

PUGET SOUND

SURGICAL CENTER



PATIENT RECORD OF DISCLOSURES

NAME: _____ BIRTHDATE: _____

I wish to be contacted in the following manner (check all that apply):

Cellular Telephone Number _____

- OK to leave message on machine/voicemail, with detailed information
- OK to leave message with detailed information, with (specify name) _____
- Leave message with call-back number only

Home Telephone Number _____

- OK to leave message on machine/voicemail, with detailed information
- OK to leave message with detailed information, with (specify name) _____
- Leave message with call-back number only

Work Telephone Number _____

- OK to leave message on machine/voicemail, with detailed information
- OK to leave message with detailed information, with (specify name) _____
- Leave message with call-back number only

Written Communication

- OK to mail to my home address
- OK to mail to my work/office address
- OK to fax to this number _____

Other _____

Patient Signature

Date

Puget Sound Surgical Center Financial Policy

Welcome to our practice, please review and sign our financial policy.

We require payment pre-authorization for services to be rendered. Please complete the attached form, which will be securely kept on file for your convenience.

Referrals: If your insurance requires a referral, please bring that with you on your first visit.

Insurance Plans: As a courtesy to our patients, we will file your claims for you to your insurance company. If for some reason your insurance company declines to pay for the services rendered, then you, the patient, are responsible for the entire bill. Any co-pays, co-insurance and deductibles will be collected at the time of service.

Surgical Procedures: If you are to have surgery, our office will contact your insurance company for benefits and pre-authorization. Prior to the procedure being completed, our office will contact you regarding your financial responsibility. Any amounts due to PSSC from patient for surgeries are to be paid 1 (one) week prior to the scheduled procedure. If for some reason payment is not collected and/or other arrangements have not been made, then the surgical procedure will be postponed.

Labor and Industries: Labor and Industries patients are welcome. Since we are not primary care providers, a referral is required from your primary care doctor upon your first visit.

Self-Pay Patients: Payments are due at the time services are rendered. We may be able to give you an estimate over the phone, but please remember it is only an estimate. Charges will be determined once the patient has actually seen the doctor.

Forms: It is inevitable that forms unrelated to the filing of medical insurance claims, such as return to work and disability applications, time loss reports, and Family Medical Leave Act (FMLA) be provided by us. We will provide, free of charge, the first FMLA/disability form that a patient requires for each episode of surgery. Additional forms will be completed at a rate of \$20 per form. The fee MUST be paid in full at the time the form is dropped off. Please allow 5 business days for completion of forms.

Delinquent Accounts: Any accounts 90 days or older will be forwarded to our collection agency. The patient will be responsible for any fees incurred by PSSC to collect this debt. Fees include, but are not limited to, collection fees, attorney's charges and/or court fees incurred by PSSC.

Return Check Policy: There is a \$25.00 service fee on each returned check. A NSF check must be redeemed with cash within 5 business days of bank notification.

Minor Patients: An adult or legal guardian must accompany all minors to each office visit. The adult or legal guardian accompanying the minor assumes all financial responsibility for the cost of the minor's visit.

Attorney Protections/Letters of Guarantee: PSSC does not accept letters of guarantee from attorney offices.

If you cannot make your scheduled appointment time, please contact our office 24 hours prior to your appointment. If you cannot keep your surgery date or time, we require at least a 72 hour notification.

I have read and understand the above financial policy and agree to abide by the terms of this policy. For your convenience, PSSC accepts the following forms of payment: Visa, MasterCard, cash, check, money orders and cashier's checks.

Patient Signature

Date

revised 1/2010



APPOINTMENT/SURGERY CANCELLATION POLICY

Our goal is to provide quality medical care in a timely manner. In order to do so we have implemented an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation/"No Show" of an Appointment

In order to be respectful of the medical needs of our patients, please be courteous and call the office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment we require that you provide 24 hours notice. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care. Failure to provide 24 hours notice, or a "No Show" for an appointment will result in a **fee of \$50** to be billed to you for payment.

Cancellation/"No Show" for a surgery or procedure

Please provide a minimum of 48 hours notice to cancel or reschedule your surgery or procedure. Failure to provide a minimum of 48 hours notice to cancel or reschedule your surgery, or a "No Show" for your surgery will result in a **fee of \$300** to be billed to your account. Failure to provide a minimum of 48 hours notice to cancel or reschedule your procedure or a "No Show" for your procedure will result in a **fee of \$125** to be billed to your account.

Cancellation/"No Show" for Cosmetic Surgeries

Policy for Cosmetic Surgeries is as follows:

10% of the total fee if cancelled 4-8 days before surgery date

25% of the total fee if surgery is cancelled 3 days or less before the surgery date

Please call our office to cancel or reschedule your appointment at:

Edmonds location: 425.778.2220

Bellingham location: 360.676.1111

We understand that there may be unforeseen emergencies that may not allow for you to give the required notice, and exceptions to the policy may be made by management.

I have read and acknowledge receipt of the cancellation/No show policy

Printed Patient Name

Patient Signature

Date

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

We understand that information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this office, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose your health information. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to health information about you.
- Follow the terms of the notice that is currently in effect.

How we may use and disclose health information about you:

- For treatment
- For payment
- For health care operations
- For appointment reminders
- As required by law
- To avert a serious threat to health and safety
- As required by the Military of Veterans and Worker Compensations
- Public Health Risks
- Health oversight activities
- Lawsuits and Disputes
- Law enforcement
- Coroners, health examiners and funeral directors
- National Security and Intelligence activities
- Protective Services for the President and others
- Security Official for inmates

Your rights regarding health information about you:

- Right to inspect and copy
- Right to amend
- Right to an accounting of disclosures
- Right to request a restriction
- Right to request confidential communication
- Right to a paper copy of this notice (full notice is available upon request).

Changes to this notice:

We reserve the right to change this notice. We will post a copy of this current notice in our facility with the current effected date on this page.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact the administrator at the location where you were treated to file a complaint.

Acknowledgement of receipt of this notice:

We will request that you sign a separate form acknowledging that you have received a copy of this notice. This acknowledgement will become part of your records.

NOTICE OF PRIVACY PRACTICE-ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the administrator of the location at which you have been treated. Please call the main office phone number and ask for the administrator.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practice.

Patient signature or legal authorized individual

Date

Printed name if signed on behalf of the patient

Relationship to patient

PATIENT RIGHTS AND RESPONSIBILITIES

This facility and medical staff have adopted the following list of patient rights and responsibilities. This list includes, but is not limited to:

PATIENT RIGHTS

- Impartial treatment without regard to race, color, sex, national origin, religion, handicap or disability.
- Considerate and respectful care at all times and under all circumstances.
- To receive care free from abuse.
- Knowledge of the name and professional status of those caring for you.
- To receive information from the surgeons about your diagnosis, treatment plan and prognosis to the best of the physicians' knowledge.
- To participate actively in decisions regarding your medical care. To the extent permitted by law, this includes the right to refuse treatment.
- Full consideration of privacy concerning your medical care program. Case discussion, examination and treatment are confidential and should be conducted discretely.
- To be informed that Advanced Directives cannot be honored at this facility and to be advised that should an unexpected life threatening event occur the patient will be transferred to a facility that will honor this directive.
- Confidential treatment of all communications and records pertaining to care. Written permission shall be obtained before medical records can be made available to anyone not directly concerned with your care.
- Responsible responses to any reasonable request for service.
- To leave the facility even against medical advice.
- To expect reasonable continuity of care.
- To be advised if the physician proposes to engage in or perform experimentation affecting your care or treatment and the right to refuse to participate in this activity.
- To be informed of the continuing health care requirements following discharge from the center.
- Examine and receive an explanation of a bill for service, regardless of source of payment.
- To report any comments concerning the quality of care provided to you and expect follow-up on your comments.

PATIENT RESPONSIBILITIES

- To provide accurate and complete information concerning his/her present complaints, past medical history and other matters relating to their health.
- To notify us of the existence of an Advanced Directive (e.g. a living will) as those cannot be honored at this facility.
- To make it known whether he/she clearly comprehends the course of treatment and what is expected of him/her.
- For following the treatment plan established by the physician, including the instructions of nurses and other health care professional as they carry out the physicians' orders.
- For keeping his/her appointment and notifying the facility if unable to do so.
- To provide a responsible adult to drive them home and stay with them 24 hours after surgery.
- For assuring that the financial obligations of their care is fulfilled as promptly as possible.
- For being considerate of the rights of other patients and facility personnel.

PATIENT RIGHTS AND RESPONSIBILITIES (cont.)

FEEDBACK

Our goal is to provide the best surgical experience possible while in our Ambulatory Surgery Center. Patients, clients, families or visitors have the right to express complaints or concerns about any aspects of their care or experience with our ASC. Please be assured that expressing a complaint or concern will not compromise your care and will be addressed according to our policy. Concerns may be directed to any facility staff or the ASC Manager, or you may mail your comments to us.

If you feel it is necessary, complaints may also be shared with:

**MARY SELECKY, SECRETARY OF HEALTH
WASHINGTON STATE DEPARTMENT OF HEALTH
HEALTH SYSTEMS QUALITY ASSURANCE
COMPLAINT INTAKE
310 ISRAEL ROAD SE
P.O. BOX 47857
OLYMPIA, WA 98504-7857
360-236-4700
HSQAComplaintIntake@doh.wa.gov**

**OFFICE OF THE MEDICARE BENEFICIARY OMBUDSMAN
OFFICE OF THE REGIONAL ADMINISTRATOR
DIVISION OF SURVEY AND CERTIFICATION OPERATIONS
CHRIS MARTIN, BRANCH MANAGER
2201 6TH AVENUE, SUITE 801
SEATTLE, WA 98121, 206-615-2313
1-800-MEDICARE (1-800-633-4227)
1-877-486-2048 (TTY)
www.medicare.gov**

STATEMENT OF PHYSICIAN FINANCIAL INTERESTS OR OWNERSHIP Your physician has an ownership interest in Puget Sound Surgical Center which includes the surgery center at which you are having your procedure. As with all of your care, you may request to have your procedure performed at another facility where your surgeon has privileges to practice.

ACKNOWLEDGEMENT OF PATIENT RIGHTS AND RESPONSIBILITIES

Our **Patient Rights and Responsibilities** statement describes in more detail your rights and responsibilities as a patient of Puget Sound Surgical Center.

By my signature below I acknowledge receipt of the Patient Rights and Responsibilities statement.

Patient Signature or legally authorized individual

Date

Printed name if signed on behalf of the patient

Relationship to patient

Puget Sound Surgical Center

PATIENT NAME _____ BIRTHDATE ____/____/____

SOC. SEC. # ____/____/____ AGE _____ MALE FEMALE

Mailing Address _____ APT # _____

City _____ State _____ Zip _____ + 4 _____ Email Address _____

HOME PHONE () _____ - _____ WORK PHONE () _____ - _____ CELL PHONE () _____ - _____

REFERRED BY _____ **PRIMARY CARE DR** _____

MARITAL STATUS: Single Married Widowed Divorced Separated Other _____

RACE (optional): Caucasian African American Hispanic Pacific Islander Asian
 Asian American American Indian Other _____

RESPONSIBLE PARTY: _____
(if other than patient) Name _____ Date of Birth _____ Relationship to patient _____

PATIENTS EMPLOYER _____ SPOUSES EMPLOYER _____

Full-Time Full-Time

OCCUPATION _____ Part-Time OCCUPATION _____ Part-Time

ADDRESS _____ ADDRESS _____

CITY, STATE, ZIP _____ CITY, STATE, ZIP _____

IN CASE OF EMERGENCY NOTIFY:

OKAY TO DISCLOSE INFORMATION

Name Relationship Phone number YES NO

Name Relationship Phone number YES NO

PREFERRED PHARMACY:

Pharmacy _____ Address _____

Phone _____ City, ST, Zip _____

How did you hear about us? _____

Signed _____ Date _____

Puget Sound Surgical Center

PRIMARY INSURANCE: _____ PLAN COPAYS\$ _____

Insurance Company Address: _____
Street or PO Box City, State Zip+4

Insurance Company Phone Number: _____

Subscriber ID #: _____ Group ID #: _____

Subscriber Name: _____ Relationship to the Patient: _____

Male Female Birth Date: _____ Soc. Sec.#: _____

Subscriber Employer: _____

SECONDARY INSURANCE: _____ PLAN COPAYS\$ _____

Insurance Company Address: _____
Street or PO Box City, State Zip+4

Insurance Company Phone Number: _____

Subscriber ID #: _____ Group ID #: _____

Subscriber Name: _____ Relationship to the Patient: _____

Male Female Birth Date: _____ Soc. Sec.#: _____

Subscriber Employer: _____

NOTES:

I hereby authorize my insurance benefits be paid directly to the physician. I also authorize the doctor or insurance company to release information required for this claim. I consent to the release of medical information from or to other doctors and healthcare institutions as is necessary to my care and treatment.

Payment: I am financially responsible for any balance due, I agree to make payment arrangements; pay \$5 per month on unpaid balances over 30 days and all the reasonable expenses such as attorney fees and court costs should account be referred for collections.

Signed _____ Date _____



Venous Health History

C Classification, Payor Guidelines & Treatment Plan Options

Patient Name: _____ **Date of Birth:** _____

Directions: Please answer the following questions. Provide estimates for date of occurrence.

Past Medical History

1. Have you ever had vein stripping surgery Yes No
If yes, when and which leg? _____
2. Have you ever had vein injections? Yes No
If yes, which leg and where on the leg? _____
3. Have you ever had a blood clot? Yes No
If yes, which leg and when? _____
4. Have you ever had phlebitis? Yes No
If yes, which leg and when? _____

Family History

Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers or swollen legs?

- | | | |
|------------|------------------------------|-----------------------------|
| Father | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Mother | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Brother(s) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sister(s) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

1. Do you experience any of the following in your legs?

- | | | | | | | |
|--------------------|------------------------------|-------------------------------------|------------------------------|-----------------------------|--------------------------------------|------------------------------------|
| Aching/pain? | <input type="checkbox"/> Yes | During activity or prolong standing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> LT / RT leg | <input type="checkbox"/> Both legs |
| Heaviness? | <input type="checkbox"/> Yes | During activity or prolong standing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> LT / RT leg | <input type="checkbox"/> Both legs |
| Tiredness/fatigue? | <input type="checkbox"/> Yes | During activity or prolong standing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> LT / RT leg | <input type="checkbox"/> Both legs |
| Itching/burning? | <input type="checkbox"/> Yes | During activity or prolong standing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> LT / RT leg | <input type="checkbox"/> Both legs |
| Swollen ankles? | <input type="checkbox"/> Yes | During activity or prolong standing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> LT / RT leg | <input type="checkbox"/> Both legs |
| Leg cramps? | <input type="checkbox"/> Yes | During activity or prolong standing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> LT / RT leg | <input type="checkbox"/> Both legs |
| Restless legs? | <input type="checkbox"/> Yes | During activity or prolong standing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> LT / RT leg | <input type="checkbox"/> Both legs |
| Throbbing? | <input type="checkbox"/> Yes | During activity or prolong standing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> LT / RT leg | <input type="checkbox"/> Both legs |

Venous Health History Form (cont.)

No pain		Mild		Moderate		Severe		Excrutiating		
0	1	2	3	4	5	6	7	8	9	10

VAS Scale -Rate the intensity of pain _____ Persistent Yes No

2. Have your veins gotten worse in recent months? Yes No
Describe: _____

3. Do you take any medication for pain (i.e., Advil, Motrin) Yes No
If yes, what medication(s) do you take and how many times/mgs per day? _____

4. Do you elevate your legs to relieve discomfort? Yes No
If yes, how long per day do you elevate and does it provide relief? _____

5. Do you exercise? Yes No
If yes, what kind of exercise and how often? _____

6. Do you wear prescription compression stockings? Yes No
If yes, what type and gradient? How long have you worn them? _____

*If yes, what is the name of the physician who prescribed your compression stockings and when were they prescribed? _____

7. Do you wear light support hose (i.e., Sheer Energy)? Yes No
If yes, do they provide relief? _____

8. Do you have any problem walking? Yes No
If yes, describe how it interferes with your activities of daily living, which activities? (worse at night, after standing/sitting long periods or after exercise) _____

9. What type of work do you do? _____
How long do you stand (hours per day) at work? _____ At home? _____
Describe how your symptoms are/ if interfering with your essential job function of your specific occupation, which activities: (inability to walk or stand for long hours) _____

10. Have you ever had any test(s) done on your veins? Yes No
If yes, when and what type of test and where on the leg? _____

11. Were you diagnosed with saphenous vein reflux? Yes No

12. Name of referring Physician and how long have you been under his care for treatment of this condition?

Patient Signature: _____

Date: _____

PATIENTS: Please stop here. The physician may go over additional questions with you.

PHYSICIAN TO COMPLETE BELOW THIS POINT: B-F sections

B. Initial Physician Evaluation

Date of Initial Physician Evaluation: _____

Check all that apply:

- Reviewed Venous history Physical examination of the affected leg(s) Edema severity test completed
- Duplex or Doppler Scan order of the affected leg(s)
- Graduated, elasticized compression stockings (30-40 mmHg), **prescribed by a physician not in our practice**, have been used by the patient for at least 90 days.
- Prescription for graduated, elasticized compression stockings given to patient.
 - Today Given at an earlier date (specify date): length of time to be wore _____
- Standing Photos taken of leg(s) Front Back Front and back
- Clinical notes received from referring physician Other causes of patient's leg(s) symptoms have been ruled out
- Instruction given on medication dosage Instruction given on daily leg elevation
- Instruction given for mild exercise Instruction given for weight reduction

PHYSICIAN TO COMPLETE

C. Re-evaluation Visit

C. Date of Physician Reevaluation: _____

(To review results of trial of conservative therapy-lasting at least 3-6 months):

Patient is symptomatic with varicosities despite compliance with conservative therapy. Has failed conservative treatment.

Check all that apply:

- Other causes of patient's leg(s) symptoms have been ruled out
- Completed conservative treatment to include: compression stockings, medication, leg elevation, mild exercise & weight reduction (as appropriate). Time length of consecutive conservative treatment: _____

Patient is symptomatic with varicosities causing the following: (check all that apply):

- Has persistent aching, cramping, burning, pain, itching, and/or swelling during activity or after prolonged standing.
- Significant, recurrent superficial phlebitis
- Skin Conditions : discoloration /stasis dermatitis /venous eczema
- Hemorrhage from a ruptured varix
- Non-healing skin ulceration of the leg
- Other complications associated: _____

Duplex or Doppler Ultrasound of the venous system demonstrate:

- Absence of deep venous thrombosis
- Greater and/or lesser saphenous vein or accessory valvular incompetence/reflux that correlates with patients symptoms
- Perforator valvular incompetence/reflux that correlates with patients symptoms

Re-evaluation physician signature: _____ **Date:** _____

Physician Additional Comments:

PHYSICIAN TO COMPLETE

D. CEAP Classification (Vein Classes) Source: *Venous Digest*, Volume 12, Number 3 www.venousdigest.com 3-2005

- Clinical Classification
 - A classification system for visible and palpable signs of venous disease
 - Does not assess or classify subjective symptoms such as leg pain, aching, heaviness, etc.
- Etiology (congenital, primary, secondary)
- Anatomy (superficial, deep, or perforator, etc. alone or in combination)
- Pathophysiology dysfunction (reflux or obstruction, alone or in combination)

CEAP Clinical Classifications:

(C) Class

- 0- Asymptomatic. No visible or palpable signs of venous disease
- 1 - Spider veins, reticular veins, Telangiectasias
- 2 - Varicose veins
- 3 - Edema
- 4 - Skin changes
- 5 - Healed ulcer
- 6 - Active ulcer



Class 2



Class 3



Class 4-5



Class 6

(E) Etiology: Congenital Primary Disease Secondary Disease

(A) Anatomic Findings: Alone/ in combination –Superficial Deep Perforator

(P) Pathophysiology Dysfunction: Reflux Obstruction Both Reflux & Obstruction

Physician Comments:

PHYSICIAN TO COMPLETE

F. Projected Treatment Plan

Date: _____

Patient is symptomatic with varicosities despite compliance with conservative therapy and has failed conservative treatment. Medical necessity- this condition requires medical treatment to allow patient to return to a normal quality of life.

Recommendation of the following procedure(s)

- | | |
|--|---|
| <input type="checkbox"/> Endovenous ablation- RFA of Greater Saphenous Vein | Right Date _____ Left Date: _____ Bilateral _____ |
| <input type="checkbox"/> Endovenous ablation- RFA of Lesser Saphenous Vein | Right Date _____ Left Date: _____ Bilateral _____ |
| <input type="checkbox"/> Endovenous ablation- RFA of Perforating Vein (s) -RFS | Right Date _____ Left Date: _____ Bilateral _____ |
| <input type="checkbox"/> Adjunctive Sclerotherapy of varicose tributaries /varicosity | Right Date _____ Left Date: _____ Bilateral _____ |
| <input type="checkbox"/> Adjunctive Ultrasound Guided Sclerotherapy | Right Date _____ Left Date: _____ Bilateral _____ |
| <input type="checkbox"/> Adjunctive Stab Phlebectomy of varicose tributaries /varicosity | Right Date _____ Left Date: _____ Bilateral _____ |
| <input type="checkbox"/> Other: _____ | Right Date _____ Left Date: _____ Bilateral _____ |

Physician Comments: _____

Date: _____

Patient is asymptomatic and cosmetic in nature: patient is responsible / will not submit to Insurance Company

- | | |
|--|---|
| <input type="checkbox"/> Sclerotherapy -Spider/ Telangiectatic Veins | Right Date _____ Left Date: _____ Bilateral _____ |
| <input type="checkbox"/> Ultrasound Guided Sclerotherapy | Right Date _____ Left Date: _____ Bilateral _____ |
| <input type="checkbox"/> Stab Phlebectomy | Right Date _____ Left Date: _____ Bilateral _____ |

Physician Comments: _____

