Vein Specialists of Central Florida

Patient Registration

Today's Date: _____

Name: _____ _____ ____ Sex: Male ☐ Female ☐
Last First M.I.

Mailing Address:
Street: _____ City: _____ State: ____ Zip: _____

Phone: Home: _____ Cell: _____ Work: _____
Please circle the preferred number to reach you during our working hours.

Email: _____

Age: _____ Birth Date: _____ Social Security Number: _____

Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐

Occupation: _____ Employer: _____

Health Insurance Company: _____ Identification #: _____

Insured's Name (if different from patient): _____ Relationship: _____

Referring Physician: _____ Primary Care Physician: _____

Is there anyone else we may speak to concerning appointments and medical information other than your doctor?

☐ No ☐ Yes If yes please list: _____

_____
Patient's Signature

Pharmacy: Name: _____ Phone: _____

RACE:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Black or African American
- ☐ White
- ☐ Hispanic
- ☐ Other Race
- ☐ Unreported / Refused to report

ETHNICITY:
- ☐ Hispanic or Latin
- ☐ Not Hispanic or Latin
- ☐ Refused to Report

LANGUAGE:
- ☐ English
- ☐ Other
- ☐ Indian (includes Hindi & Tamil)
- ☐ Spanish
- ☐ Russian

REFERRAL INFORMATION

How did you hear about Surgical Consultants of Central Florida?
☐ Dr. Referral ☐ Friend ☐ Magazine Advertisement ☐ Yellow Pages
☐ Website / Internet ☐ Other (specify) _____

PATIENT'S NAME: _____

WHAT PROBLEM(S) ARE YOU SEEKING CARE FOR?

1. _____ 2. _____

MEDICAL HISTORY

DO YOU TAKE ANY OF THESE MEDICATIONS?

Coumadin / warfarin: Yes ☐ No ☐ Pradaxa: Yes ☐ No ☐ Plavix: Yes ☐ No ☐
Aspirin: Yes ☐ No ☐ Vitamin E Yes ☐ No ☐

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (Including over the counter and vitamins)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

HAVE YOU EVER BEEN DIAGNOSED WITH:

High blood pressure	Yes ☐ No ☐	Anemia	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐	Epilepsy	Yes ☐ No ☐
DVT (Blood Clot in Vein)	Yes ☐ No ☐	Hepatitis	Yes ☐ No ☐
Bleeding/Clotting Disorder	Yes ☐ No ☐	Kidney Failure	Yes ☐ No ☐
Rheumatic Heart Disease	Yes ☐ No ☐	Emphysema	Yes ☐ No ☐
Arthritis	Yes ☐ No ☐	C.O.P.D.	Yes ☐ No ☐
Stroke	Yes ☐ No ☐	Asthma	Yes ☐ No ☐
Heart Trouble	Yes ☐ No ☐	Mental Illness	Yes ☐ No ☐
Liver Disease	Yes ☐ No ☐	Heart Attack	Yes ☐ No ☐
Tuberculosis	Yes ☐ No ☐	HIV / AIDS	Yes ☐ No ☐
Mitral Valve Prolapse	Yes ☐ No ☐	Seizures	Yes ☐ No ☐
Cancer	Yes ☐ No ☐		

If yes what type(s): _____

OTHER SERIOUS PAST ILLNESSES:

_____ _____ _____
_____ _____ _____

ALLERGIES:

Adhesive Tape: Yes ☐ No ☐
Latex: Yes ☐ No ☐
Medicines: Yes ☐ No ☐ If yes please list: _____
_____

PATIENT'S NAME: _____

PREVIOUS SURGICAL OPERATIONS (Give type, approximate date and hospital):

_____ _____ _____
_____ _____ _____
_____ _____ _____

FAMILY HISTORY

Has any blood relative been diagnosed with any of the following (Write Relationship):

☐ AIDS _____ ☐ Diabetes _____ ☐ Heart Attack _____
☐ Colon Cancer _____ ☐ Lung Cancer _____ ☐ Breast Cancer _____
☐ Other Cancers (Type: _____) _____ ☐ Other _____

Are there any hereditary diseases in your family? _____

PERSONAL HISTORY

Are you a:

☐ Current Smoker How many packs a day? _____ For how long? _____
☐ Former Smoker How long ago did you quit? _____
☐ Nonsmoker

Do you drink alcohol?

Yes ☐ No ☐ How many drinks per week of: Beer _____ Wine _____ Whiskey _____

What is your present weight? _____ What is your height? _____

Date of last Colonoscopy: _____ ☐ Never had one

If Female: Are you pregnant? Yes ☐ No ☐ Date of last menstrual period: _____

Date of last Mammogram: _____ Date of last PAP smear: _____

REVIEW OF SYMPTOMS:

Check any symptoms you have experienced in the past year:

☐ Frequent or severe headaches
☐ Fainting or unconscious spells
☐ Seizures
☐ Blurred vision / visual changes
☐ Persistent hoarseness
☐ Difficulty swallowing
☐ Chest pain or angina
☐ Palpitations or fluttering heart
☐ Bloody sputum / coughed up blood
☐ Frequent shortness of breath
☐ Heartburn
☐ Recent frequent vomiting
☐ Vomited blood
☐ Blood in stools
☐ Frequent diarrhea
☐ Frequent constipation
☐ Difficulty starting urination
☐ Pain on urinating
☐ Getting up frequently at night to urinate
☐ Joint pains
☐ Joint swelling
☐ Kidney stones
☐ Blood in urine
☐ Stroke

Surgical Consultants of Central Florida, PA
1830 SE 18th Ave., Suite 3
Ocala, FL 34471
Phone: 352-690-6000 Fax: 352-690-6643

ATTENTION ALL PATIENTS

Please take note, that if your insurance requires a referral and/or authorization from your primary care physician to see Dr. Oraedu this has to be obtained **before** the time of your appointment.

Please check with your primary care physician to be sure all the necessary forms have been submitted to your insurance company in order for you visit to be covered.

All charges for visits and/or procedures **will be the responsibility of the patient** if the referral/authorization is not done, or not done correctly by your primary care physician and the insurance company rejects your claim for lack of or improper referral.

_____ _____

Patient Signature Date

SURGICAL CONSULTANTS OF CENTRAL FLORIDA, P.A.
Deerwood II, 1830 SE 18th Ave., Suite 3, Ocala FL 34471
Phone: 352-690-6000 Fax: 352-690-6643

FINANCIAL POLICY

Surgical Consultants of Central Florida, P.A. is committed to providing you with the best possible care and we are please to discuss our professional fees with you at anytime. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your responsibility.

RELEASE OF INFORMATION: I, the below named patient do hereby authorize Surgical Consultants of Central Florida, P.A. to release to any third or third party provider (such as Insurance Company, government agency, physicians or hospitals) any medical information and records concerning diagnosis and treatment for services rendered for its us in connection with determining a claim for payment for such treatment and or diagnosis or when required by a third party provider in the assessment planning and/or implementation of my care.

MEDICARE/MEDICAID: Patients certification authorization to release information and payment request: I certify that the information given by me in applying payment under Title XVIII/IX of the Social Security Act is correct. I authorize any holder of medical information about me to release the Social Security Administration/Division of Family Services or its intermediaries or carriers, any information needed for this related Medicare/Medicaid claim, I understand that I am responsible for any health insurance deductibles and co-insurance; I hereby certify that all Medicare/Medicaid benefits shall be assigned to Surgical Consultants of Central Florida, P.A. It is the policy of the practice "NOT" to accept Medicaid as a secondary payer, except those cases where Medicare is the primary payer. Surgical Consultants of Central Florida, P.A. dose adhere to the Florida Medicaid Agreement and Title 42 Code of the Federal Regulation 447.20 and Civil Rights Act of 1964.

COLLECTIONS: In the event my account is turned over to a collection agency or attorney for collection, I will be responsible for any and all costs incurred.

WORKERS' COMPENSATION: We will call to authorize your visit prior to your appointment. We will file with your company's insurance. In the event you fail to prosecute the claim for Workers' Compensation for this illness/condition or it is determined by the Workers' Compensation case you agree to pay the usual and customary fees for services rendered to you in this case.

AUTHORIZATION FOR SERVICES: I understand that my insurance company may require an authorization for service. If for any reason my insurance company does not give authorization for services incurred by me I will responsible for any and all charges.

FEES FOR SERVICES: I understand that all fees and or charges explained to me by this office is only an estimate of charges and will be considered as such. Fees may consist of several items for various separate procedures and tests. An actual charge can only be determined after services have been performed.

CHECKS: All checks presented must have a current address printed on the check. Checks can only be accepted with valid state identification i.e. driver's license. We are unable to accept postdated checks or to hold checks. A service fee will be applied to all returned checks.

CHILDREN OF DIVORCED PARENTS: The Guardian accompanying the minor child at the time services are rendered will be responsible for payment no matter who is said to be the responsible party by order of the divorce decree.

AGREEMENT: I will be responsible for the entire amount due for services rendered if the expense is not covered under my policy. Surgical Consultants of Central Florida, P.A. will not become involved in disputes between you and your insurance company regarding deductibles, co-payments covered charges or usual and customary charges other than to supply factual information as necessary.

The undersigned will pay all costs and expenses including a reasonable attorney's fee incurred or paid by Surgical Consultants of Central Florida, P.A. in the collection of this obligation by suit or otherwise. The entire amount is due and payable upon billing.

Patient Name: _____ (Print Name) Date of Birth: _____

Guarantor Signature _____ (Legal Signature) Date: _____ Phone: _____

Guarantor Social Security # _____ Address: _____

Surgical Consultants of Central Florida

Christian O. Oraedu, M.D., FACS

Financial Policies Cont.

Please read, initial, and sign at the bottom of the page indicating your understanding of the following information.

If you have questions, please do not hesitate to ask. It is important that you understand these specific policies of our office and that you understand how your insurance company will handle your claims.

____ **It is your responsibility to provide the office with current and correct insurance information.**

Failure to do so could result in your insurance company rejecting your claims for failing to obtain authorization or timely filing. In the event that this should happen, you will be responsible for incurred charges.

____ **It is your responsibility to verify coverage and adhere to the restrictions of your plan.**

We participate with most major insurance companies. However, insurance companies frequently specify the time frame in which patients can be seen and the coverage varies widely group to payor. If appointments are made that are not covered by your insurance plan, you will be responsible for your payment.

____ **Non-covered services.**

You agree to pay for services rendered that are subsequently determined to be "not covered" and applied to patient liability by your insurance company.

____ **It is your responsibility to know if you have a deductible, if your deductible has been met, or if you have co-insurance.**

We do not always have that information. You are responsible for all charges that are not paid by your insurance company, including those applied to your deductible or co-insurance.

____ **You will need to pay in full at the time of services if you are self-pay.**

If you are unable to do so, a payment agreement may be discussed with our billing supervisor and signed by both parties. All current payment arrangements must be finalized before new services will be provided.

____**If you have a co-pay, you are expected to pay this when you check in for your visits.**

Most insurance companies assign a co-payment to the patient and it is our responsibility to collect this at the time of service. We take cash, checks and credit cards. Be prepared to pay your co-pay when you check out for each appointment.

____ **If you have scheduled a procedure, you will be charged $50 if you fail to show up for your appointment or if you cancel your procedure with less than 72 hours notice.**

Procedure scheduling and preparation requires a great deal of time and effort for our staff. Exceptions may be made for inclement weather or emergencies. The correct number to call when canceling an appointment is 352-690-6000. If you cannot speak to a staff member over the phone you must leave a message.

Signature of Patient/Guardian:_____Date:_____

Printed Name of Patient: _____

Printed Name of Guardian if signing:_____

Surgical Consultants of Central Florida

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

* *

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

SURGICAL CONSULTANTS OF CENTRAL FLORIDA, P.A.

1830 SE 18th Ave., Suite 3, Ocala, Florida 34471
Phone: (352) 690-6000 Fax: (352) 690-6643

Patient's Name: _____

Date of Birth: _____ Social Security #: _____

Doctor's Name Dr. Christian Oraedu Phone: (352) 690-6000 Fax: (352) 690-6643

Doctor's Address: 1830 SE 18th Ave., Suite 3, Ocala, FL 34471

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Florida law requires that information contained in medical records be held in strict confidence and not be released without your written authorization.. The authorization you sign on this page will remain in effect until you request in writing that your authorization be withdrawn, which you may do at any time. You have a right to receive a copy of this authorization upon your request.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____ authorize _____
TO RELEASE TO SURGICAL CONSULTANTS OF CENTRAL FLORIDA, P.A. ANY OR ALL THAT APPLY:

_____ Cardiac Clearance
_____ Medical Clearance
_____ Colonoscopy/ Flexible Sigmoidoscopy Report
_____ Op Report
_____ Pathology
_____ Labs
_____ Radiology Reports
_____ Records from te following provider(s): _____
_____ The general records created at the medical facility
_____ _____

Signature of patient / legal guardian: _____ Date: _____

Witness: _____ Date: _____