

PATIENT INFORMATION

Name _____ MI _____ DOB _____ Age _____
S.S # _____ Male _____ Female _____ Single _____ Married _____
Address _____ City _____ State _____ Zip _____
Phone# _____ Cell # _____
Parent/Guardian if patient is a minor _____

Email

*Would you like to correspond by email and receive our e-newsletter (circle) YES / NO

Insured's Employer _____ Work# _____

Date of Injury _____ Motor Vehicle accident _____ Work Related _____

Primary Insured's Name _____ D.O.B. _____

Insurance _____ Phone # _____

Address _____

I.D. # _____ Policy/Group # _____ Co-Pay \$ _____ Deductable \$ _____

Self _____ Spouse _____ Child _____ Coinsurance (circle) YES / NO

Secondary Insured's Name _____ D.O.B. _____

Insurance _____ Phone # _____

Address _____

I.D. # _____ Policy/Group # _____

Workman's Compensation Insurance _____ Claim # _____

Adjuster Name _____ Ph # _____ Fax # _____

Employer _____ Address _____ Ph# _____

***** WE CANNOT PROCESS YOUR CLAIM W/O THIS INFORMATION! *****

Referred By _____ Phone _____

PCP _____ Phone _____

PLEASE READ AND SIGN BELOW: AUTHORIZATION FOR RELEASE OF INFORMATION:

I hereby authorize The Vu Center for Plastic and Hand Surgery, PC to release any information requested by my insurance company, or to release information to any hospital or physician I may be referred to by this office. I also acknowledge that I have received a copy of the privacy practices.

ASSIGNMENT OF BENEFITS:

I authorize assignment of payment of medical benefits due me to The Vu Center for Plastic and Hand Surgery, P.C. for professional services she may render in the course of my treatment. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. **I HERBY AGREE TO PAY ALL CHARGES THAT EXCEED OR ARE NOT COVERED BY INSURANCE.**

Signature _____ **Date** _____

PATIENT HISTORY

Patient Name: _____ Date of Birth: _____

Date of Visit: _____ Reason for Visit: _____

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS?

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Diabetes	___	___	High Blood Pressure	___	___
Thyroid Disease	___	___	Heart Disease	___	___
Jaundice	___	___	Kidney Disease	___	___
Mental Disease	___	___	Lung Disease	___	___
Breast Cancer	___	___	Depression	___	___

Any other medical Condition: _____
If female: date of LMP _____ Any possibility of pregnancy _____

HAVE YOU HAD ANY SURGERY IN THE PAST?

PLEASE LIST SURGERY TYPE AND DATE

1. _____
2. _____
3. _____
4. _____

ARE YOU TAKING ANY MEDICATION?

PLEASE LIST MEDICATION NAMES AND DOSAGE

1. _____
2. _____
3. _____
4. _____

ARE YOU ALLERGIC TO ANY MEDICATION?

PLEASE LIST: _____

SOCIAL HISTORY:

Children? _____ Married or Single? _____
Hobbies? _____ Type of work you do? _____
Smoke? How Much? _____ Alcohol? How much? _____
Intravenous Drug Use? _____

DOES ANY OF YOUR FAMILY MEMBERS HAVE ANY OF THE FOLLOWING?

PLEASE INDICATE WHICH FAMILY MEMBER

1. Diabetes _____
2. High Blood Pressure _____
3. Kidney Disease _____
4. Heart Disease _____
5. Bleeding Disorder _____
6. Breast Cancer _____

Any other medical condition – Please Explain _____

DO YOU HAVE ANY RECENT SIGNS OF SYMPTOMS OF THE FOLLOWING?

1. Headache
2. Dizziness
3. Respiratory Infection
4. Chest Pain
5. Heart Burn
6. Reflux
7. Gastrointestinal Bleeding
8. Genitourinary Difficulty
9. Bleeding Disorder
10. Musculoskeletal: Comprising the skeleton and the muscles.

Any other medical condition: Please explain _____

PAYMENT POLICY

Please read the following statements and initial at the end indicating that you have read and understand your financial responsibility.

1. WORKERS COMPENSATION/PERSONAL INJURY PROTECTION:

- ☞ It is your responsibility to fill out the 827 form when you come to our office for your first visit. We need your employer's name, phone number, and insurance carrier.
- ☞ It is your responsibility to bring someone with you to your appointment at The Vu Center to fill out your paperwork if you do not have use of your writing hand.
- ☞ You are responsible for contacting your employer and informing them immediately of your injury.
- ☞ We are not responsible for contacting your insurance carrier. It is your responsibility as a patient to find out if your claim is or is not approved. If your claim is approved then you are not responsible for the bill unless otherwise said by your adjuster.
- ☞ If your worker's compensation claim or personal injury claim is denied then you are responsible for providing your health insurance information if you do have coverage. In a situation where you don't have medical insurance you are responsible for all charges.
- ☞ *There will also be an additional \$25.00 collection fee if account gets transferred into collection agency.*

Please initial _____

2. INSURANCE PATIENTS/NON WORKERS COMP:

- ☞ Dr. Vu may or may not be a participant with your insurance carrier. We will bill your insurance(s) first. You are responsible for any remaining balance the insurance does not cover including all deductibles and coinsurance.
- ☞ If you do not pay the patient balance within 30 days after receiving the initial statement, we will contact you to establish a payment plan.
- ☞ After 90 days, if we have not received payment from you or been contacted about payments, your bill will be submitted to a collection agency or small claims court depending on the amount due.
- ☞ We do ask for the insurance co-pay at the time of your visit. There will be a \$25.00 billing fee if you are not able to make your co-pay at that time.
- ☞ Our office policy requires that if you have a coinsurance or a deductible that has not been met you are required to pay \$25.00 at each appt. *This is NOT a co-pay. If you have a co-pay you will pay that instead.*
- ☞ If you need to cancel any future appointments please give us at least 24 hours notice.
- ☞ *There will also be an additional \$25.00 collection fee if account gets transferred into collection agency.*

Please initial _____

3. UNISURED/SELF PAY-PATIENTS:

- ☞ If you require a surgical procedure, you must pay half of the charge in advance (for example, if Dr. Vu's fee for a particular surgery is \$1,200.00, you are expected to pay \$600.00 before surgery is scheduled).
- ☞ You will be directly billed for all services provided. If you do not pay the patient balance within 30 days after receiving the initial statement, we will contact you to establish a payment plan.
- ☞ After 90 days, if we have not received payment form you or been contacted about payments, your bill will be submitted to a collection agency or small claims court, depending on the amount due.
- ☞ If you need to cancel any future appointments please give us at least 24 hours notice.
- ☞ *There will also be an additional \$25.00 collection fee if account gets transferred into collection agency.*

Please initial _____

4. ALL OUTSTANDING BALANCE (ALL PATIENTS):

- ☞ You will be directly billed for all services provided. If you do not pay the patient balance within 30 days after receiving the initial statement, we will contact you to establish a payment plan.
- ☞ After 90 days, if we have not received payment form you or been contacted about payments, your bill will be submitted to a collection agency or small claims court, depending on the amount due.
- ☞ All outstanding balances will have a reoccurring administrative fee of \$25.00 per month. You are able to dispute the charges after the entire principal balance is paid in full, but it is on a case by case basis. Please speak to your billing representative for further questions.
- ☞ *There will also be an additional \$25.00 collection fee if account gets transferred into collection agency.*

Please initial _____