GRANDVIEW SURGICAL ASSOCIATES, PC
VEINCARE OF ARIZONA
MITCHELL J. GIANGOBBE, M.D., F.A.C.S.
13629 WEST CAMINO DEL SOL
SUITE 180
SUN CITY WEST, AZ 85375
PHONE (623) 584-7874 • FAX (623) 584-8137

Dear ________________________:

You have been scheduled for an appointment with Dr. Giangobbe by either yourself or your doctor's office. Your appointment is scheduled for ________________________________ at ______________________.

Enclosed is the paperwork that will be needed by Dr. Giangobbe at the time of your appointment. Please complete the enclosed paperwork and bring it with you along with your insurance card (s) and a photo ID to your scheduled appointment. **Please check in 20 minutes before your appointment. Failure to do this will cause your appointment to be rescheduled.**

PLEASE BE SURE TO BRING YOUR INSURANCE CARDS AS WELL AS ANY REPORTS REQUESTED BY OUR OFFICE WITH YOU TO YOUR APPOINTMENT. IF YOU COME TO YOUR APPOINTMENT WITHOUT THIS INFORMATION, YOU MAY BE REQUIRED TO EITHER PAY CASH AT THE TIME OF YOUR VISIT OR YOUR VISIT MAY BE RESCHEDULED. PLEASE CALL OUR OFFICE IF YOU HAVE QUESTIONS ON THIS MATTER.

We look forward to having you as a patient in our practice. Thank you.

Sincerely,

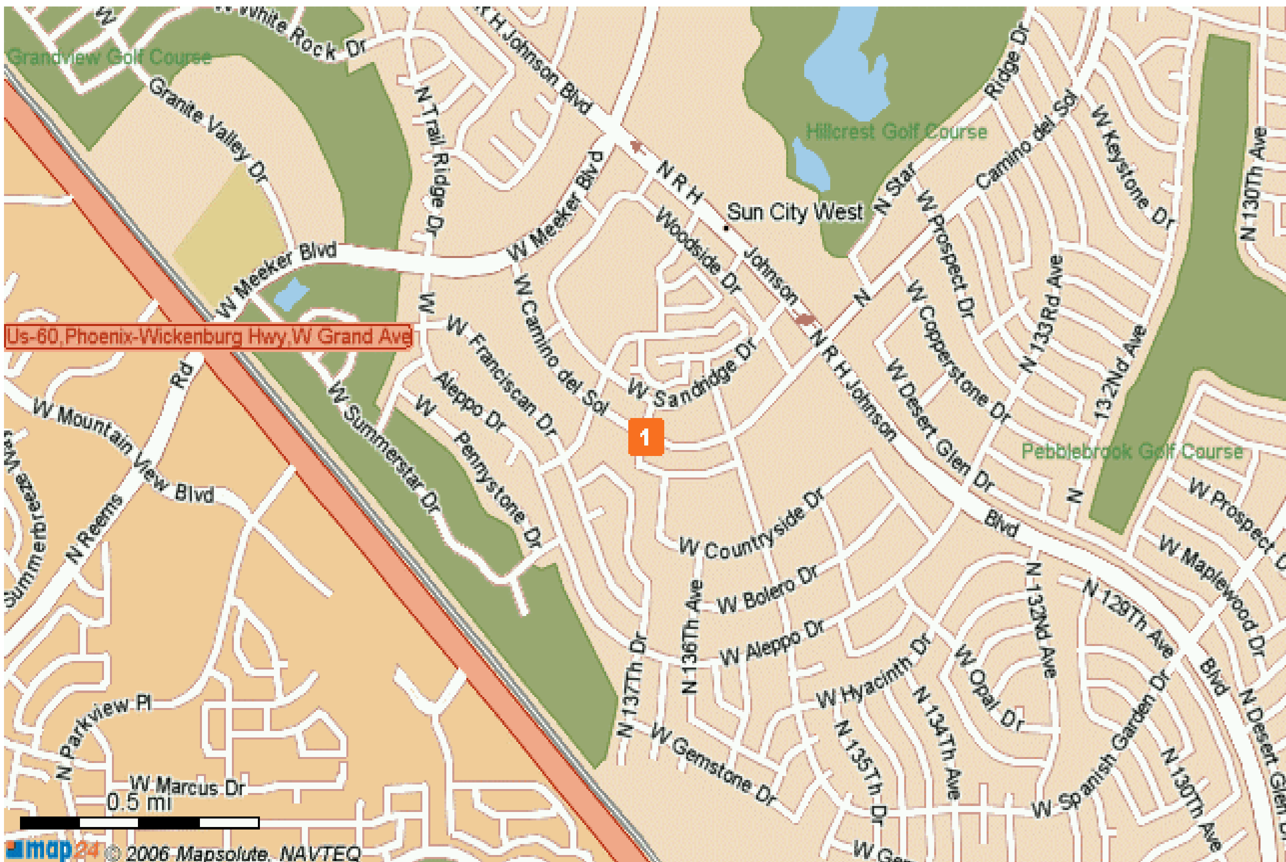
Office of Mitchell J. Giangobbe, M.D.
Grandview Surgical Associates
Veincare of Arizona

GRANDVIEW SURGICAL ASSOCIATES, PC

OUR OFFICE BUILDING

GRANDVIEW SURGICAL ASSOCIATES
13629 W Camino del Sol
Suite 180
Sun City West, AZ 85375
(623) 584-7874 phone
(623) 584-8137

OFFICE OF MITCHELL J GIANGOBBE, MD



GRANDVIEW SURGICAL ASSOCIATES, PC
VEINCARE OF ARIZONA
Patient Record of Disclosures

In general, the HIPAA privacy rule allows individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also allowed to request confidential communications or that a communication of PHI be made by alternate means, such as directing correspondence to their business address instead of the individual's home address.

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

[ ] Home Telephone ____________________________

[ ] Ok to leave message with detailed information

[ ] Leave message with call back number only

[ ] Ok to fax to this number: ______________________

[ ] Work Telephone ______________________________

[ ] Ok to leave message with detailed information

[ ] Written Communication

[ ] Ok to mail to my home address

[ ] Ok to mail to my work/office address

[ ] Cell/Mobile ____________________

[ ] Leave message with call back number only

I authorize Dr. Giangobbe or his staff to discuss my treatment or results with:

____ ____________________________
(Relationship to Patient)

____ ________________________________
Patient Signature Date

____ ________________________________
Patient's Printed Name Patient Date of Birth

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests the PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.
Healthcare entities must keep records of PHI disclosures. Information provided below will constitute an adequate record.

Record of Disclosures of Protected Health Information (PHI)

DATE	DISCLOSURE TO: ADDRESS OR FAX NUMBER	BY WHOM DISCLOSED

GRANDVIEW SURGICAL ASSOCIATES, PC

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Grandview Surgical Associates, PC's Notice of Privacy Practices effective 08/01/2016

Name (please print): ____

Signature: ____

Date: ____

I am a parent or legal guardian of ______________________ (patient name). I have received a copy of Grandview Surgical Associates, PC's Notice of Privacy Practices effective 08/01/2016.

Name (please print): ____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: ____

Date: ____

<u>If</u> the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective 08/01/2016 given to individual on _______________ (date)

☐ In Person ☐ Mailing ☐ Email ☐ Other ______________________

Reason individual or parent/legal guardian did not sign this form:

☐ Did not want to
☐ Did not respond after more than one attempt
☐ Other ______________________________________

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

☐ In person conversation ____
☐ Telephone contact ____
☐ Mailing ____
☐ Email ____
☐ Other ____

Staff Name (please print): ______________________________ Title: _______________

Signature: ______________________________ Date: ______________________

GRANDVIEW SURGICAL ASSOCIATES, P.C.   VEINCARE OF ARIZONA

PATIENT INFORMATION

NAME: (First, MI, Last):____

ADDRESS:____

MAILING ADDRESS:____
(if different from above)
CITY,STATE,ZIP:____

SOCIAL SECURITY#:______________________ BIRTH DATE:________________________

HOME PHONE:_____________________ MSSG OR CELL PHONE:____________________

E-Mail Address_______________________________________

MARITAL STATUS:
( ) Married ( ) Single ( ) Widowed ( ) Divorced ( ) Legally Separated ( ) Other
Spouse information is necessary only if your coverage is under your spouse's plan. If not, proceed to the employment status line.

SPOUSE'S NAME: ____________________________________ ________________

SPOUSE'S EMPLOYER:____

SPOUSE'S SSN_____________________________ SPOUSE DOB:_____________________

YOUR EMPLOYMENT STATUS:
( ) Fulltime ( ) Part Time ( ) Retired ( ) Student ( ) Unemployed ( ) Disabled

YOUR EMPLOYER'S NAME:____

YOUR EMPLOYER'S ADDRESS:____

YOUR EMPLOYER'S PHONE:_____________________________________

PRIMARY CARE MD NAME (PCP):____

PCP PHONE:____________________________________

YOUR EMERGENCY CONTACT
PERSON_____________________________________PHONE:___________________________

ASSIGNMENT AND RELEASE:
I understand that you will bill my insurance as a courtesy and I am responsible for any remaining unpaid charges. I hereby assign my insurance benefits to be paid directly to my physician. I understand that I am responsible for knowing what the insurance will and will not pay for. This office assumes no responsibility for lack of knowledge regarding insurance benefits. I also authorize my physician to release any information required for processing of any resulting insurance claim. I further understand that in the event my account is turned over to collections that I will be responsible for any additional collections charges.

PATIENT SIGNATURE_____________________________________DATE: ________________

FINANCIAL POLICY

We at Grandview Surgical Associates are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care. The following is a summary of our payment policy. Please review and sign this policy prior to your appointment.

As medical providers, **our relationship is with you, not your insurance company.** We will bill participating insurance companies as a courtesy to you. To do so, we will require detailed information and a copy of your insurance card(s) to be able to provide this service. Many insurance carriers require referrals and/or authorizations for medical services. A copy of your card at each visit will ensure that these necessary approvals are obtained. If we are unable to obtain the appropriate referral/authorization, your appointment will be rescheduled and/or cancelled. **Obtaining authorization is not a guarantee of payment by your insurance. You are responsible for knowing what your carrier does or does not pay; this includes deductibles, co-payments and co-insurance**. Please contact your carrier with any questions. It is also your responsibility to notify our office of any changes to your insurance coverage.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

1. **Medicare** – We accept Medicare assignment. As a Medicare patient, you are responsible for your deductible and the difference between what Medicare allows and pays (co-insurance). If you have a supplemental/secondary policy, we will file that claim as a courtesy for you.

2. **Medicare HMO/PPO, and all Commercial HMO/PPO Carriers** – All co payments must be paid at the time of service. This is part of your contract with your insurance company and cannot be waived. Deductibles, co-insurance, and any non-covered amounts will be billed to you.

3. **Self pay** – Payment must be made on the date of service unless other arrangements have been made in advance.

Missed Appointments/Procedures – Unless cancelled at least 24 hours in advance, our policy is to charge $ 50.00 for missed appointments; unless cancelled at least 72 hours in advance, our policy is to charge $100 for missed procedures. Just as we make every effort to accommodate your schedule, we expect you will make every effort to notify us if you are unable to keep your appointment.

Medical Records - Please allow 7-10 days for all medical record requests. Initial copy of your record is free of charge, but subsequent requests from you or another party you authorize is $30.00.

Statements are sent monthly and payment is due in 30 days. Please call our office if you have any questions about this policy. We strive to remain flexible and encourage you to call the office if you are experiencing a financial hardship. If your account becomes delinquent and you have not established or met payment options with our billing office, your account may be pursued by an outside agency. Please help us succeed in giving you the best care possible by keeping your account current.

I have read the financial policy and agree to its terms.

________________________________ ____________________

Patient Signature Date Signed

GRANDVIEW SURGICAL ASSOCIATES, PC
VEINCARE OF ARIZONA

DATE___________________________

NAME_____________________________________ AGE_________ BIRTH DATE_______________________

PHONE_____________________________________PLACE OF BIRTH_________________________________

OCCUPATION ____________________________ How Long? ________
(before retirement)

What is the reason for today's visit, and how long has the problem been going on?

____

____

____

Please Circle Any Illnesses That **You** Have had:

High Blood Pressure	Asthma/COPD	DVT/Phlebitis	Jaundice
Heart Trouble	Thyroid Problems	Cancer	Rheumatic Fever
Stroke/TIA	High Cholesterol	Glaucoma	
Diabetes	Kidney Disease	Hepatitis	

Please List All Previous Hospitalizations and Surgeries:

_____________________________________ ____

_____________________________________ ____

_____________________________________ ____

_____________________________________ ____

_____________________________________ ____

_____________________________________ ____

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Allergies to medications **and r**eaction:

____
____
____

Are you allergic to latex or band-aids? Y or N

Do you use tobacco now? ___________ In the past? ______________When did you quit?______________
Type and amount? ____
Do you drink alcoholic beverages? __________ In the past? _______________ Type_______________
Weekly amount_________________________________ How Long? __________________________________

Medication/Vitamins/Health Supplements

_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________
_______________________________ _______________________________

Have you ever had any wound healing problems? Y N
Have you or your family members had any problems with anesthesia? Y N
Have you ever been on long-term steroids in the past? (greater than 1 mo) Y N
Is there a possibility that you are or may become pregnant? Y N

Family History

Are there any medical conditions that run in your immediate family (such as Diabetes, Heart Disease, Cancer, etc).

____
____
____
____

REVIEW OF SYSTEMS

Are you having problems related to the following systems? Circle YES or NO. Please explain any yes answer in space provided.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Unexplained Weight Loss	Y	N
Night Sweats	Y	N

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Other________________________	Y	N

Allergic/Immunologic

Hay Fever	Y	N
Other______________________	Y	N

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Headache	Y	N
Numbness/Tingling	Y	N

Endocrine

Excessive Thirst	Y	N
Too Hot/Cold	Y	N
Tired/Sluggish	Y	N
Other______________________	Y	N

Gastrointestinal

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/Heartburn	Y	N
Other______________________	Y	N

Cardiovascular

Chest Pain	Y	N
Varicose Veins	Y	N
High Blood Pressure	Y	N

Integumentary

Skin Rash	Y	N
Boils	Y	N
Persistent Itch	Y	N
Other_______________________	Y	N

Musculoskeletal

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N
Other________________________	Y	N

Ear/Nose/Throat/Mouth

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N
Other________________________	Y	N

Genitourinary

Urine Retention	Y	N
Painful Urination	Y	N
Urinary Frequency	Y	N
Other________________________	Y	N

Respiratory

Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N
Other________________________	Y	N

Psychological

Have you ever been treated for a behavioral health issue?	Y	N

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What symptoms are you experiencing in your legs?

____

____

How long have you had these symptoms?

____

Are your symptoms interfering with your daily activities? Y N

If yes, please explain how you are affected. (inability to work,exercise,stand for long periods, etc).

____

____

____

What actions have you taken to alleviate your symptoms?

Leg elevation Y N

Over the counter pain medication (indicate name/frequency)

____

Compression stockings----daily-------occasionally----------never

Weight loss/ Dieting Y N

Exercise Y N

Other---please describe:

____

____