IZZO & ALKIRE, M.D.s, P.A.

ADVANCED VEIN & VASCULAR SOLUTIONS

Board Certified Vascular Surgeons

We would like to thank you for choosing Advanced Vein & Vascular Solutions for your care. We are committed to providing you with quality and affordable healthcare. Because you may have some questions regarding personal and insurance responsibility for services rendered, we have developed this payment and financial policy. Please read and feel free to ask any questions that you may have. Please sign in the space provided, a copy will be provided to you upon request. Our physicians participate in a number of networks; it is your responsibility to verify that the physician you are seeing is in the network. If you belong to an insurance company that requires a referral, you must have that referral with you at the time of service.

For our insured patients:

COPAYS: All copays must be paid at the time of service.
DEDUCTIBLES: Some insurance policies have deductible requirements. These are your responsibility and will be collected at the time of service.
NON-COVERED SERVICES: Some services that you receive may be non-covered, or not considered necessary by your insurance. These services are your responsibility and will be billed to you. Payment is due within 14 days of receipt of your statement.
SUBMITTING CLAIMS: We will submit your claims and assist in every reasonable way we can to get your claims paid. However, there may be times when your insurance company requires information from you directly. It is your responsibility to provide this information if or when is requested. If your claim is denied because you failed to provide this information, the balance will become your responsibility.

PROOF OF INSURANCE: All patients must complete our registration process. We must also obtain a copy of your current insurance card. If you do not have this available at your appointment, and do not produce it within a reasonable amount of time, you will be responsible for your service.
POLICIES WITHOUT OFFICE VISIT COVERAGE: If your insurance policy does not have office visit coverage, payment for your visit is due at the time of service.

CHANGES IN COVERAGE: If you're insurance changes please notify us prior to your appointment.

For our self- pay patients: Payment must be made at the time of service.

FOR ALL PATIENTS:

NO SHOW APPOINTMENTS: If we are not given the courtesy of 24 hour notice of cancelation. There will be a fee of $25.00. Please understand this is an appointment someone else might have wanted. Also a fee of $ 100.00 will be accessed if you do not show for a scheduled test or procedure. A lot of preparation goes into being ready for a procedure and we could have offered this time to another patient with 24 hour notice. If you are greater than 10 minutes late you may not be seen & maybe charged as a no show.
FORMS FEE: There is a fee of $10.00 per form for completion. Payment for this service is due before the completed form leaves the office.
COLLECTIONS PROCEDURES: If your account is over 90 days old, partial payment must be negotiated with the billing department. Please be aware that if your balance remains unpaid, we will refer your account to an outside collections agency and you and your immediate family members may be subject to discharge from the practice. If referred, the balance must be paid in full before you are scheduled again.

Forms of payments: We accept CASH, PERSONAL CHECKS, MONEY ORDERS, VISA, AND MASTER CARD

RETURNED CHECKS: There will be a $25.00 fee added to any balance with a returned check.
Thank you for your understanding our payment and financial policy. Please let us know if you have any questions or concerns.
** I have read and understand the above payment and financial policy and agree to abide by its guidelines.

_____	_____	_____
Print Patient Name	Signature of Patient	Date

Revised 08/03/2018

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Edward G. Izzo, Jr., M.D., FACS • Mark J. Alkire, M.D., FACS
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PATIENT INFORMATION

PLEASE PRINT

Date: ___/___/___

Name: _____ Date of Birth: _____ Age: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Work Phone: _____Cell: _____

Are you a resident of a Nursing Home? (PLEASE CIRCLE ONE) Yes /No. If yes which facility: _____

E-mail_____ (provide if ok to contact you by e-mail)

S.S. #:_____ Sex: _____ Marital Status: _____

Spouse's Name: _____ Spouse's Employer: _____

Ethnicity: _____ Race: _____ Language Spoken: _____

Referred By: Dr_____Friend_____ Internet_____ Facebook_____

Primary Care Physician: _____Employer: _____ Full Time/Part Time

Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Holder's Name: _____ Birth Date: _____

Secondary Insurance: _____

Policy Holder's Name: _____ Birth Date: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Signature_____ Date: _____

Witness_____

Sun City Center • Town & Country • Brandon
Mail Correspondence to: 1901 Haverford Ave Ste 105 Sun City Center, Fl 33573
Phone: 813.258.4533 • www.izzoalkire.com

PATIENT, FAMILY AND SOCIAL HISTORY

NAME: _____ DATE_____BIRTH DATE_____AGE_____

CHIEF COMPLAINT_____
(REASON FOR TODAY'S VISIT)

ALLERGIES TO MEDICINES, FOODS, LATEX, IODINE? _____

LIST ALL CURRENT MEDICATIONS & DOSAGES

1._____6._____
2._____7._____
3._____8._____
4._____9._____
5._____10._____

HEIGHT:___FT ____IN WEIGHT: _____ NUMBER OF CHILDREN____ NUMBER OF PREGNANCIES___

LIST PATIENT'S DOCTORS (First & Last Name) _____

CIRCLE: SINGLE MARRIED SEPARATED DIVORCED WIDOWED LIVING ARRANGEMENT

MOST RECENT OCCUPATION: _____RETIRED? _____

SMOKING HISTORY :(CIRCLE ONE) CURRENT SMOKER FORMER SMOKER NEVER SMOKER
ALCOHOL USE: YES/NO DAILY? _____HOW MUCH? _____ ILLICIT DRUG USE: YES/NO
LIVING SITUATION (PLEASE CIRCLE ONE): ALONE SPOUSE FAMILY ALF

FAMILY HISTORY: 1) DIABETES 2) HEART DISEASE 3) HIGH BLOOD PRESSURE
4) STROKE 5) KIDNEY DISEASE 6) ANEMIA 7) MENTAL ILLNESS 8) TB 9) CANCER 10) ARTHRITIS

MOTHER:__,__,__,__,__,__ FATHER: __,__,__,__,__,__
BROTHER:__,__,__,__,__,__SISTER:__,__,__,__,__,__

LIST ALL PAST SURGERY/MAJOR HOSPITALIZATIONS/CANCER HISTORY WITH DATE:

1._____6._____
2._____7._____
3._____8._____
4._____9._____
5._____10._____

MOTHER LIVING_____DECEASED_____AGE____CAUSE_____
FATHER LIVING_____DECEASED_____AGE____CAUSE_____

HAS PATIENT EVER HAD PROBLEMS WITH ANESTHESIA? _____
EXPLAIN_____

HAS PATIENT EVER HAD A BLOOD TRANSFUSION? _____WHEN? _____REACTION? _____
IS PATIENT AN ORGAN DONOR? YES/NO

HEALTH HISTORY

NAME:_____

CIRCLE ALL THAT APPLY TO YOU NOW OR IN THE PAST

GENERAL
WEIGHT LOSS/GAIN
FEVER/CHILLS
FATIGUE

EYES
BLURRED/DOUBLE VISION
CATARACTS/GLAUCOMA
GLASSES/CONTACTS

MOUTH/EARS/NOSE/THROAT
HEARING LOSS
HOARSENESS
RINGING IN EARS (TINNITIS)
SINUS TROUBLE
MOUTH ULCERS/FEVER BLISTERS

CARDIOVASCULAR
ABNORMAL EKG
CHEST PAIN
HEART ATTACK
HIGH BLOOD PRESSURE
LOW BLOOD PRESSURE
SHORTNESS OF BREATH
PAIN IN CALF WHEN WALKING

RESPIRATORY
ABNORMAL CHEST X-RAY/CT SCAN
SHORTNESS OF BREATH
WHEEZING/ASTHMA
COPD/EMPHYSEMA
PNEUMONIA

GASTROINTESTINAL
NAUSEA/VOMITING
DIARRHEA/CONSTIPATION
HEARTBURN
DIFFICULTY SWALLOWING
RECTAL BLEEDING
HEPATITIS

GYN/FEMALES ONLY
LAST PERIOD_____ PELVIC PAIN AGE OF MENOPAUSE_____

MUSCULOSKELETAL
JOINT PAIN/SWELLING
ARTHRITIS
BACK TROUBLE
FRACTURES
GOUT

SKIN
RASH ITCHING
DRY SKIN HIVES
ECZEMA

NEUROLOGICAL
FREQUENT HEADACHES PRIOR STROKE
DIZZINESS MEMORY LOSS
SEIZURE EPILEPSY

PSYCH
DEPRESSION ANXIOUS/STRESSED

ENDOCRINE/URINARY
WEIGHT CHANGE EXCESSIVE THIRST
EXCESSIVE URINATING DIABETES
THYROID PROBLEM KIDNEY FAILURE/DIALYSIS

HEMATOLOGIC/LYMPHATIC
SWOLLEN GLANDS ANEMIA
BRUISE EASILY HEMOPHILIA
BLEED EASILY

ALLERGIES/IMMUNOLOGIC
RUNNY NOSE IMMUNE DEFICIENCY
NASAL CONGESTION HIV POSITIVE

VARICOSE VEINS
VEIN STRIPPING BLOOD CLOT SWELLING
ITCHING/BURNING LEG HEAVINESS ULCER
INJECTIONS PHLEBITIS

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AUTHORIZATION AND ASSIGNMENT

Dear Patient:

Insurance is not a substitute for payment. Some companies pay a fixed allowance for certain procedures while others pay a percentage of the charge. It is your responsibility to pay any deductible, co-pay uncovered services or any balance not paid by your insurance.

Patient Name: _____
Print Name

I hereby assign all medical and / or surgical benefits to which I am entitled, including Medicare, Private Insurance and other Health Plans to:

IZZO & ALKIRE, MD P.A.

This assignment will remain in effect until revoked by me in writing. I also, hereby authorize said assignee to release all necessary information to secure payment. A photo static copy of this Authorization and Assignment may be accepted.

If this account is assigned to an Attorney and / or agency for collection, the prevailing party shall be entitled to reasonable fees and costs of collection.

Responsible Party's

Signature: _____ Date: _____

PATIENT'S MEDICARE AUTHORIZATION (ONLY)

Patient's Medicare Number: _____
I request that payment of authorized Medicare benefits be made either to me or on my behalf to:
IZZO & ALKIRE, M.D.S P.A

For any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim, If "other health insurance" is indicated in the item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Responsible Party's

Signature: _____ Date: _____

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____
(Patient's name)

D.O.B._____ LAST FOUR OF SS#_____

GIVE: _____

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION REGARDING MY MEDICAL STATUS TO:

_____
(Name)

_____
(Address) (Phone) (Fax)

THE FOLLOWING TYPES OF INFORMATION ARE SPECIALLY AUTHORIZED FOR RELEASE:

_____

_____

_____

_____

EXPIRATION DATE OF THIS AUTHORIZATION: _____/_____/_____

_____ _____
(Patient's signature) (Date)

_____ _____
(Witness signature) (Date)

Our Notice of Privacy Practices provided information about our use of a patient's protected health information (PHI). The Notice contains a Patient Rights section describing your rights under the law. Patients have the right to access, inspect, and copy protected health care information used to make decisions about them.

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