PLEASE BRING THE FOLLOWING ITEMS WITH YOU:

- Photo ID or Driver’s License (some form of Identification)
- Insurance Card(s)
- Referral for services rendered (ONLY if you require one)
- If you do require a referral, we must have it in the office 2 days prior to your appointment, if we don’t, your appointment will be cancelled.
- A list of current medications and drug allergies
- Any recent reports having to do with the reason you are being seen. (CT scans, Ultrasounds, MRI, MRA, Etc.)
- Please arrive 10-15 minutes prior to appointment time. This will give us time to input your demographic information and give you time to finish any paperwork.
- May need pictures of problem areas for insurance purposes; so wear comfortable, loose fitting clothing.

PLEASE BE AWARE THAT YOU WILL BE RESCHEDULED IF YOU ARRIVE LATE FOR YOUR SCHEDULED APPOINTMENT TIME.

Thank you,
The Vein and Vascular Institute Staff
**Personal Information**

<table>
<thead>
<tr>
<th>Name: (please print):</th>
<th>Last</th>
<th>First</th>
<th>MI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth:</td>
<td>Age:</td>
<td>SS#:</td>
<td>Subscriber of Insurance: Yes  No</td>
</tr>
<tr>
<td>Address:</td>
<td>City</td>
<td>State</td>
<td>Zip</td>
</tr>
<tr>
<td>Home Phone:</td>
<td>(    )</td>
<td>Sex: M F</td>
<td>Married</td>
</tr>
<tr>
<td>Cell Phone:</td>
<td>(    )</td>
<td>E-mail Address:</td>
<td></td>
</tr>
<tr>
<td>Employer Name:</td>
<td>Work Phone #: (    )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse's Name:</td>
<td>Spouse's SS#:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse's DOB:</td>
<td>Phone Number:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred by:</td>
<td>Phone #: (    )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician:</td>
<td>Phone #: (    )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Physicians:</td>
<td>Phone #: (    )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy:</td>
<td>Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone #:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Insurance Information**

<table>
<thead>
<tr>
<th>Insurance Name:</th>
<th>ID Number:</th>
<th>Group Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber of Insurance:</td>
<td>Insurance Address:</td>
<td></td>
</tr>
<tr>
<td>SECONDARY INSURANCE: YES or NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary Insurance Name:</td>
<td>ID Number:</td>
<td>Group Number:</td>
</tr>
<tr>
<td>Subscriber of Insurance:</td>
<td>Insurance Address:</td>
<td></td>
</tr>
</tbody>
</table>

**Medical Information**

<table>
<thead>
<tr>
<th>Current Medications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies to Medication:</td>
</tr>
<tr>
<td>Has the above patient had any previous treatment or <strong>ultrasounds</strong> related to the reason for visit?  NO    YES</td>
</tr>
<tr>
<td>Facility Name:</td>
</tr>
<tr>
<td>Reason for visit:</td>
</tr>
</tbody>
</table>
**Emergency Contact**

Local person to contact in case of emergency (this is a person who does not live in the same household):

Name: _________________________________________            Phone #: _________________________________
Relationship to patient: __________________________              Cell #: _____________________________________

**Release and Assignment**

I hereby authorize Thomas M. Kerr, M.D. / Kenneth J. Wright, M.D. / Alberto J. Gonzalez, M.D. to release my medical records to the insurance companies covering the illness/injury for which I have been treated. Further, I authorize said insurance companies to issue payment directly to Thomas M. Kerr, M.D. / Kenneth J. Wright, M.D. / Alberto J. Gonzalez, M.D. for any claims submitted. I understand that I am personally responsible for any balances not paid by my insurance.

Signature of Patient/Guarantor: ___________________________  Date: __________ / __________ / __________
Relationship to Patient: ____________________________________________

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**FINANCIAL AND INSURANCE POLICY**

Thank you for choosing VVIT as your medical care provider. We are committed to providing you with quality and affordable health care. As some of our patients have had questions regarding patient, and insurance, responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Insurance is a contract between you and your insurance company. We are not a party to this contract, in most cases. We will inform you if we are a provider with your insurance, and will process claims in accordance with our agreement. We file insurance claims as a courtesy. We will not become involved in a dispute between you and your insurance company regarding deductibles, co-payments, secondary insurance, usual and customary charges, etc., other than to supply factual information as necessary. You are responsible for timely payment of your account. If a balance remains after 30 days we retain the right to recover this amount as soon as possible.

1. **Insurance.** We participate in most insurance plans, including Medicare. Always bring your insurance card with you when you come in for a visit. If you are not insured by a plan we do business with, payment is expected at the time of each visit. If you are insured by a plan we do business with, but don’t have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage.

2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contractual agreement with your insurance company. Please help us by paying your co-payment at each visit.

3. **Acceptable forms of payment.** We accept cash, check, and money order, Visa, MasterCard, American Express and Discover. A fee of $25.00, if the face value does not exceed $50.00; $30.00, if the face value exceeds $50.00, but does not exceed $300.00; $40.00, if the face value exceeds $300.00 or an amount of up to 5% of the face amount of the check, whichever is greater, will be assessed for each personal check returned by your bank as non-sufficient funds.
4. **Referrals.** It is your responsibility to know whether your insurance carrier requires a referral. We must have the referral from your primary care physician in our office no later than two business days before your appointment. If you have the referral in hand, it will be your responsibility to fax or bring to the office no later that two business days before your appointment. If we do not have the referral two days prior to your appointment, your appointment will be cancelled.

5. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by your insurance company. The fact that the insurance company doesn’t cover the service doesn’t mean that you don’t need it. Your doctor will explain why he or she thinks that you can benefit from a service or procedure. If you elect to have the non-covered service, you must pay at the time of visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

6. **Medicare patients:** If we believe you are receiving a service that Medicare considers not reasonable or necessary for your condition, you will be notified in writing on a form called an Advance Beneficiary Notice (ABN). This will provide you the opportunity to decide if you will proceed with the service ordered. This process is required by Medicare and preserves your right to appeal their decision. If you have secondary insurance, it is your responsibility to provide this information at the time of the visit.

7. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

8. **Coverage changes.** If your insurance coverage changes, please notify us no later than two days prior to your next scheduled appointment, so we can make the appropriate changes. If you do not inform the office two days prior to your appointment, your scheduled appointment will be canceled.

9. **Nonpayment.** Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you will be assessed a 30% surcharge to cover agency fees. Partial payments will not be accepted unless otherwise negotiated. Extended payments need to be discussed with the billing office at 813-348-9088.

10. **Missed appointments.** We reserve the right to charge for any missed appointment that is not cancelled within 5 days to 48 hours of the appointment date. Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. The fees change on the type of appointment and how many days prior that you cancelled or no showed. Thank you for understanding our payment policy. If you have any questions or concerns, please contact our billing department at (813) 348-9088. **Our fees are as follow:**

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>5 days prior</th>
<th>3 days prior</th>
<th>48 hours or less</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit</td>
<td>No Charge</td>
<td>No Charge</td>
<td>$50</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>No Charge</td>
<td>No Charge</td>
<td>$100</td>
</tr>
<tr>
<td>Sclerotherapy</td>
<td>No Charge</td>
<td>No Charge</td>
<td>$100</td>
</tr>
<tr>
<td>EVLT</td>
<td>$100</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td>Outpatient Center Procedure</td>
<td>N/A</td>
<td>$250</td>
<td>$500</td>
</tr>
</tbody>
</table>

**Signature:** ___________________________________________  **Date:** ____________________________
WAVING COPAYS, CO-INSURANCE OR DEDUCTIBLES:

Your contract prohibits any provider from waiving co-pays, deductible amounts and percentages; these are considered part of your reimbursement and part of the member’s benefit plan.

It is the law, as well as part of the contract that the doctor signs with the insurance company, that we collect the patient’s responsibility amount. If we do not collect, it is a breach of the doctor’s contract.

As you know, we regularly send you statements to keep you updated on your responsibility due from your insurance carrier. If you need to make payment arrangements, please contact our office and we will be pleased to assist you.

If you are unsure of your benefits, please contact the phone number under member services on your insurance card. If you wish to wait to be treated until you are aware of your benefits, please speak to the front desk to make other arrangements.

Signature:_________________________________________ Date:____________________________

RELEASE OF INFORMATION WITH REGARD TO SERVICES FURNISHED TO A BENEFICIARY:

I hereby authorize my insurance carrier to furnish Dr. Kerr/Dr. Wright/Dr. Gonzalez any information obtained in the adjudication of any claim in regard to services furnished to me by him. This authorization is valid until rescinded by me in writing. I further authorize Dr. Kerr/ Dr. Wright/Dr. Gonzalez to furnish complete information requested by my insurance carrier or its intermediaries regarding services rendered. **Privacy act statement:** I understand that as part of my health care, Dr. Kerr/ Dr. Wright/Dr. Gonzalez, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided,
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

Signature:_________________________________________ Date:____________________________

Patient Portal:

Our office has recently developed a secure patient portal for easier, at home, access to your personal information. We appreciate your participation with this program. If you are a new patient please inform staff of your current email address and you will receive an invite from our office.

**To access website:**

Look for an Email Invite from **Follow MY Health**

Follow the directions to create a portal account
NOTICE OF PRIVACY PRACTICES
Effective Date: January 1, 2010

After reading and signing the following below, we will also have you sign it electronically. This must be signed yearly by the patient.

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.

We are required by law to maintain the privacy of your health information and to give you notices of our legal duties and privacy practices with respect to your protected health information. This Notice summarizes our duties and your rights considering your protected health information. Our duties and your rights are set forth more fully in 45 C.F.R., part 164. We are required to abide by the terms of the Notice that is currently in effect.

USES AND DISCLOSURES OF INFORMATION THAT WE MAY MAKE WITH YOUR WRITTEN AUTHORIZATION

We may use or disclose protected health information for the following purposes without your written authorization. These examples are not meant to be exhaustive.

- Treatment
- Payment
- Healthcare Operations
- Required by Law
- Threat to Health or Safety
- Abuse or Neglect
- Communicable Diseases
- Health Oversight Activities
- Judicial and Administrative
- Law Enforcement
- National Security
- Public Health Activities
- Coroners and Funeral Directors
- Research
- Worker's Compensation
- Business Associates
- Military
- Inmates or Persons in Police Custody
- Organ Donation
- Health Care Operations
- National Security
- Public Health Activities
- Coroners and Funeral Directors
- Research
- Worker's Compensation
- Business Associates
- Military
- Inmates or Persons in Police Custody
- Organ Donation

USES AND DISCLOSURES OF INFORMATION THAT WE MAY MAKE UNLESS YOU OBJECT

We may use and disclose protected health information in the following instances without your authorization unless you object. If you object, please notify the Privacy Contact identified below.

- Persons Involved in Your Health Care. We may disclose information to a member of your family, relative, close friend, or other person identified by you who is involved in your health care or the payment of your health care. We will limit disclosure to the information relevant to that person’s involvement in your health care or payment.

- Notification. We may use or disclose protected health information to notify a family member or other person responsible for your care of your location and condition. Among other things, we may disclose protected health information to a disaster relief agency to help notify family members.

- Photograph Consent. I agree to have Dr. Kerr/Dr. Wright/Dr. Gonzalez or his assistants take photographs of my legs and my face for medical records purposes. These photographs will be held in confidentiality according to HIPAA regulations. Photographs of my name and face will not be used in the future for any publication.
I do consent to the future use of my leg photographs, both before and after proposed procedures, at Dr. Kerr/Dr. Wright/Dr. Gonzalez’s discretion for the purpose of presentation, insurance authorization, and patient and physician education.

**USES AND DISCLOSURES OF INFORMATION THAT WE MAY MAKE WITH YOUR WRITTEN AUTHORIZATION**

We will obtain a written authorization from you before using or disclosing your protected health information for purposes other than those summarized above. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below.

**YOU’RE RIGHTS CONCERNING YOUR PROTECTED HEALTH INFORMATION**

You have the following rights concerning your protected health information. To exercise any of these rights you must submit a written request to the Privacy Contact identified below.

- Right to Request Additional Restrictions
- Right to Receive Communications by Alternative Means
- Right to Inspect and Copy Records
- Right to Request Amendment to Record
- Right to an Accounting of Certain Disclosures
- Right to a Copy of this Notice

**CHANGES TO THIS NOTICE**

We reserve the right to change the terms of our Notice of Privacy Practices at any time, and to make the new Notice provisions effective for all protected health information that we maintain. If we materially change our privacy practices, we will prepare a new Notice of Privacy Practices, which shall be effective for all protected health information that we maintain. We will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the current Notice or by contacting the Privacy Contact identified below.

**COMPLAINTS**

You may complain to us or to the Secretary of Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying us at THE VEIN & VASCULAR INSTITUTE OF TAMPA BAY, 2809 W. Waters Ave., Tampa, FL 33614. All complaints must be in writing. We will not retaliate against you for filing a complaint.

**PRIVACY CONTACT**

If you have any questions about this Notice or if you want to object to or complain about any use or disclosures or exercise any right as explained above, please contact our Privacy Officer:

Holly Kerr, Privacy Officer
2809 W. Waters Ave.
Tampa, FL 33614
Privacy Notice Acknowledgement

Patient Name: ____________________________       DOB: __________________

Acknowledgement

I acknowledge that I have received a copy of the Privacy Notice for The Vein & Vascular Institute of Tampa Bay, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice.

Signature: ____________________________       Date: ______________________

This contract is active until written notice of your revocation is received

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: ____________________________       Witnesses by: ______________________

Designate a Spokesperson

Our policy is to speak about the patients’ condition to the patient only, and only in person. If you wish to designate one spokesperson that is authorized to speak for you in the event of your indisposition or need for translation, you must indicate your preference in writing.

Spokesperson: ____________________________       Telephone #: ______________________

Relationship: ____________________________

Spokesperson: ____________________________       Telephone #: ______________________

Relationship: ____________________________

Spokesperson: ____________________________       Telephone #: ______________________

Relationship: ____________________________

Telephone/Answering Machines

I hereby authorize The Vein & Vascular Institute of Tampa Bay, to disclose the following protected health information to remind me of treatment alternatives or to report normal test results, upcoming appointments, surgery date and time, and yearly recalls?

☐ You may leave a message with detailed information on my answering machine at home.

☐ You may leave a message with detailed information on my voice mail at work.

☐ You may send me Vascular Disease information via email. Email address: ____________________________

Signature: ____________________________       Date: ______________________

Thank you again for choosing The Vein and Vascular Institute of Tampa Bay. We value your healthcare.