



ADVANCED VEIN & VASCULAR SOLUTIONS
Board Certified Vascular Surgeons

We would like to thank you for choosing Advanced Vein & Vascular Solutions for your care. We are committed to providing you with quality and affordable healthcare. Because you may have some questions regarding personal and insurance responsibility for services rendered, we have developed this payment and financial policy. Please read and feel free to ask any questions that you may have. Please sign in the space provided, a copy will be provided to you upon request. Our physicians participate in a number of networks; it is your responsibility to verify that the physician you are seeing is in the network. If you belong to an insurance company that requires a referral, you must have that referral with you at the time of service.

For our insured patients:

COPAYS: All copays must be paid at the time of service.

DEDUCTIBLES: Some insurance policies have deductible requirements. These are your responsibility and will be billed to you. Payment is due within 14 days of receipt of your statement.

NON-COVERED SERVICES: Some services that you receive may be non-covered, or not considered necessary by your insurance. These services are your responsibility and will be billed to you. Payment is due within 14 days of receipt of your statement.

SUBMITTING CLAIMS: We will submit your claims and assist in every reasonable way we can to get your claims paid. However, there may be times when your insurance company requires information from you directly. It is your responsibility to provide this information if or when is requested. If your claim is denied because you failed to provide this information, the balance will become your responsibility.

PROOF OF INSURANCE: All patients must complete our registration process. We must also obtain a copy of your current insurance card. If you do not have this available at your appointment, and do not produce it within a reasonable amount of time, you will be responsible for your service.

POLICIES WITHOUT OFFICE VISIT COVERAGE: If your insurance policy does not have office visit coverage, payment for your visit is due at the time of service.

CHANGES IN COVERAGE: If your insurance changes please notify us prior to your appointment.

For our self-pay patients: Payment must be made at the time of service.

FOR ALL PATIENTS:

NO SHOW APPOINTMENTS: We give you an opportunity for the first missed appointment. For the second and forward there would be a \$25.00 fee for appointments not cancelled within 24 hours.

FORMS FEE: There is a fee of \$10.00 per form for completion. Payment for this service is due before the completed form leaves the office.

COLLECTIONS PROCEDURES: If your account is over 90 days old, partial payment must be negotiated with the billing department. Please be aware that if your balance remains unpaid, we will refer your account to an outside collections agency and you and your immediate family members may be subject to discharge from the practice. If referred, the balance must be paid in full before you are scheduled again.

Forms of payments: We accept CASH, PERSONAL CHECKS, MONEY ORDERS, VISA, AND
MASTER CARD

Thank you for your understanding our payment and financial policy. Please let us know if you have any questions or concerns.

** I have read and understand the above payment and financial policy and agree to abide by its guidelines.

Print Patient Name

Signature of Patient

Date



Edward G. Izzo, Jr., M.D., FACS ÉMark J. Alkire, M.D., FACS
Board Certified in Cardiac, Vascular & Thoracic Surgery

PATIENT INFORMATION

PLEASE PRINT

Date: ___/___/___

Name: _____ Date of Birth _____ Age: _____

Address _____ Home Phone _____

City: _____ State: _____ Zip: _____ Work Phone: _____ Cell: _____

E-mail _____ (provide if ok to contact you by e-mail)

S.S. #: _____ Sex: _____ Marital Status: _____

Referred By: Dr _____ Friend _____ Internet _____ Newspaper _____

Spouseø Name: _____ Employer: _____

Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Holderø Name: _____ Birth Date: _____

Secondary Insurance: _____

Policy Holderø Name: _____ Birth Date: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Signature _____ Date: _____

Witness _____

PATIENT, FAMILY AND SOCIAL HISTORY

NAME: _____ DATE _____ BIRTH DATE _____ AGE _____

CHIEF COMPLAINT _____
(REASON FOR TODAY'S VISIT)

ALLERGIES TO MEDICINES, FOODS, LATEX? _____

LIST ALL CURRENT MEDICATIONS

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

LIST PATIENT'S DOCTORS _____

CIRCLE: SINGLE MARRIED SEPERATED DIVORCED WIDOWED LIVING ARRANGEMENT

MOST RECENT OCCUPATION: _____ RETIRED? _____

NUMBER OF CHILDREN _____ NUMBER OF PREGNANCIES _____ HEIGHT _____ WEIGHT _____

SMOKING HISTORY: YES/NO QUIT? _____ WHEN? _____ HOW MUCH? _____ HOW LONG? _____

CAFFEINE USE: YES/NO HOW MUCH? _____

ALCOHOL USE: YES/NO DAILY? _____ HOW MUCH? _____ ILLICIT DRUG USE: YES/NO

FAMILY HISTORY: (CIRCLE) DIABETES HEART DISEASE HIGH BLOOD PRESSURE STROKE
KIDNEY DISEASE ANEMIA MENTAL ILLNESS TB CANCER ARTHRITIS

EXPLAIN: _____

LIST ALL PAST SURGERY WITH DATE AND MAJOR HOSPITALIZATIONS:

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

MOTHER LIVING _____ DECEASED _____ AGE _____ CAUSE _____

FATHER LIVING _____ DECEASED _____ AGE _____ CAUSE _____

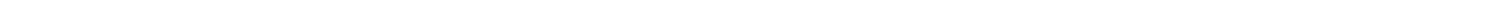
HAS PATIENT EVER HAD PROBLEMS WITH ANESTHESIA? _____

EXPLAIN _____

HAS PATIENT EVER HAD A BLOOD TRANSFUSION? _____

WHEN? _____ REACTION? _____

IS PATIENT AN ORGAN DONOR? YES/NO



HEALTH HISTORY

NAME:

PLEASE **CIRCLE** ALL THAT APPLY TO YOU NOW OR IN THE PAST:

GENERAL

WEIGHT LOSS
FATIGUE

EYES/EARS/NOSE/THROAT

GLASSES/CONTACTS
CATARACTS
GLAUCOMA

VERTIGO
SINUS TROUBLE
HEARING AID

ENDOCRINE/BLOOD/IMMUNE/ALLERGIC

DIABETES

HYPOGLYCEMIA

THYROID PROBLEMS

ANEMIA

CANCER

IMMUNE DEFICIENCY

ENLARGED GLANDS

HIV POSITIVE

BRUISE EASILY

MONONUCLEOSIS

HIVES

ECZEMA

HEMOPHILIA

BLOOD DISORDER

GASTROINTESTINAL

HEARTBURN

CIRRHOISIS

DIARRHEA

CONSTIPATION

JAUNDICE

HEPATITIS

NAUSEA/VOMITING

CARDIOVASCULAR

ABNORMAL EKG

ANGINA

HEART ATTACK

HIGH BLOOD PRESSURE

LOW BLOOD PRESSURE

SHORT OF BREATH

GENITOURINARY

BURNING ON URINATION

BLEEDING ON URINATION

KIDNEY PROBLEMS

SEXUALLY TRANSMITTED DISEASE

FREQUENCY

ABNORMAL DISCHARGE

DIALYSIS

MUSCULOSKELETAL/NEUROLOGICAL

ARTHRITIS

BACK TROUBLE

FRACTURES

GOUT

EPILEPSY

SEIZURES

MUSCLE WEAKNESS

MEMORY LOSS

STROKE

JOINT SWELLING

RESPIRATORY

ABNORMAL CHEST X-RAY

ASTHMA

COPD/EMPHYSEMA

FREQUENT UPPER RESPIRATORY INFECTIONS

PNEUMONIA

CYSTIC FIBROSIS

VARICOSE VEINS

VEIN STRIPPING

BLOOD CLOT

ULCER

HEAVINESS

ITCHING/BURNING

VEIN INJECTIONS

PHLEBITIS

ACHING/PAIN

TIREDNESS/FATIGUE

SWOLLEN ANKLES

LEG CRAMPS

RESTLESS LEGS

FEMALES ONLY

LAST PERIOD _____

AGE OF MENOPAUSE _____

REVIEWED BY DR. _____ DATE _____



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AUTHORIZATION AND ASSIGNMENT

Dear Patient:

Insurance is not a substitute for payment. Some companies pay a fixed allowance for certain procedures while others pay a percentage of the charge. It is your responsibility to pay any deductible, co-pay uncovered services or any balance not paid by your insurance.

Patient Name: _____

Print Name

I hereby assign all medical and / or surgical benefits to which I am entitled, including Medicare, Private Insurance and other Health Plans to:

IZZO & ALKIRE, M.D.s P.A.

This assignment will remain in effect until revoked by me in writing. I also, hereby authorize said assignee to release all necessary information to secure payment. A photostatic copy of this Authorization and Assignment may be accepted.

If this account is assigned to an Attorney and / or agency for collection, the prevailing party shall be entitled to reasonable fees and costs of collection.

Responsible Partyø

Signature: _____ Date: _____

PATIENTøS MEDICARE AUTHORIZATION (ONLY)

PatientøS Medicare Number: _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to:

IZZO & ALKIRE, M.D.S P.A

For any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim, If øother health insuranceø is indicated in the item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Responsible Partyø

Signature: _____ Date: _____



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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____
(Patient's name)

D.O.B. _____ LAST FOUR OF SS# _____

GIVE: _____

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION REGARDING MY MEDICAL STATUS TO:

(Name)

(Address) (Phone) (Fax)

THE FOLLOWING TYPES OF INFORMATION ARE SPECIALLY AUTHORIZED FOR RELEASE:

EXPIRATION DATE OF THIS AUTHORIZATION: ____/____/____

(Patient's signature) (Date)

(Witness signature) (Date)

Our Notice of Privacy Practices provided information about our use of a patient's protected health information (PHI). The Notice contains a Patient Rights section describing your rights under the law. Patients have the right to access, inspect, and copy protected health care information used to make decisions about them.