TEXAN VEIN & VASCULAR

1785 E Whitestone Blvd., Suite# 300
Cedar Park, TX 78613-5635

Dr. Vinit Varu, MD, RPVI, FSVS
Board Certified Vascular Surgeon

Ph: (512) 387-0114
Fax: (512) 456-7695
Web: www.texanvv.com

Hours of Operation:
Mon - Fri
8AM - 5PM
Lunch Daily 12PM - 1PM

Hello!

Thank you for entrusting Texan Vein & Vascular with your care—we truly appreciate the opportunity to be part of your health journey.

Enclosed, you will find your new patient paperwork. Please complete these forms at your convenience and bring them with you to your first appointment. This will help us ensure a smooth and efficient check-in process.

At the time of your visit, please remember to bring:

- A valid government-issued photo ID
- Your insurance card(s)

If your insurance plan requires a copay, it will be collected upon check-in for each visit.

Your appointment is confirmed for:

Mon Tue Wed Thurs Fri _____ at _____ **AM PM**

If you need to reschedule your appointment, we kindly ask that you provide as much notice as possible by calling **(512) 387-0114** and selecting **option #1**.

Thank you again for choosing Texan Vein & Vascular. We look forward to seeing you soon!

Warm regards,

Texan Vein & Vascular Team

TEXAN VEIN & VASCULAR

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Cedar Park, TX 78613-5635
Ph: (512) 387-0114 | Fax: (512) 456-7695

NEW PATIENT

INFORMATION AND CONSENT FORMS

Initial Appointment Details:

DATE:

TIME:

PATIENT INFORMATION

Legal Name: _____

Preferred Name: _____ Date of Birth: *mm/dd/yyyy* _____

Cell Phone #: _____ Alternate Phone #: _____

Email Address: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Employer: _____

Birth Gender: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Divorced ☐ Life Partner ☐ Single ☐ Widowed ☐ Other

What is your current **height**? _____	What is your current **weight**? _____	What is your preferred language? ☐ **English** ☐ **Spanish** ☐: _____
What is your preferred method of contact? ☐ **Voice Call** ☐ **Text** ☐ **Email**	For **CELL** phone, is it ok to leave a voicemail? ☐ **Yes, Extended** ☐ **Yes, Brief** ☐ **No**	For **ALT** phone, is it ok to leave a voicemail? ☐ **Yes, Extended** ☐ **Yes, Brief** ☐ **No**

EMERGENCY CONTACT

Name: _____

Phone Number: _____ Relationship: _____

PHARMACY INFORMATION

Name of Pharmacy: _____

Cross streets: _____

Pharmacy Phone: _____

City & State: _____

CARE TEAM

Were you referred to us?: ☐ No, I self-referred. ☐ Yes, by: _____

Referring physician's practice name or address: _____

Who is your Primary Care Physician (PCP)?: _____

Primary physician's practice name or address: _____

Who is your Cardiologist?: _____

Cardiologist's practice name or address: _____

PLEASE PRINT YOUR NAME HERE:

_____

TEXAN VEIN & VASCULAR

NEW PATIENT FORM

CURRENT MEDICATIONS

Please list all medications (prescription, over-the-counter (OTC), and vitamins) you currently take.

If additional space is needed, please continue your medication list on a separate sheet of paper.
If you already have a printed or handwritten list of your current medications,
you may simply attach it to this form instead of completing below table.

MEDICATION/OTC/VITAMIN NAME *(e.g. Atorvastatin)*	**DOSE** *(e.g. 10mg)*	**FREQUENCY** *(e.g. once daily)*	**MEDICATION/OTC/VITAMIN NAME** *(e.g. Atorvastatin)*	**DOSE** *(e.g. 10mg)*	**FREQUENCY** *(e.g. once daily)*

MEDICAL HISTORY

Please indicate by checking the appropriate box if you **CURRENTLY** have,
or have **PREVIOUSLY** had, any of the following conditions.
You may also list any additional medical conditions you believe are relevant in the "Other" sections provided.

☐ Heart Failure	☐ Dementia	☐ Seizure Disorder
☐ Diabetes (DM)	☐ Asthma	☐ Bleeding / Clotting Disorder
☐ Anemia	☐ Deep Vein Thrombosis (DVT)	☐ Pulmonary Embolism (PE)
☐ HIV	☐ Depression	☐ Drug Abuse
☐ Obstructive Sleep Apnea (OSA)	☐ Peptic Ulcer Disorder (PUD)	☐ Stroke / TIA
☐ Coronary Arterial Disease (CAD)	☐ High Cholesterol / Hyperlipidemia	☐ Hypertension / Hypotension
☐ Atrical Fibrillation (AFib) / Arrhythmia		☐ Liver Disease / Cirrhosis
☐ Chronic Kidney Disease (CKD) / End Stage Renal Disease (ESRD)		☐ Hepatitis
☐ Myocardial Infarction (MI) / Heart Attack		☐ Other:
☐ Chronic Obstructive Pulmonary Disease (COPD) / Emphysema		☐ Other:

DRUG ALLERGIES

Do you have any known drug/medication allergies? ☐ **NONE** ☐ **YES** (please list below)

MEDICATION (or AGENT) NAME	**REACTION**

For additional space, please attach a separate page with this form.

PLEASE PRINT YOUR NAME HERE:

_____

TEXAN VEIN & VASCULAR

NEW PATIENT FORM

SURGICAL & HOSPITALIZATION HISTORY

Please indicate by checking the appropriate box if you have had any procedures related to:

SURGERY / PROCEDURE / TREATMENT / HOSPITALIZATION	DATE (MM/YY) (ESTIMATE OK IF UNKOWN)	PHYSICIAN NAME
Varicose Vein Treatment(s) *SPECIFY:*		
Any angioplasty / stent / bypass *SPECIFY:*		
Coronary Bypass Graft (CABG)		
Other:		
Other:		
Other:		

For additional space, please attach a separate page with this form.

FAMILY HISTORY

Please indicate by checking the appropriate family member if they **have** or **have had** any of the following conditions.

CONDITION	MATERNAL *(Mother's Side)*	PATERNAL *(Father's Side)*	FULL OR HALF SIBLING
Type II Diabetes	☐Mother ☐Grandmother ☐Grandfather	☐Father ☐Grandmother ☐Grandfather	☐Sibling
Hypertension	☐Mother ☐Grandmother ☐Grandfather	☐Father ☐Grandmother ☐Grandfather	☐Sibling
Heart Disease	☐Mother ☐Grandmother ☐Grandfather	☐Father ☐Grandmother ☐Grandfather	☐Sibling
Stroke	☐Mother ☐Grandmother ☐Grandfather	☐Father ☐Grandmother ☐Grandfather	☐Sibling
Aneurysm	☐Mother ☐Grandmother ☐Grandfather	☐Father ☐Grandmother ☐Grandfather	☐Sibling
Varicose Veins	☐Mother ☐Grandmother ☐Grandfather	☐Father ☐Grandmother ☐Grandfather	☐Sibling
Other **Vascular** Problems	☐Mother ☐Grandmother ☐Grandfather	☐Father ☐Grandmother ☐Grandfather	☐Sibling
Specify:			

CHIEF COMPLAINT

Briefly explain the reason for your visit. Please do not leave blank. Please do not just write "referred".

_____

_____

_____

_____

Please Initial Here: _____

PLEASE PRINT YOUR NAME HERE:

_____

TEXAN VEIN & VASCULAR

NEW PATIENT FORM

SOCIAL HISTORY

Nicotine Use? ☐**Current User** ☐**Former User** ☐**Nonuser**

NOTE: *Nicotine use includes, but is not limited to: cigarettes, vaping, chewing tobacco, pipe tobacco, snuff, cigars, nicotine pouches, and other nicotine products.*

Form **Current or Previous** *(cigarettes, vape, chew, pipe, ect.)*	**Frequency** **Current or Previous**	**Number of years** ***OR*** **Number of years quit**
	☐ 1-9 cigs/day (or **LIGHT** use for other forms) ☐ 10-19 cigs/day (or **MODERATE** for other forms) ☐ 20-39 cigs/day (or **HEAVY** for other forms) ☐ 40+ cigs/day (or **VERY HEAVY** for other forms)	

If you are a current nicotine user, would you be interested in resources to help you quit? ☐**Yes** ☐**No**

Alcohol Use? ☐**Yes** ☐**No** *(if no, can skip the remaining questions)*

NOTE: *For this form, one "drink" means one standard alcoholic drink, such as: 12 oz. of regular beer, 5 oz. of wine, or 1.5 oz. of liquor/spirits.*

If 'Yes' : How often did you have a drink containing alcohol in the past year?	**If 'Yes' : How many drinks did you have on a typical day when you were drinking in the past year?**	**If 'Yes' : How often did you have six or more drinks on one occasion in the past year?**
☐Never ☐Monthly or less ☐2 to 4 times per **month** ☐2 to 3 times per **week** ☐Daily or almost daily	☐1 to 2 drinks ☐3 or 4 drinks ☐5 or 6 drinks ☐7 to 9 drinks ☐10 or more drinks	☐Never ☐Less than monthly ☐2 to 4 times a **month** ☐2 to 3 times per **week** ☐4 or more times a week

CONSENT TO TREATMENT

I voluntarily consent to receive medical care from Texan Vein & Vascular ("the Practice") and its physicians, providers, employees, and authorized staff.

I understand that my care may include, but is not limited to:

✦Medical history review and physical examination ✦Diagnostic testing, including vascular ultrasound examinations ✦Laboratory testing, when appropriate ✦Office-based medical treatments and procedures as recommended by my provider ✦Prescription medications, when appropriate ✦Coordination of care with other healthcare providers involved in my treatment

I understand that I have the right to ask questions regarding my medical condition, recommended tests, treatments, and procedures. I also understand that I have the right to refuse any recommended treatment or procedure after discussing the risks, benefits, and alternatives with my provider.

I understand that the practice of medicine is not an exact science and that no guarantees or assurances have been made regarding the results of any examination, diagnosis, test, or treatment. I understand that diagnostic testing, imaging studies, recommended treatments, and medical services are based on my provider's clinical judgment and may not be covered by my health insurance. I acknowledge that I remain financially responsible for any applicable patient responsibility as outlined in the Practice's Financial Policy.

I understand that this general Consent to Treatment does not replace separate informed consent forms that may be required for specific procedures or treatments. This consent shall remain in effect for all future care and treatment provided by the Practice unless revoked by me in writing. Revocation shall not affect any treatment provided prior to the date the written revocation is received.

I understand that revocation of such consent constitutes my withdrawal of consent for future evaluation and treatment and, as a result, I understand that the Practice may be unable to continue providing non-emergency medical care unless a new Consent to Treatment is executed.

By signing below, I acknowledge that I have read, understand, and voluntarily consent to receive medical evaluation, diagnostic testing, and treatment from Texan Vein & Vascular.

Signature: _____ **Date:** _____

PLEASE PRINT YOUR NAME HERE:

_____

TEXAN VEIN & VASCULAR

NEW PATIENT FORM

INSURANCE INFORMATION

Please complete the health insurance information section below. You may skip this section if you have already provided–or will provide when submitting this form–your current insurance card(s) or a clear photocopy of both the front and back of each card.

Please note: Our office may still require a copy of your current insurance card(s) to verify your coverage and maintain accurate records.

Insurance Plan / Company Name	**Policy / Member / ID Number**	**Group Number**	**Subscriber's Name and DOB** (if not you)	**Plan Type** (HMO, PPO, POS, OAP, etc)

INSURANCE REFERRALS & COVERAGE RESPONSIBILITY

Please read carefully. One of the most common reasons patients receive unexpected medical bills is because their insurance plan requires a referral that was not obtained or not obtained properly.

Many insurance plans (including many HMOs, some POS plans, and others) require a referral from your **Primary Care Provider (PCP)** before specialty services are covered. A referral from another specialist (such as a cardiologist, dermatologist, podiatrist, orthopedic surgeon, or other physician) **may not** satisfy your insurance company's referral requirements as they are not your PCP.

If a required referral is not obtained or is invalid, or if we are not contracted with your plan, your insurance company may deny payment for services rendered. **In such cases, you may be financially responsible for the full allowable amount.**

As outlined in the Financial Policy, it is ultimately **your responsibility** to verify that Texan Vein & Vascular participates with your insurance plan, determine whether a referral is required, ensure that any required referral and/or prior authorization has been properly obtained and is valid for your visit, and understand your insurance benefits and coverage limitations. We recommend checking this prior to each visit as referrals do expire and network participation may change.

If you are unsure about any of the above, we strongly recommend that you contact your insurance company before your appointment.

.....→ **Please Initial Here:** _____
Indicating you've read the above section.

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION (PHI)

I authorize Texan Vein and Vascular to discuss my medical condition, treatment, appointments, test results, billing information, and other protected health information with the following individual(s):

Important: Federal privacy laws (HIPAA) require your permission before we can discuss your medical information with another person, **including your spouse, adult children, parents, or friends/caregivers**. If you would like us to be able to communicate with anyone besides yourself, please list them below.

Name of Authorized Person: _____

☐ I authorize all medical and billing information. **OR** ☐ Only this information: _____

Name of Authorized Person: _____

☐ I authorize all medical and billing information. **OR** ☐ Only this information: _____

Please know that you may add to and/or revoke this authorization for any and/or all persons listed at any time by providing written notice to Texan Vein & Vascular.

PLEASE PRINT YOUR NAME HERE:

_____

TEXAN VEIN & VASCULAR

NEW PATIENT FORM

PATIENT RESPONSIBILITIES

You understand it is your responsibility, as the patient, to:

- Provide accurate medical and insurance information.
- Inform the office of any changes to your insurance, address, telephone number, or medications.
- Arrive on time for appointments.
- Follow your provider's treatment recommendations.
- Ask questions if you do not understand your diagnosis or treatment plan.

NOTICE OF PRIVACY PRACTICES

Texan Vein & Vascular is committed to protecting the privacy of your health information.

Our Notice of Privacy Practices explains how your medical information may be used and disclosed, as well as your rights regarding your protected health information under federal law.

A copy of our Notice of Privacy Practices is available for your review in our office at any time. You may also request a printed or emailed copy to keep for your records.

APPOINTMENT REMINDER CONSENT

Texan Vein & Vascular may contact you regarding appointments, scheduling changes, test results, billing matters, and other healthcare-related communications by telephone, text message, email, or through the patient portal.

Please note: We respect your privacy. We will never sell your contact information (e.g. physical or mailing addresses, phone numbers, email addresses) or send unsolicited advertisements or spam.

If you prefer that we not contact you by one or more of these methods, please indicate:

☐ **Do not call me** ☐ **Do not email me**

☐ **Do not send portal messages** ☐ **Do not text me**

MEDICAL PHOTOGRAPHY CONSENT

As part of my evaluation and treatment, If clinically indicated during my care, I authorize Texan Vein & Vascular to obtain clinical photographs and/or video images of my legs, wounds, or other relevant areas when medically necessary. These images may be used for documentation of my medical condition, treatment planning, monitoring of my progress, communication among healthcare providers involved in my care, and inclusion in my confidential medical record. This consent does not apply to diagnostic imaging studies (such as ultrasound examinations), which are performed as part of my medical care.

☐ **I authorize** the above. ☐ **I do not authorize** the above.

☐ (**Optional**) I also **authorize** the use of de-identified photographs and/or video images for educational, training, or marketing purposes. I understand that no information or photo (including head or face) that directly identifies me will be used and that my decision regarding this optional authorization will not affect my medical care or treatment.

Signature: _____ **Date:** _____

HOW DID YOU HEAR ABOUT US?

☐ I was referred by my doctor ☐ An online search ☐ An online ad ☐ Other ad (not online)

☐ A patient of our practice ☐ Drove by ☐ Social media ☐ Other:_____

PLEASE PRINT YOUR NAME HERE:

_____

TEXAN VEIN & VASCULAR

NEW PATIENT FORM

FINANCIAL POLICY

Thank you for choosing Texan Vein & Vascular ("the Practice") for your healthcare needs. We are committed to providing quality medical care and maintaining a transparent financial relationship with our patients. **Please review the following policy carefully.**

Insurance and Financial Responsibility: As a courtesy, the Practice will file claims with participating insurance carriers on your behalf. However, your insurance policy is a contract between you and your insurance company. It is your responsibility to understand your insurance benefits, coverage limitations, network status, deductibles, copayments, coinsurance obligations, referral requirements, and authorization requirements.

While we will make every reasonable effort to verify insurance benefits, any information provided by our office is only an estimate and is not a guarantee of payment. Final determination of coverage is made by your insurance carrier.

You are responsible for providing accurate and current insurance information at each visit. Failure to provide updated insurance information may result in you being responsible for the full balance of services rendered.

Any portion of charges determined by your insurance company to be your responsibility, including deductibles, copayments, coinsurance, non-covered services, denied claims, or services requiring authorization that was not obtained, will be billed directly to you and are your responsibility to pay.

Payment Policy: Copayments, deductibles, coinsurance amounts, and self-pay balances are due at the time of service unless other arrangements have been made in advance.

We accept cash, checks, Visa, Mastercard, American Express, Discover, and CareCredit.

A fee of **$35.00** will be assessed for any check returned by a financial institution for insufficient funds or any other reason. In the event a check is returned, the Practice reserves the right to refuse future payments by personal check and may require all future payments to be made by other approved forms of payment. Additionally, the Practice reserves the right to decline personal checks for balances exceeding $100.00.

Patients without insurance coverage, patients with out-of-network plans, or patients whose insurance coverage cannot be verified prior to service may be required to pay for services at the time of their visit.

Missed Appointment and Late Cancellation Policy: We respectfully request at least 24 business hours' notice if you need to cancel or reschedule an appointment. Missed appointment fees are not covered by insurance and are the sole responsibility of the patient. Repeated missed appointments or late cancellations may result in dismissal from the Practice in accordance with applicable law and Practice policies.

A fee of up to ****$85.00**** may be charged for:

- Failure to provide at least 24 business hours' notice of cancellation
- Failure to arrive for a scheduled appointment ("No Show")
- Arriving more than 15 minutes late for a scheduled appointment (at which point the appointment must be rescheduled)
- Failure to complete required paperwork prior to the appointment resulting in the appointment being rescheduled

Medical Records Requests: Patients may request copies of their medical records in accordance with applicable federal and Texas law. The Practice may charge a reasonable, legally permitted fee for copies of medical records, electronic media, imaging studies, mailing, or affidavits when applicable. Fees are not billable to any insurance company and are the responsibility of the requesting party.

Fees will be communicated in advance, and a list of current medical record copy fees is posted in our waiting room and/or available upon request. The Practice will not charge for searching for or retrieving records and will not withhold records solely because of an outstanding account balance. Exceptions to copy fees may include, but are not limited to, patient portal access, electronic transmission when available and appropriate, or direct transmission to another verified healthcare provider's office by fax or electronic means.

Account Credits and Refunds: Credit balances may result from insurance payments, patient payments, or other account adjustments. Refunds will not be issued until all claims submitted to all insurance carriers on file for the patient have been fully processed and finalized, even if unrelated to the specific date of service or payment that created the credit.

To the extent permitted by law and payer requirements, the Practice may apply credit balances to other outstanding balances owed by the patient or by any dependent for whom the patient is financially responsible. Any remaining verified credit balance will be refunded to the appropriate party by business check, which may be picked up at our office or mailed to the address on file with permission. Please allow reasonable processing time for refund requests.

If the Practice is unable to refund or apply a credit balance after reasonable efforts, the balance may be reported and remitted to the Texas Comptroller as unclaimed property as required by Texas law.

Collection of Unpaid Balances: Any unpaid balance remains the responsibility of the patient. Accounts that become significantly past due may be referred to a collection agency or attorney for collection. The patient may be responsible for any reasonable costs associated with collection efforts to the extent permitted by law.

Cosmetic Services: Cosmetic procedures and services are generally not covered by health insurance plans. Payment for cosmetic services, including cosmetic sclerotherapy and related treatments, is due in full prior to treatment unless other arrangements have been made in advance. Patients are financially responsible for all cosmetic services rendered, regardless of any insurance coverage determination.

Assignment of Benefits: I hereby authorize payment of medical benefits directly to the Practice for services rendered. I authorize the release of medical information necessary to process insurance claims and obtain payment for services.

Acknowledgment: I have read and understand the Financial Policy of the Practice. I agree to be financially responsible for all charges incurred on my behalf or on behalf of any dependent for whom I am legally responsible, regardless of insurance coverage or payment determination.

Signature: _____ **Date:** _____