MIDWEST SURGICAL CENTER

Patient Label

Advance Directive Policy

As an Ambulatory Surgery Facility, we at Midwest Surgical Center are required to advise patients about the nature of Advance Directives and how this affects patients' care in this facility.

The Governing Board, the Medical Director and the Medical Staff have elected to decline to implement elements of an advance directive on the basis of conscience and the fact that patients at this center are pre-screened to limit the possibility of the need for resuscitation.

By policy, the medical staff at this facility will always attempt to resuscitate a patient and transfer that patient to a hospital in the event of deterioration. It is the right of the patient to change facilities if there is any objection to this policy. Each patient should read the paragraph regarding Advance Directives included in the context of the operative consent.

We ask that you, the patient, bring a copy of a Living Will and/or Durable Power of Attorney for Health Care if you have either document to your surgical appointment. If you do not have the aforementioned documents, we will ask you to note that on your operative consent form.

If you have any further questions regarding this matter, please ask a member of the medical team.

- I have received a copy of Midwest Surgical Centers' Patient Rights and Responsibilities.
- I have been informed my physician has ownership in the Midwest Surgical Centers' Patients Rights' and Responsibilities.
- I have been informed of the grievance process and contact information.
- Yes_____ or No _____

_____ _____
Print Name Date

_____ _____
Patient Signature Date

_____ _____
Witness Date

Midwest Surgical Center
7100 Orchard Center Drive Suite A
Holland, Ohio 43528
(419) 866-2000

Revised 08.07.20

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(Please Print)

PATIENT REGISTRATION FORM

Primary Care Doctor Name: _____
Primary Care Doctor Phone: (___)_____-_____

How did you hear about us? ☐Primary Care Doctor ☐TV Commercial ☐Groupon Website ☐Senior Center Visit ☐Billboard ☐Postcard/Mailer ☐Family/Friend ☐Free Screening Event ☐Shopping Cart Ad

Federal Red Flag Rules require us to verify your identity to prevent healthcare fraud. Please provide your Driver License or State ID.

☐Single ☐Married ☐Widowed Birth Date: ___/___/___ SS#: ___-___-____ Driver License#_____

Last Name: , First Name: , Mid Int.:

Street Address: APT/PO BOX:

City: State: Zip Code:

Home Phone#( ) - Cell Phone#( ) - Email Address:

We are required by the Center for Medicare and Medicaid Services to obtain the following Information. You may decline answering by marking "Decline".

Sexual Identification: □ Heterosexual □ Homosexual □ Bisexual □ Other_____ □Don't Know □Decline		
Gender Orientation: □ Male □Female □Transgender(Female-to-Male) □ Transgender(Male-to-Female) □Other_____ □Decline		
Primary Language Spoken: □English □Other_____	Race: □White □Black/African American □Asian □American Indian □Pacific Islander □Decline to answer	Ethnicity: □Hispanic or Latino □ Not Hispanic or Latino □Decline to answer

INSURANCE INFORMATION *It is the patient's responsibility to provide an insurance card. If not provided, the account will remain self-pay.*

Primary Insurance Name: Policy Holder's Name:_____

Policy Holder's Birth Date: / / Policy Holder's Relationship to Patient: ☐Self ☐Spouse ☐Dependent

Secondary Insurance Name: Policy Holder's Name:_____

Policy Holder's Birth Date: / / Policy Holder's Relationship to Patient: ☐Self ☐Spouse ☐Dependent

IN CASE OF EMERGENCY *Please list a relative or friend that can be contacted in case of an emergency at our office.*

Name: Phone#: ( ) Relationship to Patient:_____

My signature on this form verifies that the information above is true and correct. I understand that by signing this form, I authorize/release of my insurance benefits to be paid directly to the physician. I also authorize Midwest Vascular and my insurance company to release any and all information necessary to process my claims, verify prescription medication history, and transmit drug prescriptions/lab orders/radiology orders. I also understand that I am financially responsible for any balances not paid by my insurance. I acknowledge that I have been given the opportunity to ask questions regarding this form and that all questions have been answered to my satisfaction.

	/ /		/ /
Patient Signature	Today's Date	Patient Representative Signature	Today's Date

MIDWEST VASCULAR & VARICOSE VEIN CENTER

Medical/Vein History Questionnaire

Patient Name_____ Date of Birth _____

Who is your Primary Doctor? _____

What Pharmacy do you use? _____ What location? _____

Have you ever had surgery of any kind? If yes, please list month and year: _____

_____

Please list any allergies you may have. _____

_____

Please list all of the names of medications that you currently take, include Dose and Frequency:

_____

_____

What is the reason for being seen today?

_____

Do you experience any of the following symptoms in your legs? (Please circle choice)

Aching/Pain	YES	NO	Throbbing	YES	NO
Swelling/Swollen Ankles	YES	NO	Cramps/"Charlie Horse"	YES	NO
Heaviness	YES	NO	Restless Leg	YES	NO
Tiredness	YES	NO	Skin Discoloration	YES	NO
Itching /Burning Feeling	YES	NO	Sores/Ulcers	YES	NO

How long have you had the symptoms you marked YES? _____

Are your symptoms worse at the end of the day? _____

Have you ever had any vein treatments or procedures? If yes, which one: _____

_____

List any medications, including non-prescription, you have taken for these symptoms?

_____

Do you or have you ever worn compression stockings, support hosiery, wraps? _____

How long have you used compression treatment? _____

Did compression treatment help? _____

Have you ever had a blood clot in your legs? If yes; month & year _____, which leg _____

Describe how these symptoms are affecting your everyday life: _____

_____

_____

Patient Signature _____ Date _____

MIDWEST VASCULAR
& VARICOSE VEIN CENTER

PAD Patient Questionnaire

Patient Name_____ Date of Birth _____

(Please complete and return to front desk before you see the doctor)

Do you currently smoke or have a history of smoking?	Yes	No
Do you have type I or type II diabetes?	Yes	No
Do you take blood pressure medication to control high blood pressure or high cholesterol?	Yes	No
Do you take cholesterol medication to control high cholesterol?	Yes	No
Have you ever had a heart attack or stroke?	Yes	No
Have you ever had an angioplasty or stent placed in the heart or leg?	Yes	No
Do you ever have to **stop walking** because you have pain or cramping in your buttocks, thighs, or calves? Does it go away after a short rest?	Yes	No
Do you ever experience cramping, tightness, “charlie horses” or pain in the legs or feet when lying down that improves when you stand up?	Yes	No

Additional comments you would like to tell the doctor?

_____

_____

_____

_____

Patient Signature _____ Date _____

PATIENT AUTHORIZATION FOR RELEASE OF PHI

Patient Name _____
Date of Birth: _____

Phone Number _____ Chart Number _____

Protected Health Information (PHI): PHI means information about a patient, including demographic information that may identify a patient, relates to the patient's past, present or future physical or mental health or condition, related health care services or payment for health care services

Sensitive Protected Health Information (SPHI): SPHI means Protected Health Information that pertains to particularly sensitive information, as defined by state law, such as (i) an individual's HIV status or treatment of an individual for an HIV-related illness or AIDS, or (ii) an individual's substance abuse condition or treatment of an individual for mental illness.

I authorize disclosure of the following information to the individuals listed below: (Please checkmark choices)

☐ **PHI** ☐ **SPHI**

Name: _____ Relation to Patient: _____ Name: _____ Relation to Patient: _____

I refuse authorization for disclosure of the following information to the individuals listed below:

☐ **PHI** ☐ **SPHI**

Name: _____ Relation to Patient: _____ Name: _____ Relation to Patient: _____

I Acknowledge that:

- This Authorization is voluntary; treatment will not be conditional on whether I sign this authorization.
- I have the right to refuse to sign this authorization.
- This authorization will expire on ____/___/___ OR one year from date of signature below.
- The information disclosed pursuant to this Authorization, except information protected by Federal/State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other state or federal laws.
- This authorization CANNOT be used to disclose Psychotherapy Notes.
- If I sign this authorization, I may revoke it later by sending a written notice of revocation to the privacy office at the practice.

  (*The only exception to your right to revoke is if the practice has already acted in reliance upon the authorization*).

Patient signature _____ Date _____

●●●●

Sign below if you are a personal representative of the patient:

Representative signature _____ Date _____

Print Name _____Relationship to Patient _____

MIDWEST VASCULAR
& VARICOSE VEIN CENTER

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.
- Submit Prescriptions for Medication to my pharmacy electronically, and receive medication history reports from my pharmacy.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and accreditation.

Patient Signature Date

Patient Printed Name

For Office Use Only

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

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

_____

Staff signature **Date**

MIDWEST VASCULAR
& VARICOSE VEIN CENTER

Many Health Insurance Companies are now requiring certain criteria to be met in order to approve outpatient surgical procedures for Varicose Veins. These can vary widely from company to company, but the most common criteria include:

- Patient has worn COMPRESSION STOCKINGS for 3 months or more.
- Patient practices LEG ELEVATION consistently to alleviate swelling
- Patient has engaged in, and achieved significant WEIGHT LOSS
- Patient has tried medication to control pain and inflammation such as NSAIDS (Tylenol, Motrin, Ibuprofen, Advil…)

As the patient, it is your responsibility to check with your own insurance company to ensure the Dr. Innocent Ubunama, DO is in-network under your plan. Additionally, our billing specialists try to ensure that your required procedure is covered by your insurance, but the responsibility ultimately remains with the patient. If your insurance expires or changes at any time; please let us know and provide us with the updated insurance card.

_____ _____

Patient Printed Name Date

_____

Patient Signature

2016

Midwest Vascular and Varicose Vein Center, LLC
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED, AND HOW YOU CAN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on January 1, 2016, and will remain in effect until it is amended or replaced by us.
It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made. You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Dr. Ubunama. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your protected health information (PHI) including electronic protected health information (ePHI) to provide you with our professional services which may include electronic disclosure. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.
Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

(a) Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your health information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. **(b) Right to Request Restriction of PHI:** You may request a restriction on our use and disclosure of PHI, but we are not required to agree to your request. The HITECH Act restricts provider's refusal of an individual's request not to disclose PHI in instances where the disclosure is to a health plan for purposes of carrying out payment or health operations (and is not for purposes of carrying out treatment); and the PHI pertains solely to a healthcare item or service for which our facility has been paid out of pocket in full.

Payment: We may use and disclose your PHI and ePHI to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.
Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.
Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

TYPICAL DISCLOSURE REASONS CONTINUED……..

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.
Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, and disease/infection exposure and to prevent and control disease, injury and/or disability.
Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.
National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get electronic copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $0.25 for each page.
Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.
Non-routine Disclosures: You have the right to request and receive an accounting of certain non-routine disclosures of your identifiable health information. We are required to maintain a log of these non-routine disclosures for a period of no less than six years beginning April 14, 2003. You can request non-routine disclosures going back 6 years starting on April 14, 2003.
Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement (Except in emergencies). Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.
Breach Notification Requirements: Beginning September 23, 2009, in the event unsecured protected information about you is 'breached" and the use of the information poses a significant risk of financial, reputable or other harm to you, we will notify you of the situation and any steps you should take to protect yourself against harm due to the breach. We will inform HHS and take any other steps required by law.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Practice Name: Midwest Vascular and Varicose Vein Center, LLC.
Privacy Officer: Dr. Ubunama
Telephone: 419-866-2000 Fax: 419-866-2010
Address/Locations: 7100 Orchard Center Dr. Holland OH 43528 or 735 Haskins Rd Ste. G Bowling Green OH 43402

Reviewed 1/31/13, 1/1/14, 1/1/15, 1/1/16AL

Patient Financial Policy

Thank you for choosing Midwest Vascular & Varicose Vein Center for your vascular healthcare!

We are committed to building a successful physician-patient relationship with you and your family. We believe a clear understanding of our Patient Financial Policy is important to our relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities.
**It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.).*

Minors or Guardianship
The parent or guardian is responsible for full payment and will receive the billing statements. It is our policy that the adult signing the registration form will be held as the responsible party for billing purposes. A signed release to treat is required as well-being accompanied by the parent/guardian.
Minor- a person under 18 not legally responsible
Guardianship-The legal relationship that exists between a person (the guardian) appointed by a court to take care of and manage the property of a person (the ward) who does not possess the legal capacity to do so, by reason of age, comprehension, or self-control.

Participating Insurances
We participate with Medicare, Ohio Medicaid, and most major insurance carriers. Contact your insurance carrier or our office if you are unsure if we accept and participate with your insurance plan.

Insurance Referrals
If your insurance company requires a referral you are responsible for obtaining it. Failure to obtain the referral may result in a lower or no payment from the insurance company, and the balance will be your responsibility.

Insurance Pre-authorizations
Our office will contact your insurance carrier for a pre-authorization for all medical and/or surgical procedures prior to the service. This may take a few weeks for your insurance to complete. ***A pre-certification, prior authorization, or pre-determination- is not a guarantee of payment only that insurance deems it as medically necessary services and is subject to coverage at the time of service.***
It is ultimately the patients' responsibility to know their insurance benefits. Therefore we recommend that the patient also contact their insurance to verify services are covered and not exclusion on the policy. We are happy to provide you with procedure codes and diagnosis codes needed to check with your insurance.

Insurance Claims
Health Insurance is a contract between you and your insurance company. In most cases, we are NOT a part of this contract. We will bill your health insurance company as a courtesy to you.

In order to properly bill your insurance company we require that you provide all insurance information including primary and secondary insurance, as well as, any change of insurance information. Every patient is expected to present an insurance card at each visit. Failure to provide <u>complete</u> insurance information may result in patient responsibility for the entire bill.

T*he insurance company makes the final determination of your eligibility and benefits.*

If your insurance company denies any of your medical claims, you agree to pay all balances, including but not limited to those charges above the usual and customary allowance. If we are not in-network with your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Patient Financial Policy Continued…..

Workers' Compensation Claims
In the case of a workers' compensation injury, you must obtain a First Report of Injury form (FROI) or the BWC claim number, phone number, contact person, and name and address of the insurance carrier prior to your visit. If this information is not provided, you may be asked to reschedule your appointment. Continued failure to provide viable BWC claim information will result in the account balance becoming a self-pay balance.

Automobile Accidents & Third Party Responsibility Claims
Care related to automobile accidents & Third Party Responsibility Claims will not be held for pending court cases, it must be able to be filed and subrogated through your health insurance. Third party liability coverage definition, is personal liability coverage that protects the customer from damages they incur due to the wrongful acts of others when the liable person is uninsured

Co-pays
All co-payments are due at the time of check-in unless previous arrangements have been made with a billing coordinator.

Self-pay Accounts & Patients with Major Medical or a High Deductible Plan
- patients without insurance coverage
- patients covered by insurance plans in which the office does not participate
- patients without an insurance card on file with us
- Liability cases will also be considered self-pay accounts. *We do not accept attorney letters or contingency payments.*

It is always the patient's responsibility to know if our office is participating with their plan.
If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Selfpay patients will be required to pay 2/3 of the service cost before services/procedures are rendered.

Extended payment arrangements are available if needed to pay the remaining 1/3 balance. Please ask to speak with a billing coordinator to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

Billing Statements
Statements are automatically mailed once a balance is transferred to patient responsibility. An automated reminder phone call will be made 15 days after each statement date if no payment is received. Payment is expected within 32 days from the statement date. In the event no payment is made within the three 32 day statement cycles; your account will be moved into a pre-collection status. It is the patient/guarantor's responsibility to make sure we have your current address and phone number in our records.
(*A limit of 3 statements total will be sent in the event of continued non- payment)*

NSF/Non-Sufficient Funds/Returned Checks
The charge for a NSF/returned check is $35.00 and payable only by cash or money order. This will be applied to your account in addition to the amount of the NSF check. You may be placed on a cash only basis following any returned check. Please be aware that our bank may try to process your NSF check a second time; in this case there will be two, $35.00 returned check fees assessed to the account.

No-Show/ Missed Appointments: Patients are required to provide a 24-hour notice of appointment cancellation. Patients will be charged $30.00 per missed appointment in which no prior notice was given. The first missed appointment will be forgiven with no fee charged. The 2nd and consecutive missed appointments will be charged 1 time per scheduled visit. Please be aware that this charge is to, in a small part, re-coupe the physician's losses from a non-usable appointment slot. This charge will not be filed to health insurance, as insurance does not cover noshow/missed appointment fees. Pursuant to state and federal law; Medicaid patients will not be charged a no show fee; However, Medicaid patients that continually no-show and disrupt normal scheduling practices will be subject to discharge from the practice.

MIDWEST VASCULAR
& VARICOSE VEIN CENTER

General Consent

The undersigned consents to the medical treatment and care as deemed necessary or advisable in the judgement of the physician and medical staff of Midwest Vascular & Varicose Vein Center. Health services may include but not limited to the examination, preventative treatment, x-ray, laboratory assessment, medical diagnosis and any consultation deemed necessary at the provider's discretion.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required and is given to encourage the provider to exercise his or her best judgement as to the requirements of such diagnosis or medical treatment.

_____ _____

Printed Name of Patient Date of Birth

_____ _____

Signature of Patient Date

_____ _____

Witness Date

MIDWEST VASCULAR & VARICOSE VEIN CENTER
Dr. Innocent Ubunama, D.O.
Vascular Surgeon

HOLLAND
7100 Orchard Center Drive, Suite B
Holland, OH 43528

FINDLAY
1710 Manor Hill Rd Suite # 1
Findlay, Ohio 45840

Phone (419)866-2000 Fax (419)866-2010 Medical Records Fax (877)849-9298

PATIENT RIGHTS AND RESPONSIBILITES

Thank you for choosing **Midwest Vascular and Varicose Vein Center** as your care provider. We feel that your involvement in your health care is crucial for a successful partnership. **Midwest Vascular and Varicose Vein Center** recognizes and affirms your rights as a patient.

Please let us know if you do not understand your rights as a patient of **Midwest Vascular and Varicose Vein Center** or if you have questions about your rights.

Midwest Vascular and Varicose Vein Center places emphasis on your involvement in your health care. Our goal is for you and your health care provider(s) to form a partnership that will result in the best care for you. For this partnership to be successful, a level of responsibility is required on your part.

I have read and I understand the attached listed Patient Rights and Responsibilities, Consents, Notice of Privacy Practices, and Financial Policy for **Midwest Vascular and Varicose Vein Center**. I agree to accept the full responsibility as described on the attached information given.

_____ _____

Patient/Responsible Party **Date**