



Welcome!

Welcome to Vein Care Coastal Bend. We are a specialty surgery practice dedicated to the diagnosis and treatment of varicose veins and venous insufficiency.

Our goal is to thoughtfully guide you through the patient experience before, during and after your scheduled appointment so that you feel well-connected to your physician and our care team every step of the way. Thank you for entrusting us with your care.

BEFORE YOUR APPOINTMENT

We strive to provide timely care to all our patients. To aide in the time waiting in our practice the day of your first visit, please have the attached forms completed in their entirety and bring a copy of all insurance cards, a photo ID and a list of all current medications and/or medication bottles when you arrive to your appointment. Having these forms completed when you arrive will greatly be appreciated and speed up your wait time in our office. Plan on being in our office about two hours total.

DURING YOUR APPOINTMENT

Our team will take the time to get to know you, listen to your concerns and develop the best plan of care for you. Most patients have a very detailed venous ultrasound performed by our Register Vascular Technicians on their first visit to aid in the proper diagnosis depending on the presenting complaints. This is a painless scan but does require about 45 to 60 minutes just for the scan not including the physician visit. After the scan you will see Dr. Charles Rodman who will develop a plan of treatment for you based on the results of your venous ultrasound results. This is your opportunity to ask any questions or concerns you may have about your venous health.

AFTER YOUR APPOINTMENT

If you are a candidate for surgery, the doctor will send a surgery order to our pre-certification department to start to work on an authorization from your insurance company *if applicable*. This process can take up to 30 days in some cases.

Once authorized, our surgery scheduler will call you with your estimated costs due, *if any*, and then schedule for your surgery.

**If you have any questions, please call our office at 361-371-8100
or visit our website at www.veincarecoastalbend.com**



Charles J. Rodman, M.D.
JCM Vein, PLLC.
3301 South Alameda Street, Suite 402
Corpus Christi, Texas 78411

PATIENT DEMOGRAPHICS

PATIENT INFORMATION:

Patient Name: _____ SS# _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: ____/____/____ Sex: ☐Male ☐Female Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed

Race: ☐American Indian or Alaskan Native, ☐Asian, ☐Black or African American, ☐Caucasian, ☐Chinese, ☐Filipino, ☐Hispanic, ☐Japanese, ☐Multi-racial, ☐Native, ☐Hawaiian, ☐Pacific Islander, ☐Other, ☐Undetermined, ☐Pt Declines

Language: ☐English, ☐French, ☐German, ☐Japanese, ☐Korean, ☐Latin, ☐Spanish, ☐Vietnamese, ☐Patient Declines

Ethnicity: ☐Hispanic or Latino, ☐Not Hispanic or Latino, ☐Patient Declines to State

Employer (if applicable): _____ Occupation: _____

Employment Status: ☐Full-time, ☐Part-time, ☐Housewife, ☐Unemployed, ☐Retired

Student Status: ☐Full-time, ☐Part-time

Pharmacy Name / Location: _____ Patient Email Address: _____

RESPONSIBLE PARTY INFORMATION: (complete only if different from patient)

Guarantor: _____ Date of Birth: ____/____/____ SS# _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact: (or someone not in your household)

Name: _____ Relation: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

INSURANCE INFORMATION:

Primary Insurance Name: _____

Policy #: _____ Group: _____

Name of Insured: _____ Date of Birth of Insured: ____/____/____

Secondary Insurance Name: _____

Policy #: _____ Group: _____

I hereby authorize JCM Vein, PLLC. Vein Care Coastal Bend to furnish any information needed by any insurance carrier to process any claim(s) for services rendered to the above named patient by JCM Vein, PLLC. Vein Care Coastal Bend and/or Charles J. Rodman, M.D. and authorize all insurance payments be paid directly to JCM Vein, PLLC. Vein Care Coastal Bend and/or Charles J. Rodman, M.D. *I agree to be responsible for any amount and/or supplies not covered by insurance or for the full amount if the above named patient does not have insurance.*

SIGNATURE: _____ DATE: _____

ASSIGNMENT OF BENEFITS

(AOB)

Assignment of Insurance Benefits – Appointment as Legal Authorized Representative

I hereby assign all applicable health insurance benefits and all rights and obligations that I have under my health plan to JCM Vein PLLC Vein Care Coastal Bend - Charles J. Rodman M.D. and its representatives (hereinafter, "My Authorized Representatives") and I appoint them as my authorized representative with the power to:

- File medical claims to the health plan
- Direct all payment of medical benefits payable directly to JCM Vein PLLC Vein Care Coastal Bend - Charles J. Rodman M.D.
- File appeals and grievances with the health plan
- Discuss or divulge any of my personal health information with any third party including the health plan

I certify that the health insurance information that I provided to JCM Vein PLLC Vein Care Coastal Bend - Charles J. Rodman M.D. is accurate as of the date set forth below and that I am responsible for keeping it updated.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from JCM Vein PLLC Vein Care Coastal Bend - Charles J. Rodman M.D. are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I understand I can revoke this authorization in writing at any time.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Patient

Date



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HEALTH ASSESSMENT AND HISTORY

Name: _____ Date: ____/____/____
DOB: ____/____/____ Age: _____ Sex: _____ Height _____ Weight _____

CHIEF COMPLAINT:

Primary Care Physician: _____ Phone: _____
Home Health Agency: _____ Phone: _____
Pharmacy: _____ Phone: _____

CURRENT MEDICAL CONDITIONS: (example: High blood pressure, Diabetes)

Illness / Condition	Illness / Condition

SURGICAL HISTORY: (example: Hysterectomy, Appendectomy, Stent, Angiogram?)

Surgery	Date	Surgery	Date

HOSPITALIZATIONS: (Have you ever had a serious illness requiring a hospital stay other than surgery?)

Reason	Year	Hospital	Reason	Year	Hospital

Current Medications: (Please list prescriptions, over the counter, over the counter NSAIDS, vitamins, herbs, etc)

Medication	Dose	How often	Medication	Dose	How often

Allergies: Are you allergic to any medications, food, environmental, IODINE, SHELLFISH, LATEX or other substances? Please specify allergy and reaction

☐ No Known Allergies

Allergy	Reaction	Allergy	Reaction

Have you ever taken steroids / cortisone / prednisone? ☐ Yes ☐ No If yes, last date taken: _____

Have you, or a blood relative, had a reaction to anesthetic? ☐ Yes ☐ No

If yes, please explain: _____



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HEALTH ASSESSMENT AND HISTORY Cont'd

Social History:

Occupation: _____ ☐ Full-time, ☐ Part-time, ☐ Retired, ☐ Homemaker, ☐ Unemployed, ☐ Disabled

Alcohol Use Screening:

<input type="checkbox"/> No	<input type="checkbox"/> Yes
	How often did you have a drink containing alcohol in the past year? <input type="checkbox"/> Monthly or less <input type="checkbox"/> 2-4 times a month <input type="checkbox"/> 2-3 times a week <input type="checkbox"/> 4 or more times a week
	How many drinks did you have on a typical day when you were drinking in the past year? <input type="checkbox"/> 1 or 2 <input type="checkbox"/> 3 or 4 <input type="checkbox"/> 5 or 6 <input type="checkbox"/> 7 to 9 <input type="checkbox"/> 10 or more
	How often did you have 6 or more drinks on one occasion in the past year? <input type="checkbox"/> Never <input type="checkbox"/> Less than monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Daily or almost daily

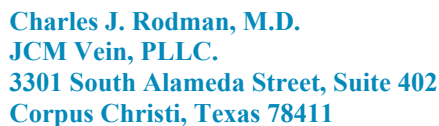
Tobacco Use Screening:

<input type="checkbox"/> Nonsmoker	<input type="checkbox"/> Former Smoker	<input type="checkbox"/> Current Smoker
	How long has been since you last smoked? <input type="checkbox"/> 1-3 months <input type="checkbox"/> 3-6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> 1-5 years <input type="checkbox"/> 5-10 years <input type="checkbox"/> > 10 years	How often do you smoke cigarettes? <input type="checkbox"/> everyday <input type="checkbox"/> some days
		How many cigarettes a day do you smoke? <input type="checkbox"/> 5 or less <input type="checkbox"/> 6-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-30 <input type="checkbox"/> 31 or more
		soon after you wake up do you smoke your first cigarette? <input type="checkbox"/> within 5 minutes <input type="checkbox"/> 6-30 minutes <input type="checkbox"/> 31-60 minutes <input type="checkbox"/> after 60 minutes
		Are you interested in quitting? <input type="checkbox"/> Ready to quit <input type="checkbox"/> Thinking about quitting <input type="checkbox"/> Not ready to quit

Family History

- | | | |
|---------------------------------------|--------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Aneurysms | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Leg swelling |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> DVT (Blood Clots) | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Stroke / TIA | <input type="checkbox"/> Lupus | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Lymphedema | | |

Patient Name _____ DODOB: _____



DOB

Respiratory	Yes	No
Asthma		
Wheezing		
Shortness of Breath		
TB – History		
Emphysema		
Collapsed Lung		
Cardiovascular	Yes	No
Chest Pain		
Shortness of Breath		
Pacemaker		
Congestive Heart Failure		
Angina		
Heart Attack		
Bleeding Disorders		
Blood Clots (DVT/PE)		
Phlebitis		
Peripheral Vascular Disease		
Blood Transfusions		
Gastrointestinal	Yes	No
Abdominal Pain		
Diverticular Disease		
Blood in Stools		
Frequent Diarrhea		
Frequent Constipation		
Heartburn / Indigestion		
Nausea / Vomiting		
Special Diet		
Recent Weight Large Amount of Loss?		
Musculoskeletal	Yes	No
Arthritis		
Muscle Disease		
Physical limitation Cane/Walker		
Wheelchair/ Prosthesis		
Amputations/ Shoe Inserts		
Skin	Yes	No
Change in skin color		
Wounds		
Bruises		
Lesions		
Rash		

[illegible]

VENOUS HEALTH HISTORY

Patient Name: _____ DOB: ____/____/____

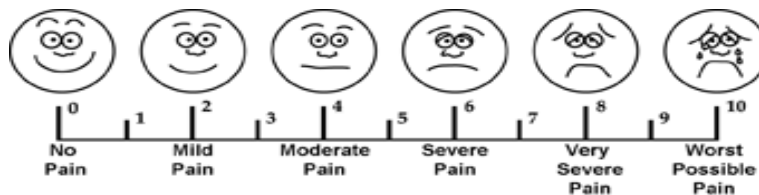
Do you experience any of the following in your legs?

	Left	Right	Comments (optional)
Aching / Pain	<input type="checkbox"/>	<input type="checkbox"/>	
Heaviness	<input type="checkbox"/>	<input type="checkbox"/>	
Tiredness / Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	
Itching / Burning	<input type="checkbox"/>	<input type="checkbox"/>	
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	
Leg Cramps	<input type="checkbox"/>	<input type="checkbox"/>	
Restless Legs	<input type="checkbox"/>	<input type="checkbox"/>	
Throbbing	<input type="checkbox"/>	<input type="checkbox"/>	
Sleep Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	
AM Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

Activities Affected by Legs: Walking, Shopping, Exercising, Cleaning, Cooking, Showering, Job Functions:

What is the pain level in your legs? (select one)

Occupation: _____



Have you ever had the following?

	No	Left	Right	Date	Comments (optional)
Vein Stripping or Ablation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Vein Injections (Cosmetic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Leg Ulcerations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Blood Clots (DVT / PE)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Do you have a family history of varicose veins? ☐Yes ☐No Who? _____

Have your symptoms worsened in recent months? ☐Yes ☐No

Do you take any medication for pain in your legs? ☐Yes ☐No What? _____ For how long? _____

Do you elevate your legs for discomfort? ☐Yes ☐No How long? _____

Do you exercise? ☐Yes ☐No How often? _____ Type? _____

Do you wear / have you worn compression stockings? ☐Yes ☐No Rx or OTC? _____ How Long? _____

Do you have difficulty walking? ☐Yes ☐No

Does your occupation require prolonged standing? ☐Yes ☐No

Does your occupation require prolonged sitting? ☐Yes ☐No



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VENOUS HEALTH HISTORY Cont'd

Patient Name: _____ **DOB:** ____/____/____

Special Needs: ☐ Cultural ☐ Communication ☐ Literate ☐ Developmental ☐ Religious
☐ Financial ☐ Foreign Language

Learning Style: ☐ Verbal ☐ Written ☐ Demonstration

PRESENT LIVING ARRANGEMENTS

- ☐ Home Alone
☐ Home with Family / Caregiver (who) _____ ☐ Part-Time ☐ Full-Time
☐ Nursing Home (name) _____ Group Home (name) _____
☐ Other, Explain: _____ Are pleased with the care you are receiving: ☐ Y ☐ N

PERSONAL CARE NEEDS (Based on Health Status)

Do you currently need or will you need, help with the following (check all that apply):

- ☐ Standing ☐ Walking ☐ Toileting ☐ Eating ☐ Wound Care ☐ Cooking
☐ Dressing ☐ Bathing ☐ Preparing Medications ☐ Transportation for health care needs

Explain: _____

DO YOU USE ANY OF THE FOLLOWING? (Check all that apply)

- | | |
|--------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Dentures Uppers (<input type="checkbox"/> Full / <input type="checkbox"/> Partial) | <input type="checkbox"/> Dentures Lower (<input type="checkbox"/> Full / <input type="checkbox"/> Partial) |
| <input type="checkbox"/> Glasses / Contacts | <input type="checkbox"/> Braces or retainers |
| <input type="checkbox"/> Loose, chipped or cracked teeth | <input type="checkbox"/> Hearing Aids (<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Both) |
| <input type="checkbox"/> Capped teeth or bridge work | <input type="checkbox"/> Prosthesis / Implant |
| <input type="checkbox"/> Hospital Bed | <input type="checkbox"/> IV Therapy |
| <input type="checkbox"/> Respiratory treatments / Inhalers | <input type="checkbox"/> Oxygen ____ L/minute |
| <input type="checkbox"/> Bi-Pap / C-Pap | <input type="checkbox"/> Other: _____ |

Advanced Directives – <i>Please Bring with you</i>	Yes	No	Explanation
Durable Power of Attorney	<input type="checkbox"/>	<input type="checkbox"/>	
Health Care Representative	<input type="checkbox"/>	<input type="checkbox"/>	
Do Not Resuscitate Document	<input type="checkbox"/>	<input type="checkbox"/>	
Living Will	<input type="checkbox"/>	<input type="checkbox"/>	
Life-Prolonging Procedures	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any of the above documentation?	<input type="checkbox"/>	<input type="checkbox"/>	
Where is the copy of the document	<input type="checkbox"/>	<input type="checkbox"/>	



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VENOUS HEALTH HISTORY Cont'd

Patient Name: _____ **DOB:** ____/____/____

Have you ever had the following tests?

Stress Test on the heart? ☐ Yes ☐ No When / Where? _____

MRI or CT scan? ☐ Yes ☐ No When / Where? _____

Angiogram of blood vessels? ☐ Yes ☐ No When / Where? _____

Lung function test / pulmonary function test? ☐ Yes ☐ No When / Where? _____

Heart catheterization / angiogram? ☐ Yes ☐ No When / Where? _____

Signature of Patient

Date



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CONSENT TO PHOTOGRAPH

Patient Name: _____ **DOB** _____

The undersigned authorizes JCM Vein, PLLC. Vein Care Coastal Bend, to take and reproduce photographs of the above-named person in communication with diagnosis, care and treatment. Use of such materials and the person's name is also authorized for use in the dealing with the named person's insurance company, including filing claims, precertifications, medical necessity and appeals with the said insurance company.

_____ **Initial to indicate you have read, understand and approve authorization as stated above.**

_____ **Initial to indicate you authorize JCM Vein, PLLC. Vein Care Coastal Bend to use your lower leg photographs (*anonymously*) on their social media sites.**

I release JCM Vein, PLLC. Vein Care Coastal Bend and its' physicians, employees and consultants from any liability in connection with the use of such materials. I understand that this authorization will remain effective until revoked in writing.

Patient Signature

Date

Signature of Patient's Legal Representative (if applicable)

Date

Print Name of Legal Representative

Relationship to patient



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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I, _____ DOB _____, acknowledge and agree that I have reviewed a copy of **JCM Vein, PLLC. Vein Care Coastal Bend's Notice of Privacy Practices** that are available on the practice website and accessible in patient waiting room.

I have also given my permission for JCM Vein, PLLC. Vein Care Coastal Bend to discuss my medical history and billing information with the following person(s):

Name: _____ Phone: _____

Name: _____ Phone: _____

Patient Signature

Date

Signature of Patient's Legal Representative (if applicable)

Date

Print Name of Legal Representative

Relationship to patient

CLINIC USE ONLY:

JCM Vein, PLLC. Vein Care Coastal Bend made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of the Notice of Privacy Practices: **[Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.]:**

Signature of Employee

Date

Print Name of Employee

Title



MEDICAL RECORDS RELEASE FORM

Patient Name: _____

Date of Birth: ____ / ____ / ____

Social Security #: ____ - ____ - ____

I hereby authorize the following health care professional, medical facility, or laboratory, etc.

_____ to release the following medical

Name of Physician, Laboratory, Clinic, Hospital or Healthcare Facility

records to JCM Vein, PLLC., Vein Care Coastal Bend, Charles J. Rodman, M.D.

_____ All medical records from _____ (date) to _____ (date)

_____ Initial Exam records

_____ All Office records

_____ All Hospital records

_____ Laboratory / Pathology reports

_____ All Imaging Records

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I also understand that revocation will not apply to information that has already been released as specified by this authorization.

This consent shall become invalid ☐ 180 days or ☐ Indefinitely from the date signed unless a different expiration date, event or condition is specified. Specify: _____

I understand that:

- Information disclosed by this authorization may be re-disclosed by the recipient of your PHI. Such re-disclosure will no longer be protected by this authorization.
- I have the right to receive a copy of this authorization.
- A copy or facsimile of this authorization is as valid as the original.

Signature of Individual or Individual's Legal Representative

Date

Print Name or Print Name of Legal Representative Relationship to Individual

**Mail to: JCM Vein, PLLC., Vein Care Coastal Bend
3301 Alameda Street, Suite 402
Corpus Christi, Texas 78411-1882
Fax: 361-371-8101**



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JCM Vein, PLLC.
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PATIENT FINANCIAL POLICY ACKNOWLEDGEMENT

Patient Name: _____ **DOB:** _____

Thank you for choosing JCM Vein, PLLC. Vein Care Coastal Bend! We are committed to the success of your medical treatment and care. Please understand that payment for your services is part of your treatment and care.

For your convenience, we have answered a variety of commonly asked financial policy questions below. Your signature on this Financial Policy Acknowledgment is required no matter what level of insurance coverage you have or self pay. If you need further information about any of these policies, please ask to speak the Office Manager.

How May I Pay?

We accept payment by cash, check, VISA, MasterCard, American Express, and Discover.

Do I Need a Referral and/or Authorization?

If you have an HMO plan with which we are contracted, you need a referral and/or authorization from your primary care physician prior to your first visit. If we have not received a referral and/ or authorization prior to your arrival at the office, you will need to call your primary care physician and have a referral faxed to our office at Attn: Billing. If you are unable to obtain the referral and/or authorization at the time of service, you will be rescheduled to a later date to allow ample time for us to receive this in the office. We will not see you without this referral and/or authorization on file.

What is My Responsibility for Services?

- If services you receive are covered by your insurance plan: you will be responsible for all applicable co-pays, deductibles and out of pocket amounts at the time of service. JCM Vein, PLLC. Vein Care of Coastal Bend offers a variety of payment plans.
- If services you receive are not covered by your insurance plan: you will be responsible for the full payment at the time of service. JCM Vein, PLLC. Vein Care Coastal Bend offers a variety of payment plans.

Our practice bases your costs off what is quoted to our billing department by your insurance company based on contracted allowed amounts. When verifying benefits our billing department will ask how your insurance covers the diagnosis Varicose Veins, specialist office visits, venous Doppler (CPT codes 93970, 93971) and surgical procedures (CPT codes 36475, 36466 & 36482).

We recommend that you call your insurance company as well and check on those services and CPT codes mentioned above. You may also see what medical policy guidelines your insurance has in place that you must follow for these procedures.

JCM Vein, PLLC. Vein Care Coastal Bend will not be held responsible for any misquotes in benefits.

Patient Name: _____ **DOB:** _____

Surgical Procedures in the Office

If your physician recommends surgery, an inter-office referral will be created and sent to the Surgery Coordinator. When the Surgery Coordinator receives the inter-office referral and your office visit and ultrasound documentation is completed, a request for predetermination/ preauthorization will be sent to your insurance company with all required documentation. You will not be scheduled for surgeries until this process is done and it may take up to 30 days to get a predetermination from your insurance. Once our office has received the predetermination / preauthorization from your insurance company, an estimate of your patient responsibility will be issued and the Surgery Scheduler will call you with the estimated amount you will owe for the procedure(s) and to schedule the surgeries. This estimated amount will be expected to be paid in full at the initial surgery or appropriate pay plan initiated. At that time, if you have any questions regarding the surgeries, the scheduler will be happy to assist you or, if unable to, he/she will direct you to the appropriate department.

What if my Child Needs to See the Physician?

A parent or legal guardian must accompany patients who are minor, under the age of 18. This accompanying adult is responsible for payment of the account, according to the policy outlined above.

Walk-In Appointments:

Vein Care Coastal Bend actively encourages every patient to schedule an appointment for every episode of care. Patients in need of urgent care are asked to call ahead for an appointment even if they are only able to give minimal notice of their impending arrival. If your insurance requires referrals for office visits and there is not one on file, you will be expected to pay in full in advance of being seen.

No Show or Canceled Appointments:

If you are unable to keep your scheduled appointment, please call our office 24 hours before your appointment time to reschedule. This will allow time to provide that time slot to another patient. We reserve the right to charge \$25.00 for appointments that are not canceled at least 24 hours in advance.

Acknowledgment:

I have read, understand and agree to the above financial policy. I understand that the charges not covered by my insurance company, as well as applicable co-pays and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to JCM PLLC. Vein Care Coastal Bend.

I authorize JCM Vein, PLLC. Vein Care Coastal Bend file my my insurance and to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim and referrals/ precertifications.

Signature of Patient

Printed Name

____/____/____
Date



Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We will abide by the terms of this Notice, including any future revisions that we may make to the Notice as required or authorized by law. We reserve the right to change this Notice and to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in our offices.

Note that we are required to notify you of certain unauthorized access, acquisition or use of your medical information.

1. Uses and Disclosures of Protected Health Information For Which No Patient Authorization Is Required

Treatment: We will use and disclose your protected health information to provide, coordinate, and manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. We may also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you or to your insurance company to obtain precertifications.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use or disclose your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate the name of your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may share your protected health information with third party “business associates” that perform various activities (e.g., billing, medical software company) for the practice.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or our practice has taken an action in reliance on the use or disclosure indicated in the authorization. Examples of uses and disclosures which require your authorization include uses or disclosures for certain marketing purposes.

Other Permitted and Required Uses and Disclosures That May Be Made with Your Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health

information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. Examples of these law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, and (3) pertaining to victims of a crime.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting

national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the HIPAA Privacy and Security Rules.

Electronic Disclosure. Please note that Texas law requires that we provide you with notice that your medical information may be subject to electronic disclosure. That is, we may use and disclose your medical information electronically. For example, if your medical information is contained electronically in an electronic medical record with our offices, and another provider who is involved in your treatment requests a copy of your medical records, we may forward such records electronically.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. You have the right to inspect and copy health information that may be used to make decisions about your care. We may deny your request to inspect and copy your health information in certain limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. We do not have to agree to any restrictions except in situations where you request that we restrict disclosure of your medical information to a health plan and the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law to be disclosed and the medical information solely pertains to an item or service you, or another individual on your behalf, has paid us in full.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. Please make this request in writing to our Privacy Officer.

You may have the right to have your protected health information amended. This means you may request an amendment of protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request.

3. Complaints/Concerns/Questions

If you have any questions regarding this Notice or wish to receive additional information about our privacy practices, please contact our Privacy Officer at **361-371-8100**. If you believe your privacy rights have been violated, you may file a complaint with our clinic or with the Secretary of the U.S. Department of Health & Human Services.

To file a complaint with our clinic, contact our Privacy Officer, at:

**Vein Care Coastal Bend
ATTN: Privacy Officer
3301 Alameda Street, Suite 402
Corpus Christi, Texas 78411-1882**

To file a complaint with the Secretary of the DHHS contact the:

**U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201**

All complaints must be submitted in writing. You will not be penalized for filing a complaint. A complaint must name the entity/person(s) that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable standards, requirements, or implementation specifications stated by HIPAA, as outlined in this Notice. A complaint must be filed within 180 days of when the complainant knew or should have known that the act or omission complained of occurred, unless this time limit is waived by the Secretary of the Department of Health & Human Services for good cause shown. We will not retaliate against you for filing a complaint.

This notice is for you to keep for your records