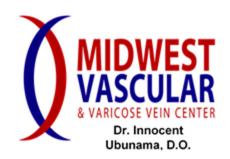


Patient Registration Form

How did you hear about us? P Billboard Postcard/Mailer _	=		
 Date:			
Last Name:	First Na	me	MI
☐ single ☐ married ☐ widow	red	Birth Date:	//
Street Address:			_APT/PO Box
City:		State:	ZIP Code:
Preferred Contact Phone Number	·		
Secondary Contact Phone Numbe	r:		
e-mail address:			
Social Security Number:/	′/	Federal Red Flag Rules requ healthcare fraud. Please pro	ire us to verify your identity to prevent ovide your Driver License or State ID
Emergency Contact Number (list a r Name:P	elative or friend that v	we can contact in case of	f an emergency in our office) tionship:
We are required by the Center for Medicare and Medicaid Sender Orientation: male female	☐ transgender (male	to female) 🗖 transge	
☐ other ☐ other ☐ heterosexual ☐	don't know	decline	
Primary Language Spoken: ☐ English ☐ Race: ☐ white ☐ black/African America			
Ethnicity: Hispanic or Latino not H			Statiaci — accimic to answer
INSURANCE INFORMATION It is the patient's re Primary Insurance Name: Policy Holder's Birth Date: / /_ Secondary Insurance Name:	Policy Holder's I	Policy Holder's Nam Relationship to Patient: Policy Holder's Nam	e: self
Policy Holder's Birth Date://_ My signature on this form verifies that the information insurance benefits to be paid directly to the physicial necessary to process my claims, verify prescription munderstand that I am financially responsible for any be questions regarding this form and that all questions I	on above is true and corre n. I also authorize MidWe nedication history and trai palances not paid by my ir	st Vascular and my insurance nsmit drug prescriptions, lab Isurance. I acknowledge that	ning this form I authorize / release my e company to release and all information orders, and radiology orders. I also
	/		
Patient Signature	today's date	Patient Representati	ve Signature today's date





Patient Name: _____ Date of Birth: **History Questionnaire** Who is your Primary Care Doctor? _____ Do you see any specialists? What Pharmacy do you use? ______ Location? _____ Please list Allergies & Reactions: Please list your current Medications, (include dose, frequency & reason taking) Please list any surgeries and major medical issues (dates if known) Do you currently smoke? Y / N How much? _____ Did you ever smoke? Y / N When did you quit? Cigarettes / Vape / other? Do you currently drink alcohol? Y / N How much / type? Did you ever have a problem with alcohol? When did you quit drinking? _____ Do you currently use recreational drugs? Y/N type? Did you ever? When did you quit? Do you or have you ever worn compression stockings, support hosiery or leg wraps? Y/N How long have you used compression treatment? _____ Did it the treatment help? Y/N Patient Signature: ______ Today's Date: _____





	Date of Birth:
Vascular Health	Screening Questionnaire
Do you have Type I Diabetes? Y / N	How are you being treated for it?
Do you have Type II Diabetes? Y / N	How are you being treated for it?
Do you have high blood pressure? Y / N	Are you being treated for it? Y / N
Do you have high cholesterol? Y/N	Are you being treated for it? Y/N
	Y / N Are you being treated for it? Y / N Where were you treated?
Have you ever had an Angioplasty or a Sten When?	t placed in your heart or legs? Y/N Where were you treated?
Have you ever had a blood clot in your legs?	? Y/N Left/Right/Both. When?
Do you experience aching or cramping in you exercise? Y / N Does the pain go away w	our buttocks, thighs or calves when you walk or with rest? Y/N
Do you have numbness or tingling in your le	egs or feet? Left / Right / Both Y / N
Do you ever experience cramping, tightness improves when you stand up? Left / Right /	s or pain in your legs or feet when lying down that / Both Y/N
Additional Comments or Information for the	e Doctor:
Patient Signature:	Today's Date:





Patient Name: _____

Date of Birth:					
	Cur	rent F	Problem		
Why are you being seen today?					
Do you experience any of the fo	ollowing sy	ympton	ns in your legs? (please circle Y	 / N)	
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 Sensation	YES	NO	Sores / Ulcers	YES	NO
Are your symptoms worse at th List any medications (including		-			
Have you ever had any vein trea	atments o	r proce	dures? YES / NO If yes please li	st them.	,
Please describe how these symp	ptoms are	affecti	ng your everyday life		
Patient Signature:			Today's Date:		





		Pa	atient Name:	
			Date of Birth:	
Dationt Aug	thorization	for Polosso	of Protected Health Informat	tion
				_
			cion about a patient, including demogra	-
•		•	tient's past, present or future physical	or mental
health or condition, relat	ed to health ca	ire services or pay	ment for health care services.	
sensitive information as o	defined by fede V-related illnes	eral/state law. Thi s or AIDS, an indiv	to Protected Health Information that is s includes an individual's (i) HIV status vidual's (ii) substance abuse condition o	or treatment
I authorize disclosure o	f the following	g information to	the individuals listed below:	
] PHI		SPHI	
Name:			Relationship:	
			Relationship:	
			SPHI Relationship: Relationship:	
I acknowledge that:			·	
	voluntary: treat	tment will not be	conditional on whether I sign this auth	orization
 I have the right to ref 				0.124.101.
-	_		or one year from date of signature be	elow.
			ion, except for SPHI which is protected	
			sure by the recipient and is no longer p	
Federal Privacy Regul	· ·	-	· · · · · · · · · · · · · · · · · · ·	
 This authorization CA 		•		
		•	written notice of revocation to the pri	vacv office at
_	•		actice has already acted upon the authorization	•
Patient Signature:			Date:	
			Date:	
			Relationship:	





Patient Name:	
Date of	Birth:

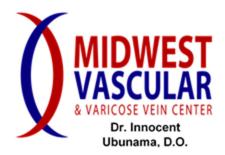
Acknowledgement of Receipt of HIPAA Privacy Notice

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 or 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 assessment and accreditation.

Patient Signature:	Date:	
For Office	Use Only	
We attempted to obtain written Acknowledger Practices, Acknowledgment could not be obtain Individual refused to sign.	,	
☐ Communication barriers prohibited obtaining	ng the Acknowledgment.	
$\ \square$ An emergency situation prevented us from obtaining Acknowledgment.		
☐ Other (please specify)		
Staff Signature:	Date:	





Patient Name:	
Date of Birth:	

Insurance Companies Common Criteria

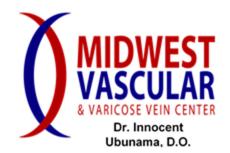
Many Health Insurance Companies are now requiring certain criteria to be met in order to approve outpatient surgical procedures for Varicose Veins. These can vary widely from company to company, but the most common include:

- 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 etc.)

As the patient it is your responsibility to check with your own insurance company to ensure that 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 Signature:	Date:





Patient Name:	
Date of Birt	h:

Advance Directive Policy

As an Ambulatory Surgery Center and a Vascular & Varicose Vein Center, we at Midwest Surgical Center and Midwest Vascular & Varicose Vein Centers are required to advise patients about the nature of Advance Directives and how this affects patient care in our facilities.

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 in our care are pre-screened to limit the possibility of the need for resuscitation.

By policy, the Medical Staff at Midwest Surgical Center and Midwest Vascular & Varicose Vein Centers 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 have you note that on your Operative Consent form. If you have any further questions regarding this matter, please ask a member of the medical team.

By signing I agree that:

- I am aware that Midwest Surgical Center & Midwest Vascular & Varicose Vein Centers will <u>always</u> attempt to resuscitate and then transfer the patient to a hospital in the event of deterioration.
- I have received a copy of Patient Rights & Responsibilities.
- I have been informed that my physician has ownership in the Midwest Surgical Center and Midwest Vascular & Varicose Vein Center.
- I have been informed of the grievance process and contact information.

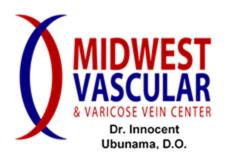
Patient Signature:	Date:	
Patient Representative Signature:	Date:	
Representative Printed Name:	Relationship:	
Witness Signature:	Date:	





Pat	ient Name:
	Date of Birth:
General Co	onsent
necessary or advisable in the judger	medical diagnosis and any
It is understood that this consent is diagnosis or treatment being require provider to exercise his or her best judiagnosis or medical treatment.	• • •
Patient Signature	Date
Witness Signature	Date





Patient Name:	
Date of Birth:	
Patient Rights and Responsibilities	
hank you for choosing Midwest Vascular & Varicose Vein Center and Midwest Surgical Cent s your care provider. We feel that your involvement in your health care is crucial for a uccessful partnership. We recognize and affirm your <i>rights</i> as a patient.	<u>er</u>
lease let us know if you do not understand your rights as a patient of our Centers or if you ave questions about your rights.	
Midwest Vascular & Varicose Vein and Center and Midwest Surgical Center place emphasis of our involvement in your health care. Our goal is for you and your health care providers(s) to prome a partnership that will result in the best care for you. In order for this partnership to be uccessful, a level of responsibility is required on your part.)
y signing I agree that: have read and I understand Patient Rights and Responsibilities, Consents, Notice of Privacy ractices and Financial Policy for Midwest Vascular & Varicose Vein Center and Midwest urgical Center. I agree to accept the full responsibility as described on the attached nformation given. I understand that I may request a copy of the above policies.	
atient / Responsible Party Signature: Date:	_