MWSC
MIDWEST SURGICAL CENTER

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

# Patient Registration Form

How did you hear about us? ___ Primary Care Doctor ___ TV Commercial ___ Website/Online __Billboard ___ Postcard/Mailer ___ Family/Friend ___ Free Screening Event

Date: _____

Last Name: _____ First Name_____ MI ____

❑ single ❑ married ❑ widowed Birth Date: _____ / _____ / _____

Street Address: _____APT/PO Box_____

City: _____ State: _____ ZIP Code: _____

Preferred Contact Phone Number: _____

Secondary Contact Phone Number: _____

e-mail address: _____

| Social Security Number: _____ / ____ / _____ | Federal Red Flag Rules require us to verify your identity to prevent healthcare fraud. Please provide your Driver License or State ID |
|---|---|

Emergency Contact Number (list a relative or friend that we can contact in case of an emergency in our office)

Name: _____ Phone Number: _____ Relationship: _____

We are required by the Center for Medicare and Medicaid Services (CMS) to obtain the following information (you may choose not to answer by marking decline).

| |
|---|
| Gender Orientation: ❑ male ❑ female ❑ transgender (male to female) ❑ transgender (female to male) ❑ other _____ ❑ don't know ❑ decline |
| Sexual Identification: ❑ heterosexual ❑ homosexual ❑ bisexual ❑ other _____ ❑ don't know ❑ decline |
| Primary Language Spoken: ❑ English ❑ other _____ ❑ I need a translator |
| 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 insurance card. If not provided, the account remains 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

My signature on this form verifies that the information above is true and correct. I understand that by signing this form I authorize / release my insurance benefits to be paid directly to the physician. I also authorize MidWest Vascular and my insurance company to release and all information necessary to process my claims, verify prescription medication history and transmit drug prescriptions, lab orders, and 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

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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: _____

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**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

Have you ever had a heart attack or stroke? Y / N Are you being treated for it? Y / N
When? _____ Where were you treated? _____

Have you ever had an Angioplasty or a Stent placed in your heart or legs? Y / N
When? _____ 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 your buttocks, thighs or calves when you walk or exercise? Y / N Does the pain go away with rest? Y / N

Do you have numbness or tingling in your legs or feet? Left / Right / Both Y / N

Do you ever experience cramping, tightness or pain in your legs or feet when lying down that improves when you stand up? Left / Right / Both Y / N

Additional Comments or Information for the Doctor: _____

_____

_____

Patient Signature: _____ Today's Date: _____

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## Current Problem

Why are you being seen today? _____

_____

Do you experience any of the following symptoms 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 |

How long have your experienced the symptoms marked YES? _____

_____

Are your symptoms worse at the end of the day? YES / NO _____

List any medications (including non-prescription) you have taken for these symptoms.

_____

_____

Have you ever had any vein treatments or procedures? YES / NO If yes please list them.

_____

_____

Please describe how these symptoms are affecting your everyday life. _____

_____

_____

Patient Signature: _____ Today's Date: _____

Patient Name: _____

Date of Birth: _____

# Patient Authorization for Release of Protected Health Information

Protected Health Information (PHI): refers to 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 to health care services or payment for health care services.

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

I authorize disclosure of the following information to the individuals listed below:

☐ PHI ☐ SPHI

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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

☐ PHI ☐ SPHI

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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 for SPHI which is protected by Federal/State regulations may be subject to re-disclosure by the recipient and is no longer protected by Federal Privacy Regulations or other Federal/State laws.
- This authorization CANNOT be use to disclose Psychotherapy notes.
- If I sign this Authorization, I may revoke it later with a written notice of revocation to the privacy office at this practice (the only exception to right to revoke is if the practice has already acted upon the authorization).

Patient Signature: _____ Date: _____

Patient Representative Signature: _____ Date: _____

Print Name: _____ Relationship: _____

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# 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 Acknowledgement of the receipt of tour Notice of Privacy Practices, Acknowledgment could not be obtained because:

- ☐ Individual refused to sign.
- ☐ Communication barriers prohibited obtaining the Acknowledgment.
- ☐ 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 Birth: _____

# 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 always 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: _____

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# 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 be limited to the examination, preventative treatment, x-ray, ultrasound, 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 diagnosis or medical treatment.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

Patient Name: _____

Date of Birth: _____

# Patient Rights and Responsibilities

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

Please let us know if you do not understand your rights as a patient of our Centers or if you have questions about your rights.

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

By signing I agree that:
I have read and I understand Patient Rights and Responsibilities, Consents, Notice of Privacy Practices and Financial Policy for Midwest Vascular & Varicose Vein Center and Midwest Surgical Center. I agree to accept the full responsibility as described on the attached information given. I understand that I may request a copy of the above policies.

Patient / Responsible Party Signature: _____ Date: _____