PRECISION SURGERY and ADVANCED VEIN THERAPY

(Please Print)

Your Name as it appears on your insurance card: Gender: Male Female

_____ Date of Birth: _____

Address: _____
Street Apt# City State Zip

Race: _____ Ethnicity: _____ Language: _____

Social Security #: __ __ __ - __ __ - __ __ __ __ Marital Status: M S W D

Home Phone Number: _____ Cell Phone Number: _____

Email Address: _____

Primary Care Physician: _____ PCP Phone Number: _____

Who referred you to our office? _____ Phone Number: _____

Emergency Contact: _____ Phone Number: _____

Relationship to Patient: _____

Name of Responsible Party: _____ Relationship to Patient: _____

Address: _____ Phone Number: _____

Employer: _____ Phone Number: _____

Title Name/Position: _____

IS THE REASON FOR YOUR VISIT A WORK-RELATED INJURY? YES NO
IS THE REASON FOR YOUR VISIT A CAR ACCIDENT-RELATED INJURY? YES NO

PLEASE FILL- IN INSURANCE INFORMATION COMPLETELY

PRIMARY INSURANCE: _____ Policy Holder Name: _____

ID #: _____ Group #: _____ Relationship to Patient: _____

Social Security Number of Policy Holder: _____D.O.B _____

SECONDARY INSURANCE: _____ Policy Holder Name: _____

ID #: _____ Group #: _____ Relationship to Patient: _____

Social Security Number of Policy Holder: _____D.O.B _____

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CURRENT MEDICATIONS:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES:

Are you allergic to any Medications? Yes No

IF YES, please list the medications that you are allergic to and your reaction to them:

Medication:	Reaction:
_____	_____
_____	_____
_____	_____

LIST ANY MEDICAL CONDITIONS:

_____

_____

_____

LIST ANY PREVIOUS SURGERIES:

_____

_____

_____

Are you currently Pregnant? _____ Due date: _____

PHARMACY:

Name: _____ Pharmacy Phone Number: _____

Pharmacy Address or Cross Streets: _____

SOCIAL HISTORY:

Smoker? Never Former Current: _____ packs / cigarettes per day

Alcohol Intake? Never Former Monthly Weekly Daily

Height: _____ Weight: _____

Are you in hospice care? Yes No

Are you allergic to Latex? Yes No

Are you in pain management? Yes No

**If you are in pain management, please provide the following information:

Name of clinic: _____ Cross streets: _____

Phone number: _____

_____ _____

Signature of Patient or Guardian **Date**

PRECISION SURGERY and ADVANCED VEIN THERAPY

Johnny L. Serrano, D.O., F.A.C.O.S.
General Surgery
Board Certified
American Osteopathic Board of Surgery

CONDITIONS FOR TREATMENT

CONSENT TO MEDICAL AND SURGICAL PROCEDURES AND PHOTOGRAPHS

The undersigned (hereinafter "Patient" which shall also include parents or legal guardians if the Patient is a minor or lacks legal capacity and representatives of the Patient), consents to the procedures and services that may be performed by:

Dr. Johnny Serrano and Precision Surgery Center, P.C.

(Hereinafter referred to as the "Provider"). I consent to the taking of pictures of my medical or surgical condition or treatment, and the use of the pictures and medical history and/or medical records for purposes of my diagnosis or treatment or for education or training programs conducted by the Provider. I understand that I have the right to request the cessation of recording or filming.

PERSONAL BELONGINGS

It is understood and agreed that the Provider shall not be liable for the loss or damage to any money, jewelry, documents, furs, fur coats and fur garments or other articles of unusual value or of any value.

FINANCIAL AGREEMENT

The Patient agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the Patient, he/she hereby individually obligates him/herself to pay the charges of the Provider in accordance with the regular rates and terms of the Provider. If the provider is In-Network with your health plan, you agree to be responsible for any and all copayments, deductibles, co-insurances and non-covered services. If the practice is out-of-network with your Health Plan, you agree to be responsible for FULL Charges after all payments are received by the practice.

Late payment of coinsurance, deductibles or patient responsibility shall be subject to interest in the amount of 1% compounded per month (12% annual). A payment shall be deemed late for purposes of interest when it is not received by the 45th day after invoice is sent by Provider or his representative.

Should the account be referred to an attorney or collection agency for collection, the Patient agrees to pay actual attorneys' fees and collection expenses that may be calculated at a percentage, of no less than 35% of the outstanding balance. _____ Initials

The Patient, his/her agent or representative, understand that medical bill submission to the Patient's Health Plan is done by the Provider's billing staff or authorized representatives as an accommodation to the Patient; that this does not in any way diminish or eliminate the Patient or his/her agent or representatives' obligation to pay their account in full after services are rendered by the Provider. Pre-authorizations of services are any required referrals are the responsibility of the patient. Payment is due at the time services are rendered. A $3.95% processing fee applies to debit and credit card payment transactions. The $3.95% fee is waived when paying by ACH, cash or check. _____ Initials

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Financial Acknowledgements

I understand that regardless of any insurance coverage or other potential co-guarantor or responsible party I am accepting full financial responsibility for payment of all charges for services provided to me, my spouse or dependents by this practice. I agree that if my employer, insurance carrier or plan sponsor denies payment to all of or ay portion of my claim, I will be financially responsible for all outstanding charges. I agree to pay a minimum monthly billing charge of $5.00 or interest rate of 1.75% per month (whichever is greater) on any balance not paid within 30 days of the date of service. In addition, should my account become delinquent and assigned to a collection agency. I agree to pay additional collection charge of 33% of the outstanding balance or a minimum of $40.00 whichever is greater to offset in part the collection agencies fee charged to this practice. Should legal action be initiated by the collection agency, I agree to pay a collection charge of 50% of the outstanding balance as well as all cost and reasonable attorney fees incurred in such collection efforts by this office or our assignee.

TCPA Acknowledgment

I authorize this office, its agents and assignees to contact me by telephone, text, SMS, and /or via an automated dialing system with live or recorded voice in connection with any of my accounts with this office and at any telephone number I have provided as of this date or in the future.

_____ _____

Patient Signature Date

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CONSENT TO COMMUNICATION BY EMAIL AND TEXT

The Patient and his/her agent or representative hereby voluntarily provide their email address and cell telephone number to the Provider and its authorized representatives. The Patient and his/her agent or representative hereby authorize the Provider and its authorized representative to send and otherwise communicate with patient or his/her agent or representative by email and text message with respect to the Patient's Medical Claims. The Patient and his/her agent or representative hereby voluntarily consent to such electronic communication as required by 15 USC 7001 and related state regulations and statutes. The Patient and his/her agent or representative may provide written notice to the Provider or its authorized representative to receive any communication on paper or non-electronic form. The Patient and his/her agent or representative agree' s that his/her consent is continuous. However, the Patient and his/her agent or representative may terminate this consent in writing to the Provider or their authorized representative. There are no hardware or software requirements needed to receive email communication from the Provider or any of their authorized representatives including other than having an active email account and a cell phone that receives text messages from a vendor that provides such email accounts and texting options. The Provider and its authorized representatives agree that it will not sell, share, or rent patient email addresses, cell phone numbers or any other personal information collected based upon this consent. My email address is _____ and my cell phone telephone number is _____ _____.

Patient/Guardian Signature

I have read and understand this patient consent agreement and I agree to its terms as a condition of medical treatment. I hereby acknowledge that at the beginning of my Treatment or services rendered by the Provider, I have been furnished with the Provider's Charity Care Policy, Policy for Collection of Patient Deductibles, Coinsurance and Other Patient Balances and this Conditions to Treatment document. I voluntarily sign this acknowledgement that I consent and agree to the Conditions of Treatment for services to be rendered by the Provider.

Agreed to by: _____ / _____
(Patient signature) (Patient Printed Name)

Date: _____ Patient Initial: _____

Agreed to by: _____ Date: _____
(Guardian of Patient)

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COVID-19/Coronavirus Patient Notice and Acknowledgement Form

In accordance with the recommendations, guidance and advisories of the Centers for Disease Control and Prevention (CDC) regarding the COVID-19/Coronavirus pandemic for health care professionals, facilities and clinicians, (many of which have been echoed by state governors and health departments), the following procedures will have observed and conducted by our practice and its patients, effective immediately:

1. The office will be prioritizing urgent and emergency visits and procedures;
2. The office will clean and sanitize the facility in accordance with CDC standards;
3. The office will screen the patient for symptoms of COVID-19 prior to any evaluation, diagnosis and/or treatment of the patient;
4. The patient will disclose and advise the practice of his/her recent international travel history prior to any evaluation, diagnosis and/or treatment of the patient;
5. The patient will disclose and advise the practice of any known potential exposure events the patient was subjected to prior to any evaluation, diagnosis and/or treatment of the patient; and
6. The office may, at its discretion, reschedule a patient's appointment for elective care if the patient is exhibiting symptoms of COVID-19, recently traveled abroad or was subject to a known exposure event.

By signing this form, the patient acknowledges that it has been advised of the practice's policies with respect to COVID-19.

AGREED TO, ACKNOWLEDGED AND ACCEPTED BY:

_____ _____

Patient's Printed Name **Patient's Signature**

Dated: _____

PRECISION SURGERY and ADVANCED VEIN THERAPY

To help us better understand our business operations,
please fill out this short survey.

How did you hear about us?
Please check on of the following options

- Facebook
- Instagram
- Google
- Yelp
- Physician Referral
- Newspaper
- Magazine
- Friend
- Family
- Other: _____

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Para ayudarnos a comprender mejor nuestras operaciones comerciales,
complete esta breve encuesta.

¿Cómo te enteraste de nosotros?
Marque una de las siguientes opciones

- Facebook
- Instagram
- Google
- Yelp
- Referencia de su Doctor
- Periodico
- Revista
- Amigo
- Familia
- Otro: _____