Vein Center Houston
Medical and Cosmetic Specialists

How did you hear about us?

Email add: _____

Physician Referral ☐ **Ad** ☐ **TV** ☐ **Website** ☐ **Billboard** ☐ **Bldg sign** ☐ **Cell #:**_____

Patient Information

Last Name:		**First:**	**MI:**
Date of Birth:	**Referring Physician name & address:**		
Social Security No:			
Pt. Address:		**Gender:** **Male**	**Female**
City:	**State:**	**Zip:**	**Marital Status:**
Employer Name & Address:			
Home Phone:	**Work Phone:**	**Emergency Contact Name and Telephone:**	

Insurance Information

Insurance name:	**Member Number:**	**Group Number:**	
Insurance Address:	**City:**	**State:**	**Zip:**
Insurance Telephone Number:		**Insurance Fax Number:**	

Policy Holder and relationship to Insured:(Guarantor)

Insured's Last name:	**First:**	**MI:**	
Insured's Address:	**City:**	**State:**	**Zip:**
Insured's Employer Name:	**Address:**	**City:**	**State:**
Zip:	**Home Phone:**	**Work Phone:**	
Employer Phone:	**Social Security:**	**Date of Birth:**	

SERVICES RENDERED ARE TO BE PAID AT TIME OF VISIT AND NON-REFUNDABLE

X _____

Patient's or Personal Representative's Signature **Date** **Insured's Signature** **Date**

Mario O. Kapusta M.D.
PO Box 6730 Houston, Texas 77265 Phone 713-349-8346, Fax 713-218-8346
www.veincenterhouston.com

Vein Center Houston
Medical and Cosmetic Specialists

Welcome to Vein Center Houston! This office is committed to you and your well-being.

Payment and Insurance Information

This office requests payment at the time services are rendered. This includes co-pays and insurance deductible. Insurance companies occasionally apply services other than office visits towards a calendar year deductible. Please be prepared to pay today. If you have any questions regarding your insurance benefits, please contact your insurance company. If you have an HMO or POS policy and require a referral please be sure that our office has this on file, otherwise, full payment will be due from you today. Please be sure that your account is current prior to scheduling your next appointment. This office accepts cash, checks, and the following major credit cards: Visa, MasterCard, American Express and Discover.

Patient Services

We do our best to schedule in a manner to minimize your wait. Occasionally, emergencies occur, making it difficult for us to see you at your scheduled appointment time. Please be assured that this office devotes itself toward serving you as promptly as possible. If you arrive 15 minutes late we may reschedule your appointment to avoid delaying other appointments.

Please note: This office reserves the right to charge a cancellation fee of $55.00 for appointments/$250.00 for surgeries cancelled without a 24-hour notice. In addition, please be sure to notify our office if any of your information has recently changed. This includes personal and insurance information. This helps us to stay in contact with you and ensures that your insurance claims are processed accurately.

Thank you for choosing our office for your health care needs.

I have read and fully understand the policies of this office and agree to the terms.

Patient signature:_____ Date: _____

Mario O. Kapusta M.D.
PO Box 6730 Houston, Texas 77265 Phone 713-349-8346, Fax 713-218-8346
www.veincenterhouston.com

Vein Center Houston
Medical and Cosmetic Specialists

Authorization and Consent for Billing

Subscriber employer: _____ Employer Phone#: _____

Patient Name: _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize and request my insurance to pay the Doctor the amount(s) due on my claim for services rendered to my dependent or me. I further agree that should the amount be insufficient to cover the entire medical and surgical expense, I will be responsible for payment of the difference; and if the nature of the disability were such that it is not covered by the policy, I will be responsible for payment of the entire bill. Furthermore, "I request that payment of authorized Medicare benefits be made to me or on my behalf to Dr. Mario Kapusta for any services furnished to me by that physician. I authorize any holder of medical information about to me to release to the Healthcare Financing Administration (HCFA) and its agents any information needed to determine these benefits or the benefits payable for related services." **INITIALS** _____

Financial Agreement/ Billing Authorization

1. **All services are to be paid at the time of service**. HMO, PPO'S and Managed Care members are billable only if we are contracted with the carrier at the time services are rendered and have a valid authorization. **ALL DIAGNOSTIC AND THERAPUTIC PROCEDURES which are classified AS COSMETIC are payable at the time services are rendered.**

2. In consideration of the services to be rendered to me/patient, **I HEREBY INDIVIDUALLY OBLIGATE MYSELF/GUARANTOR TO PAY THE ACCOUNT OF THE VEIN CENTER HOUSTON IN ACCORDANCE WITH THE RATES AND TERMS FOR THE CENTER/PHYSICIAN.** Should the account be referred to an attorney or collection agency for collection, I shall pay reasonable attorneys and collection expenses. All delinquent accounts referred to an attorney and/or collection agency shall bear interests at the legal rate.

3. I hereby authorize direct payment to the **VEIN CENTER HOUSTON** and/or Physician of any insurance benefits otherwise payable to me for their services rendered to me at a rate not to exceed the **VEIN CENTER HOUSTON**/Physician's regular charges.

4. I certify that I am the patient or am duly authorized by the patient and/or guarantor to execute this document and accept its term.

5. If my insurance is Medicare, I certify that the information given to me is applying for payment under Title XVIII of the Social Security Administration Act is correct.

6. I give **VEIN CENTER HOUSTON** the right to appeal any claims not processed correctly in my behalf.

I hereby authorize **VEIN CENTER HOUSTON** and/or Aggregate to act as an agent in the billing of Medicare or any health insurance covering services rendered by the physician and/or **VEIN CENTER HOUSTON.**

HIPAA **acknowledgement of review of Notice of Privacy Practice: I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.**
INITIALS_____

SERVICES RENDERED ARE TO BE PAID AT TIME OF VISIT AND NON-REFUNDABLE

X_____ _____

Patient/Guarantor Signature **Date:**

Print Name: _____ **Relationship (If Not Patient):** _____

Mario O. Kapusta M.D.
PO Box 6730 Houston, Texas 77265 Phone 713-349-8346, Fax 713-218-8346
www.veincenterhouston.com

Vein Center Houston
Medical and Cosmetic Specialists

HIPAA CONSENT
Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of their home.

I wish to be contacted in the following manner (check all that apply):

___Home Telephone _____
__OK to leave a message with details
__Leave message with call-back number only

___Written Communication
__OK to mail to my home address
__OK to mail to my work/office address
__OK to fax to this number _____

___ Work Telephone
__ OK to leave a message with details
__Leave message with call-back number only

___ I give authorization for VCH to leave a message in my absence with _____, _____ (indicate relation to patient) for matter regarding:
__ my appointment reminders
__my account such as billing and amount due
__ my treatment/test results

_____ Patient Name (Print)

_____ Birthdate

_____ Signature

_____ Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep record of PHI disclosures. Information provided below, if completed properly, will constitute and adequate record

Note: Uses and disclosures for Treatment Records, Payment Information and Healthcare Operations may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to whom Address or Fax number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T=Treatment Records; P=Payment Information; O=Healthcare Operations
(3) Enter How disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

Mario O. Kapusta M.D.
PO Box 6730 Houston, Texas 77265 Phone 713-349-8346, Fax 713-218-8346
www.veincenterhouston.com

Vein Center Houston
Medical and Cosmetic Specialists

Consent to Photograph

I, _____, hereby authorize Dr. Mario O. Kapusta/and staff to photograph my legs while I am under his care. I agree that he may use or permit other persons to use the negatives or prints prepared for insurance purposes. Dr. Mario O. Kapusta may utilize the pictures for publication in the medical literature or education (without identifying the patient.)

_____ _____
Patient Date

_____ _____
Witness Date

Mario O. Kapusta M.D.
PO Box 6730 Houston, Texas 77265 Phone 713-349-8346, Fax 713-218-8346
www.veincenterhouston.com

Vein Center Houston
Medical and Cosmetic Specialists

Name:_____

IF YOU EXPERIENCED ANY OF THE FOLLOWING IN THE PAST 6 MONTHS:
Check if Yes

_____Leg pain
_____Heat to touch
_____Weakness
_____Numbness
_____Bruising
_____Ankle Swelling
_____Burning sensation
_____Heaviness
_____Leg Ulcer
_____**Does it affect your daily activities?**
Additional comments:_____

_____

HAVE YOU TRIED ANY OF THE FOLLOWING FOR RELIEF IN THE PAST 6 MONTHS: Check if Yes

_____Elevation
_____Compression Stockings
_____Over the Counter Pain Relievers (Tylenol/Advil/Alieve)
_____How many times in one month?

Other current Medications:_____

_____

_____

_____

Allergic to any medications:_____

_____

PAST VEIN HISTORY- Check if Yes

_____DVT

_____Phlebitis

_____Bleeding from veins

_____Sclerotherapy (injections)

_____Venogram/Sonogram (ultrasound)

_____Aids/HIV/Hepatitis

_____Clotting Disorder

_____Prior Vein Surgery (year) _____

_____**Family History** of varicose veins

MEDICAL HISTORY
IF YOU HAVE ANY OF THE FOLLOWING:
Check if Yes

_____High blood pressure
_____Pregnancy (indicate number)
_____Diabetes
_____Seizures or convulsion
_____Fainting or dizzy spells
_____Stroke
_____Nervous breakdown
_____Frequent infection of boils
_____Abnormal or prolonged bleeding
_____Difficult skin healing or abnormal scarring
_____Breathing problems (any)
_____Asthma
_____Autoimmune disease (e.g. lupus)
_____Severe arthritis
_____ Weight gain

Other Medical History not listed above:_____

_____

_____

SURGERIES: _____

_____

_____

DO YOU TAKE ANY OF THE FOLLOWING: Check if Yes

_____Blood thinners
_____Aspirin
_____Arthritis Medications

Please provide us with your pharmacy telephone number:

_____

Patient Signature: _____
Date:_____

Mario O. Kapusta M.D.
PO Box 6730 Houston, Texas 77265 Phone 713-349-8346, Fax 713-218-8346
www.veincenterhouston.com