrombosis (DVT)	No	Yes
Diabetes	No	Yes
Heart Disease	No	Yes
Hypertension	No	Yes
Kidney trouble	No	Yes
Stroke	No	Yes

Family Medical History:

Diabetes	No	Yes
Hypertension	No	Yes
Cancer	No	Yes
Stroke	No	Yes
Heart trouble	No	Yes

Patient Social History:

Marital status: Single _____ Married _____ Divorced _____ Widowed _____

Use of alcohol: Never _____ Rarely _____ Moderate _____ Daily _____

Use of tobacco: Never _____ Previously, but quit _____ Current _____

Packs per day? _____

Use of drugs: Never _____ Type/Frequency _____

Allergies:

Drug allergies: _____

Food allergies: _____

Medications:

_____

_____

_____

valley SURGICAL, AESTHETICS & VEIN CARE
BRAD A. CASE, MD

Review of Systems:

Eyes

Glasses/contacts	yes	no
Blurred or double vision	yes	no
Eye disease or injury	yes	no

Breast

Breast pain	yes	no
Breast lump	yes	no
Breast discharge	yes	no

Cardiovascular

Chest pain	yes	no
Swelling of feet or ankles	yes	no
Irregular heartbeat	yes	no
Pacemaker	yes	no
Congestive heart failure	yes	no

Genitourinary

Frequent urination	yes	no
Burning on urination	yes	no
Blood in urine	yes	no
Kidney stone	yes	no
Prostate problems	yes	no

Respiratory

Chronic/frequent coughing	yes	no
Spitting up blood	yes	no
Shortness of breath	yes	no
Asthma	yes	no
Bronchitis	yes	no
Pneumonia	yes	no
Emphysema	yes	no

Skin

Change in skin color	yes	no
Varicose veins	yes	no
Itching/Rashes	yes	no
Psoriasis	yes	no
Moles	yes	no
Ulcers	yes	no
Skin cancers	yes	no

Ear, Nose, Throat, and Mouth

Hearing loss	yes	no
Earache or drainage	yes	no
Swollen glands in neck	yes	no
Nose bleeds	yes	no
Bleeding gums	yes	no
Mouth sores	yes	no

Musculoskeletal

Joint pain	yes	no
Cold extremities	yes	no
Muscle pain/cramps	yes	no
Difficulty walking	yes	no
Arthritis	yes	no
Gout	yes	no

Neurological

Frequent headaches	yes	no
Dizzy spells	yes	no
Numbness or tingling	yes	no
Stroke	yes	no

Endocrine

Thyroid disease	yes	no
Excessive thirst	yes	no
Hormone problem	yes	no
Diabetes	yes	no

Circulation

Varicose veins	yes	no
Leg cramps	yes	no
Cold extremities	yes	no

Psychiatric

Memory loss	yes	no
Depression	yes	no
Insomnia	yes	no

Gastrointestinal

Change in bowel movements	yes	no
Nausea or vomiting	yes	no
Rectal bleeding	yes	no
Blood in stool	yes	no
Abdominal pain/heartburn	yes	no
Constipation	yes	no
Diarrhea	yes	no
Gallbladder trouble	yes	no
Hemorrhoids	yes	no

Lymphatic

Swollen glands	yes	no
Recurrent infections	yes	no
Hepatitis	yes	no
AIDS	yes	no

Gynecological

Irregular menstruation	yes	no
Vaginal discharge	yes	no

Last menstrual period _____

Last child birth _____

C-Sections_____

Past surgical history and hospitalizations

Please list all previous hospitalizations/surgeries and serious illnesses below with dates.

LIFETIME AUTHORIZATION
INSURANCE ASSIGNMENTS AND AUTHORIZATION
TO RELEASE INFORMATION

I. **RELEASE OF INFORMATION –** I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payer (such as an insurance company or government agency, example: BlueCross BlueShield or Medicare) any medical, psychiatric condition, alcohol or drug related condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for such treatment and/or diagnosis.

II. **PHYSICIAN INSURANCE ASSIGNMENT –** I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services.

III. **MEDICARE/MEDICAID –** Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carriers any information needed for this of a related Medicare/Medicaid claim.

IV. **GUARANTEE OF PAYMENT –** I, the below named patient/guarantor, does hereby guarantee payment of all charges incurred for the account of the patient named below. I further agree to waive demand and notice of non-payment and protest: and in case suit shall be brought for the collection hereof, or the same is collected upon demand of any attorney, I agree to pay all cost of collection, including reasonable attorney's fee.

V. **I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL, WHICH IS ON FILE.** This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and us not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand that it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third payer within a reasonable period of time not to exceed 60 days.

PATIENT: _____ **DATE:** _____
SIGNATURE

SUBSCRIBER (IF DIFFERENT FROM PATIENT): _____
SIGNATURE

WITNESS: _____ **DATE:** _____
SIGNATURE

valley SURGICAL, AESTHETICS & VEIN CARE
BRAD A. CASE, MD

Patient Consent to the Use, Disclosure and Request of Health Information for Treatment, Payment, or Healthcare Operations and Acknowledgement of Health Information Privacy Practices

Patient name: _____

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, and any plans for future care or treatment. We use this information to:

- Plan your care and treatment
- Communicate with other healthcare professionals who contribute to your care
- Submit your diagnosis and treatment information for payment from insurance companies or others

By signing this document, and only as permitted by state or federal law, you are giving this practice your consent to do the following:

- To disclose, as may be necessary, your health information to other healthcare providers (such as, referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) for your treatment and/or healthcare.
- To request from other healthcare entities (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.
- To submit your diagnosis and treatment information to insurance company(s), other agencies and/or individual(s) for payment of our services.

We are providing you with the opportunity to read the *"Notice of Patient Health Information Privacy Practices"* that provides a more complete description of health information uses and disclosures. You have the following rights:

- The right to read the **"*Patient Health Information Privacy Practices*"** prior to signing this consent
- The right to request a copy of the **"*Patient Health Information Privacy Practices*"** for your own personal use

I fully understand and agree to this consent and acknowledge the above rights and disclosures.

Print Name: _____ **Signature:** _____

Date: _____

*If other than patient is signing, are you the parent, legal guardian, custodian, or have Power of Attorney for this patient, for treatment, payment or healthcare options. Yes [ ] No [ ]
Relationship: _____

*Are there persons (i.e. family members) with whom we may not share your healthcare or payment information? Please list: _____

Dr. Brad A. Case, MD, FACS
Valley Surgical, Aesthetics & Vein Care

Diplomate, American Board of Surgery
Fellow, American College of Surgeons

AUTHORIZATION FOR EXAMINATION

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

PRIMARY CARE PHYSICIAN (If medical): _____

I, _____, represent to the physicians and staff that I am 18 (eighteen) years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by my doctor and such assistant or staff as may be assigned by him/her.

I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payments of medical benefits directly to the doctor for services provided to me. A copy of this authorization shall be considered as valid as the original. In the event of any litigation arising from treatment, I agree to submit the case to arbitration. I authorize that taking photographs at the direction of my surgeon and under such conditions as may be approved by him/her. These photographs will be used solely for documentation purposes and will be kept confidential.

Have you been or are you currently involved in litigation? Yes [ ] No [ ]

I understand that there may be a consultation fee for the initial visit which is due at the time of my appointment unless other arrangements have been made in advance.

Signature: _____ Date: _____

Witness: _____ Date: _____

valley SURGICAL, AESTHETICS & VEIN CARE
BRAD A. CASE, MD

FINANCIAL POLICY FOR BRAD A. CASE, M.D.

Thank you for your confidence in choosing Dr. Brad A. Case for your vascular, aesthetic, and surgical needs. Our staff is committed to assuring that your medical care and treatment is a mutually satisfying experience. Since payment of your bill is part of your treatment, we want to be sure that our financial policies are clearly understood before beginning treatment. Please read, sing and date the following Financial Policy and ask any questions that you may have prior to your appointment.

FULL PAYMENT IS REQUIRED AT THE TIME SERVICES ARE RENDERED. OUR PRACTICE ACCEPTS CASH, CREDIT CARDS, AND CARECREDIT TRANSACTIONS OVER $300.00.

Dr. Case is a provider for many insurance companies, however, you are responsible for any co-payments, coinsurance, and/or deductible **at the time services are performed.** We will gladly file your insurance claim to your insurance carrier for all companies with whom we are contracted, as a courtesy to you.

If we are not contracted with your insurance company, you will be required to pay for services as they are rendered. We will provide you with all the information necessary to file your claim and receive reimbursement directly from your insurance company.

Payment of your account is your responsibility regardless of your insurance coverage. **Your insurance is a contract between yourself and your insurance carrier. We are not a party to that contract.** If your insurance does not pay your claim within 60 days, any balance due will become your responsibility.

Please be aware that your insurance company will pay only for services they regard as "reasonable and necessary" according to the guidelines of your particular policy, that is their opinion and does not negate the monies owed to Dr. Case for services rendered.

APPOINTMENTS MUST BE CANCELLED AT LEAST 48 HOURS IN ADVANCE OR YOU WILL BE CHARGED A LATE CANCELLATION OR NO SHOW FEE.

Patients scheduled for surgery will be required to pay any co-payments and/or deductible at least **one week prior** to surgery. If we are not contracted with your insurance company or you do not have insurance coverage, a 100% deposit of the estimated cost of your procedure will be required, prior to any procedures being performed.

I agree to pay any balance not paid by my insurance carrier. I agree to any necessary fee involved with collection of this account should it become delinquent. I have read and agree to abide by this Financial Policy set forth hereto.

Signature: _____ Date: _____

I permit a copy of this authorization to be used in place of the original and request payment of medical benefits be made to the party who accepts assignments.

Signature: _____ Date: _____

valley SURGICAL, AESTHETICS & VEIN CARE
BRAD A. CASE, MD

Patient Registration

TODAYS DATE: _____ PHONE NUMBER: _____

PRINT FULL NAME: _____

MAILING ADDRESS: _____City & State:_____ZIP:_____

DATE OF BIRTH: _____ AGE: _____ LAST 4 of SSN:_____

SEX: M ____ F ____ SINGLE ____ MARRIED ____ WIDOWED ____ DIVORCED ____

NEAREST RELATIVE NOT LIVING WITH YOU: _____ PHONE:_____

NOTIFY IN CASE OF EMERGENCY: _____ PHONE: _____

E-MAIL ADDRESS: _____

IF MEDICAL/SURGICAL VISIT:

PRIMARY INSURANCE: _____

SUBSCRIBER NAME: _____ RELATIONSHIP: _____

SUBSCRIBER D.O.B.:_____ SUBSCRIBER SSN: _____

MEMBER ID: _____ GROUP NUMBER: _____

SECONDARY INSURANCE: _____

SUBSCRIBER NAME: _____ RELATIONSHIP: _____

SUBSCRIBER D.O.B.:_____ SUBSCRIBER SSN: _____

MEMBER ID: _____ GROUP NUMBER: _____

PATIENT EMPLOYMENT: _____ PHONE: _____

IF MARRIED, SPOUSE'S NAME: _____

SPOUSE'S EMPLOYMENT: _____ PHONE: _____

PERSON RESPONSIBLE FOR BILL: _____

REFFERED BY: _____

valley SURGICAL, AESTHETICS & VEIN CARE
BRAD A. CASE, MD

Patient Name:_____ **Date**:_____
Primary Care Physician: _____ Insurance Plan: _____

Vascular History (please circle all that apply)

Do you have or have you ever been diagnosed with:

Varicose vein problems	yes	no	left leg	right leg
Phlebitis (redness/tenderness of vein)	yes	no	left leg	right leg
Deep venous thrombosis (DVT)	yes	no	left leg	right leg
Saphenous vein reflux	yes	no	left leg	right leg

Do you experience any of the following?:

Aching/pain	yes	no	left leg	right leg
Heaviness	yes	no	left leg	right leg
Fatigue	yes	no	left leg	right leg
Itching/burning	yes	no	left leg	right leg
Swelling	yes	no	left leg	right leg
Cramps	yes	no	left leg	right leg
Restless legs	yes	no	left leg	right leg
Throbbing	yes	no	left leg	right leg
Ulcers	yes	no	left leg	right leg

Other: _____

Which of the following do you currently do to improve your leg vein symptoms?

Medication	yes	no	what? _____
Elevation of legs	yes	no	
Compression support hose	yes	no	

Family History

Do any of your family members have or have a history of:

Varicose veins	yes	no	who? _____
Vein stripping	yes	no	who? _____
Blood coagulation disorder	yes	no	who? _____
Blood clots	yes	no	who? _____
Stroke, heart attack or pulmonary emboli	yes	no	who? _____

Vein Treatment History

Have you ever been treated for varicose veins with?:

Sclerotherapy	yes	no	left leg	right leg
Laser therapy (spider veins)	yes	no	left leg	right leg
Phlebectomy	yes	no	left leg	right leg
Vein stripping surgery	yes	no	left leg	right leg
RF Ablation (Closure)	yes	no	left leg	right leg

Personal activities list

Does your work require?:

Prolonged standing periods	yes	no	
Prolonged sitting periods	yes	no	
Do you exercise regularly	yes	no	
Do you smoke	yes	no	
Pregnancies	yes	no	How many? _____

valley SURGICAL, AESTHETICS & VEIN CARE
BRAD A. CASE, MD

Your appointment times are very important to us at Valley Surgical, Aesthetics and Vein Care; it is reserved especially for you, we understand that sometimes schedule adjustments are necessary; therefore, we respectfully request at least 48 hours-notice for cancellations.

STRICT AND ENFORCED 48 HOUR CANCELLATION POLICY

Please understand that when you forget or cancel your appointment without giving enough notice, we miss the opportunity to fill that appointment time, and patients on our waiting list miss the opportunity to receive services or treatments. Our appointments are confirmed 48 hours in advance because we know how easy it is to forget an appointment you booked months ago. Since the services are reserved for you personally, a Cancellation fee will apply.

Less than 48 hour notice and/or NO SHOWS will result in a charge of $75 for a technician and $125 for Dr. Case's time (this charge is not covered by insurance).

The cancellation policy allows us the time to inform our standby patients of any availability, as well as keeping our staff members schedule filled, thus better serving everyone.

CONFIRMATION CALLS/TEXTS

As a courtesy, we will call/text and confirm your appointment two days prior to your appointment date. However, if we are unable to reach you, and can only leave a message, please understand that it is your responsibility to remember your appointment dates and times to avoid late arrivals, missed appointments and the cancellation fee. You will also receive a reminder email from our scheduling software 48 hours prior to your scheduled appointment.

LATE ARRIVALS

Should you be running more than 10 minutes late for your appointment, please understand that we may have to reschedule your appointment which could incur a fee.

_____ _____

Patient's Printed Name Date

_____

Patient's Signature