MIAMI VEIN CENTER
Endovascular Venous Surgery

Jose I. Almeida, MD, FACS, RVT
Diplomate, American Board of Surgery- Vascular
Diplomate, American Board of Surgery- General
1501 South Miami Avenue, Miami, FL 33129
Office: 305.854.1555 • Fax: 786.541.2101

Patient Registration Form

Date: Pt. #:

Name:

Birth Date: SS#:

Address:

City: State: Zip : Home Phone #:

Work Phone #: Cell #:

Email: Fax#:

Sex:(Circle) M F Marital Status S M W D

Employer: Occupation:

Employer Address:

Spouse's Name: Phone#:

Emergency Contact: Phone#:

Primary Care Physician: Phone#:

Referring Physician: Phone#:

Referred By: Physician Friend:_____ Web Seach Newspaper
Pharmacy Name: **Phone#:** **Zip:**

I, the above and/or guarantor, hereby authorize all benefits covered under my insurance policies to be paid in accordance with this assignment. In consideration of hospital, medical and or surgical expenses, I hereby authorize assign and transfer all benefits due to me under the above described contract to cover the following expenses:

A photostatic copy of this assignment shall be considered effective and valid as the original for all services rendered by Jose I. Almeida, MD, PA, and/or associated provider.

1. All services are to be paid at the time of service. HMO, PPOS and Managed Care members are billed only if we are contracted with the carrier at the time services are rendered and a valid authorization has been received. All Co-Pay, Co-Ins and Deductibles are the patient's financial responsibility. ALL PROCEDURES classified AS COSMETIC are payable at the time services are rendered.

and/or associated provider IN ACCORDANCE WITH ACTIVE RATES AND TERMS. Should the account be referrred to an attorney or collection agency for collection, I shall pay reasonable attorney's, and collection expenses. All delinquent accounts refered to an attorney and/or collection agency shall bear interest at the legal rate.

3. I hereby authorize direct payment to Jose I. Almeida MD, PA and/or his associated provider of all insurance benefits otherwise payable to me for their services rendered in my behalf at a rate not to exceed the regular charges of Jose I. Almeida, MD, PAand/or associated provider.

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 terms.

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

I hereby authorize Jose I. Almeida, MD, PA and/or our Billing Dept to act as an agent in the billing of Medicare or any health insurance covering services rendered by Jose I. Almeida, MD, PA and/ or his associated providers.

I also understand this center follows the State of Florida and Federal Law concerning the privacy of Medical Information (HIPAA).

_____ **I have received a copy of the Patient Privacy Act**

Initials

Patient Privacy Act is attached to patient package.

X_____ **Date:** _____

Patient /Guarantor Signature

Print Name: _____

Relationship (If Not Patient): _____

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VENOUS HISTORY

Today's Date: _____

Patient's Name: _____ **DOB:** _____ **Age:** _____

Height:_____ Weight:_____ Sex: [ ] Male **[ ]** Female: ___#Pregnancies

Reason for visit: _____

Symptoms: (Check all that apply)
Lower Extremity:

[ ] *Leg Pain:*	[ ] Right [ ] Left	[ ] Some of the time	[ ] Most of the time	[ ]All of the time
[ ] *Heaviness:*	[ ] Right [ ] Left	[ ] Some of the time	[ ] Most of the time	[ ]All of the time
[ ] *Swelling:*	[ ] Right [ ] Left	[ ] Some of the time	[ ] Most of the time	[ ]All of the time
[ ] *Throbbing:*	[ ] Right [ ] Left	[ ] Some of the time	[ ] Most of the time	[ ]All of the time
[ ] *Itching:*	[ ] Right [ ] Left	[ ] Some of the time	[ ] Most of the time	[ ]All of the time
[ ] *Skin Changes:*	[ ] Right [ ] Left	[ ] Some of the time	[ ] Most of the time	[ ]All of the time
[ ] *Impact on work/activities:*	[ ] Right [ ] Left	[ ] Some of the time	[ ] Most of the time	[ ]All of the time
[ ] *Bleeding:*	[ ] Right [ ] Left	[ ] Some of the time	[ ] Most of the time	[ ]All of the time
[ ] *Ulcers:*	[ ] Right [ ] Left	[ ] Some of the time	[ ] Most of the time	[ ]All of the time
[ ] *Pain while Walking:*	[ ] Right [ ] Left	Distance you can walk free of pain:_____		

Have you used Compression Stockings to alleviate symptoms?
[ ] No [ ] Yes (3 to 6 months) [ ] Yes (over 6 months) [ ]Tried but could not tolerate them

Have you tried to alleviate symptoms by elevating your legs [ ] YES [ ] NO

[ ] **Pelvic Pain or Heaviness**

Medical History: (Check all that apply)

[ ] High Blood Pressure
[ ] Diabetes
[ ] High Cholesterol
[ ] Heart Attack
[ ] Stroke
[ ] Stomach Ulcers- Bleeding
[ ] Cancer: _____
[ ] Current Smoker [ ] Former Smoker
Year Started: _____
Packs Per day: _____
Quit date/year: _____

[ ] Thyroid Problems
[ ] Asthma
[ ] Migraines
[ ] Sleep Apnea
[ ] SVT- (Superficial Blood Clot)
[ ] DVT- (BLOOD CLOT)
[ ] PE (Pulmonary Embolism)
[ ] Varicocele
[ ] Positive Clotting Factor: _____
[ ] Other: _____

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Venous Surgical History:

[ ] Ablation [ ] Right [ ] Left
[ ] Stripping [ ] Right [ ] Left
[ ] Phlebectomy [ ] Right [ ] Left
[ ] Schlerotherapy [ ] Right [ ] Left
[ ] Foam Schlerotherapy [ ] Right [ ] Left
[ ] Iliac vein stent [ ] Right [ ] Left

By whom: _____ When: _____

Other Surgical History:

[ ] Hysterectomy
[ ] Pace Maker
[ ] Hernia
[ ] Tonsillectomy
[ ] Gall Bladder
[ ] Abdominoplasty
[ ] Appendectomy
[ ] Heart Surgery
[ ] Spinal Surgery
[ ] Knee Surgery
[ ] C-Section

(Please list all other previous surgeries**)**

_____

_____

Medication History:

[ ] Birth Control [ ] Long term Use of Anticoagulants

Other Medications: _____

_____

_____

Drug Allergies:

Are you allergic to any anesthesia? [ ] Yes [ ] No Iodine Allergy ? [ ] Yes [ ] No

Other Drug Allergies: _____

Family History of Venous Disease [ ] Mother [ ] Father [ ] Other:_____

Are you Breast Feeding? [ ] NO YES: [ ]
Are you Pregnant? [ ] NO YES: [ ] 1st trimester [ ] 2nd trimester [ ] 3rd Trimester

_____ _____

Patient's Signature **Jose I. Almeida, MD**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED & DISCLOSED & HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE PLEASE CONTACT OUR DIRECTOR OF OPERATIONS

OUR OBLIGATIONS:

Law to requires us:

- Maintain the privacy of health information about you.
- Give you this notice of our legal duties and privacy practices regarding health information about you; and
- Follow the terms of our notice that are currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION:

The following described the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our Director of Operations.

- **For Treatment.** We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are or who may need the information in connection with such care.
- **For Payment.** We may use and disclose Health Information so that others or we may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.
- **For Health Care Operations**. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use it for the purpose of evaluating the way we communicate with patients. We may also share Health Information with other entities that have a relationship with you (such as your primary physician.).
- **Appointments Reminder and Information About our Centers.** We may use your Health Information to send you information about an appointment that you may have with our facility (ies) or for new services that we may be providing at our center.
- **To Provide Information About Other Health-Related Treatments**. We may use and disclose information for the purpose of obtaining records for our quality assurance department. For example, we may share your Health Information with a doctor in order to obtain results of a surgical biopsy (which is required by law to follow MQSA standards in quality control of mammographic findings).
- **Individuals Involved In Caring For You Or Involved With Payment Of Your Care.** If necessary we may need to share your Health Information with a family member or a close friend. For example, we may tell a person involved close to you that you have arrived at our center.

SPECIAL SITUATIONS:

- **As Required By Law.** We will disclose Health Information when required to do so by International, Federal, State or Local law.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.
- **Business Associates.** We may disclose your Health Information to businesses that perform certain functions on our behalf. For example, some of our Business Associates perform our transcription or billing components. All of our Business Associates are required to protect the privacy of your health information and are not allowed to disclose any of your information other than as specified in our contract.
- **Workers' Compensation.** We may release Health Information for workers' compensation or similar programs.
- **Government Monitoring of Health Activities.** We may disclose Health Information to agencies responsible for the healthcare system, government programs and compliance with any other laws. These activities may include audits, investigations, inspections and licensure.
- **Lawsuits and Disputes.** We may release Health Information if there is a pending judicial or administrative proceeding. For example, we will disclose information in response to court orders, administrative orders, subpoena, discovery request or other lawful process.
- **Law Enforcement.** We may release Health Information if asked by law enforcement or any authorized federal officials.
- **Inmates or Individuals in Custody.** If you are an inmate of a correctional institution or under the custody of law enforcement official, we may release Health Information to the correctional institution or law enforcement official.

YOUR RIGHTS:

- You have the following rights regarding Health Information we have about you.
- **Right to Inspect and Copy**. You have a right to inspect and copy your Health Information that may be used to make decisions about your care or payment or your care. This includes medical and billing records. To make a copy of your Health Information you must make your request in writing to:

  Miami Vein Center
  1501 S. Miami Ave.
  Miami, Fl. 33129

COMPLAINTS:

If you would like to file a complaint for violations of your privacy rights, you may do so at our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing.

Patient Signature: _____ Date: _____

E-mail Consent Form

Patient Name _____ Date _____

Patient E-mail address _____ Patient phone number _____

The LLC and its Staff Members shall be referred to throughout this consent form as "Provider".

1. RISK OF USING E-MAIL TO COMMUNICATE WITH YOUR PROVIDER:

Provider offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail has a number of risks that patients should consider before using e-mail communication. These include, but not limited to, the following risks:

a. E-mails can be circulated, forward, and stored in numerous paper and electronic files.
b. E-mails can be immediately broadcast worldwide and be received by unintended recipients.
c. E-mail senders can easily type in the wrong email address.
d. E-mail is easier to falsify handwritten or signed documents.
e. Backup copies of e-mail may exist even after the sender or recipient has deleted his or her copy.
f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their system.
g. E-mail can be intercepted, altered, forward, or used without authorization or detection.
h. E-mail can be used to introduce viruses into the computer system.
i. E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL:

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, the patients must consent to the use of email for patient information. Consent to the use of e-mail includes agreement with the following conditions.

a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patients medical record. Because they are part of the medical record, other individuals authorized to access the medical record will have access to those e-mails.
b. Provider may forward e-mails internally to Provider's staff and agent necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward emails to independent third parties without the patients prior written consent, except as authorized or required by law.
c. The patient is responsible for protecting his/her password or other means of access to e-

E-mail Consent Form

mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.

d. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.

e. It is the patient's responsibility to follow-up and/or schedule an appointment.

3. **PATIENT RESPONSIBILITIES AND INSTRUCTIONS:**

To communicate by e-mail, the patient shall:

a. Limit or avoid using his/her employer's computer.

b. Inform Provider of changes in his/her e-mail address.

c. Confirm that he/she has received and read the e-mail from the Provider.

d. Put the patient's name in the body of the e-mail.

e. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g. billing and questions).

f. Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password.

g. Withdraw consent only by e-mail or written communication to Provider.

4. TERMINATION OF THE E-MAIL RELATIONSHIP

The Provider shall have the right to immediately terminate the e-mail relationship with you if determined in the sole Provider's discretion, that you have violated the terms and conditions set forth above or otherwise breached this agreement, or have engaged in conduct which the Provider determines to be unacceptable.

E-mail Consent Form

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have discussed with the Provider or his/her representative and I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the Provider and me, and consent to the conditions herein. I agree to the instructions outlined herein, as well as any other instructions that my Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

Patient Name (print) _____

Patient Signature _____ Date _____

HOLD HARMLESS

I agree to indemnify and hold harmless the Provider and its trustees, officers, directors, employees, agents, information providers and suppliers, and website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the Provider, and any breach by me of these restrictions and conditions.

Patient Name (print) _____

Patient Signature _____ Date _____