VANCOUVER
VEIN & SURGICAL CENTER
CHRISTOPHER RUBANO, MD

Last Name: _____ First Name: _____Initial: _____

Address: _____ City: _____State:_____Zip:_____

Home#: _____ Cell#: _____(Text: Yes/ No) Work#:_____

E-mail: _____ Date of Birth: _____

Race: _____ Marital Status: (M / S / D / W)

Employer: _____ Phone#: _____ Occupation: _____

Spouse: _____Phone #: _____

Emergency Contact: _____ Telephone #: _____

Primary Insurance (Please give front desk cards to make copies)

Insurance Carrier: _____ Insurance #: _____

Claims Address: _____

Member ID: _____ Group #: _____ Effective Date: _____

Policy Holder Name:_____Date of Birth: _____Relationship to patient: _____

Policy Holder Employer: _____Employer Phone#: _____

Secondary Insurance (Please give front desk cards to make copies)

Insurance Carrier: _____ Insurance #: _____

Claims Address: _____

Member ID: _____ Group #: _____ Effective Date: _____

Policy Holder Name:_____Date of Birth: _____Relationship to patient: _____

Policy Holder Employer: _____Employer Phone#: _____

Acknowledgment: I certify that the above information is true and correct to the best of my knowledge. I understand the importance of current information and know it is my responsibility to keep this office informed of any changes in my insurance or personal information. I realize any claims that are denied or delayed due to this information not being updated is my responsibility. I understand fully that in the event my insurance company or financially responsible part does not pay for the services I receive, I will be financially responsible for payment. By signing below, I verify the information above is correct and true.

_____ _____

(Patient or Legal Representative's Signature) (Date)

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PATIENT NAME:_____DATE OF BIRTH:_____

HOW DID YOU HEAR ABOUT OUR CLINIC? _____

REFERRING PROVDIER:_____REASON FOR VISIT:_____

DATE SYMPTOMS STARTED: _____

PAST AND CURRENT MEDICAL PROBLEMS

	AIDS/HIV		HEART DISEASE		STROKE (CARDIOVASCULAR ACCIDENTS)
	BREATHING PROBLEMS		HEMORRHOIDS		THYROID DISORDES – HYPER OR HYPO
	BREAST DISORDERS		HIGH BLOOD PRESSURE		OTHER
	DIABETES MELLITUS TYPE		CANCER		LAST MENSTRUAL CYCLE DATE_____
	KIDNEY FAILURE		SEIZURES – TYPE		ARTIFICAL IMPLANTS

FAMILY HISTORY

	TYPE AND/OR WHO
CANCER	
DIABETES	
CARDIOVASCULAR	
OTHER	

MEDICATION ALLERGIES

☐ NO KNOW DRUG ALLEGIES

MEDICATION: _____ REACTION: _____
MEDICATION: _____ REACTION: _____

SOCIAL HISTORY

☐ TOBACCO USE: _____/DAY DATE QUIT: _____
☐ ALOHOL USE: _____/DAY DATE QUIT: _____
☐ DRUGS USE: _____/DAY DATE QUIT: _____

SURGICAL HISTORY

1._____ DATE:_____
2._____ DATE:_____
3._____ DATE:_____
4._____ DATE:_____
5._____ DATE:_____
(Additional, please use back of sheet)

CURERNT MEDIATIONS

1._____DOSAGE:_____
2._____DOSAGE:_____
3._____DOSAGE:_____
4._____DOSAGE:_____
(Additional, please use back of sheet)

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PATIENT NAME:_____**DATE OF BIRTH:**_____

REVIEW OF SYSTEMS

CHECK IF YOU HAVE THESE SYMPTOMS

CHECK THIS BOX IF **NO** FOR ALL BELOW ☐

YES	CONSTITUTIONAL	YES	GENITOURINARY
	FEVER		NOCTUREA
	WEIGHT GAIN		INCONTINENCE
	FATIGUE		FREQUENCY
	CHILLS		PAIN WITH URINATION
	WEIGHT LOSS		BLOOD IN URINE
YES	**EARS/NOSE/MOUTH/THROAT/EYES**	**YES**	**MUSKULOSKELETAL**
	CHANGE IN VISION		LEG PAIN
	LOSS OF VISION		BACK PAIN
	HEADACHES		LEG CRAMPS
	NECK MASS		JOINT PAIN
	SORE THROAT	**YES**	**INTEGUMENTARY**
YES	**CARDIOVASCULAR**		RASH
	CHEST PAIN		CHANGE IN MOLE
	SYNCOPE		NEW MOLES
	CLAUDICATION		BREAST LUMPS
	MURMUR		NIPPLE DISCHARGE
	IRREGULAR HEARTBEAT	**YES**	**NEUROLOGICAL**
	LEG EDEMA		NUMBNESS/TINGLING
	VARICOSE VEINS		SPEECH DIFFICULTY
YES	**RESPIRATORY**		SEIZURES
	SHORTNESS OF BREATH	**YES**	**PSYC**
	COUGH		ANXIETY
	WHEEZING		DEPRESSION
	SLEEP APNEA		HALLUCINATION
	HOARSENESS	**YES**	**ENDOCRINE**
YES	**GASTROINTESTIAL**		EXCESSIVE THIRST
	VOMITING		HEAT INTOLERANCE
	CONSTIPATION	**YES**	**HEMETOLOGICAL**
	BLOOD IN STOOL		EASY BLEEDING
	LOWER CALIBER OF STOOL		EASY BRUISING
	BLACK TARRY STOOLS		LYMPH NODE SWELLING
	BLOATING		
	HEARTBURN		
	DIARRHEA		
	JAUNDICE		

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT CONTACT INFORMATION

Name:_____

Address:_____

Telephone:_____ E-mail:_____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to Vancouver Vein & Surgical Center, LLC ("VVSC") use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations (the "Consent") by VVSC.

Notice of Privacy Practices: You have the right to read VVSC's Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice of Privacy Practices provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

VVSC may leave voicemails and send text messages, email or mail to the contact information provided above regarding my appointments, treatment or other protected health information related to my care with VVSC _____ [*initial*]

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed below. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Vancouver Vein & Surgical Center
13115 NE 4th St #230
Vancouver, WA 98684

SIGNATURE

I,_____, have had full opportunity to read and consider the contents of this Consent and VVSC's Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to VVSC's use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature:_____ Date:_____

If this Consent is signed by a personal representative, parent or guardian on behalf of the patient, complete the following:

Personal Representative/Parent/Guardian Name:_____

Relationship to Patient:_____

Signature:_____

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CHRISTOPHER RUBANO, MD

Statement of Patient Financial Responsibility

Vancouver Vein & Surgical Center, LLC ("VVSC") appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. **You are responsible for any amounts not covered by your insurer**. If your insurance carrier denies any part of your claim, or if you or your provider elects to continue past your approved period, you will be responsible for your balance in full. Please note that VVSC may use a third-party billing service to process claims.

I have read the above policy regarding my financial responsibility to VVSC for providing services to me or the above-named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to VVSC, the full and entire amount of bill incurred by me or the above-named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Forms of Payment Accepted: Cash, Checks and Credit Card ($50 fee for returned checks)

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment. Failure to cancel within 24-hours may result in a $50 late cancellation fee. I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care. We will notify you in writing, via certified mail, if you are discharged from care.

I have read and understand the above information, and I agree to the terms described:

Patient Signature _____ Date _____

Self-Pay

I do not have health insurance and will be responsible for payment of services rendered by VVSC. Alternatively, I do have health insurance but wish to self-pay for health services rendered by VVSC. I agree to pay VVSC, the full and entire amount of treatment given to me or to the above-named patient at each visit.

Please note, Medicare beneficiaries *may not* self-pay for covered services. Those services must be billed through Medicare.

By signing below, I certify that I am not a Medicare beneficiary and will self-pay at the time of service.

Patient/Guarantor Signature _____ Date _____