

SAMUEL BUNDZ, M.D., P.A.
Interlaken Plaza
8112 Centralia Court Suite 101 Leesburg, FL 34788
Phone (352) 787-9111 FAX (352) 787-9331

Welcome to Our Office

Patient Name

We look forward to meeting you at your appointment

on _____ at _____.

In order to better serve you and keep your wait time to a minimum, please have the following items available upon arrival:

- enclosed Medical History form, filled out front and back ***in black ink.***
- Please do not write in the **FOR DOCTORS USE ONLY BOXED AREAS.**
- a list of current medications, including over-the-counter medications
 - current insurance cards and drivers license or photo ID. If address on ID does not show the patient's current address then bring a utility bill or other correspondence showing patient's current address
 - enclosed Financial Policy signed and dated

As a courtesy to our office, if you are unable to keep your appointment, please phone to inform the staff. If after hours our service will take your call and fax us the message.

In July 2008 we moved to our new office located at 8112 Centralia Ct. Ste. 101 Interlaken Plaza Leesburg, FL 34788 Centralia Court is off Professional Dr which runs between Hwy 441 and CR 44 Leg A.

From Eustis, Mount Dora,

Tavares area

Take US 441/N. Turn right onto Professional Dr. make a right onto Centralia Ct. We are in the 1st building on the right.

From The Villages, Lady Lake,

Fruitland Park, Leesburg area

Take US 441/S to CR 44 Leg A make a u-turn going back US 441/N make a right onto Professional Dr. then right onto Centralia Ct. we are in the 1st building on the right. Instead of making a u-turn, you can make a left onto CR 44 Leg A go to Professional Dr. make a left stay straight to Centralia Ct. make a left we are in the 1st building on the right.



We invite you to visit our website: samuelbundzmd.com

Date Hist Sent _____

PATIENT INFORMATION Appt Date _____

Name _____ Marital Status S M D W
Last First MI
Address _____
City _____ State _____ Zip _____ Home Phone _____
Birth date _____ Age _____ Sex: M F Cell Phone _____
Soc Sec # _____ Work Phone _____
Employed By _____ Occupation _____
Emergency Contact _____ Phone _____ Relationship _____
Referred By _____ Primary Care Physician _____

PRIMARY INSURANCE Insurance Co _____ Phone _____
Claims Address _____
City _____ State _____ Zip _____
Subscriber ID/Contract # _____ Group # _____
Subscriber (if other than patient) _____ Subscriber's DOB _____

In Netwk _____ Out of Network _____ Spec. Office Visit Co-Pay _____ Verified By _____ Date _____
Ded Amt _____ Amt Ded Met _____ Ded Remaining _____ Pays at _____ % after deductible is met.
Is Deductible Calendar Year _____ or Policy Year _____ Does deductible apply to OV _____ Office Procedures _____
Pre-Cert Req'd Outpatient Y N Inpatient Y N Spoke With _____
Confirmation Number _____ PRE-CERT Phone _____

SECONDARY INSURANCE Insurance Co _____ Phone _____
Claims Address _____
City _____ State _____ Zip _____
Subscriber ID/Contract # _____ Group # _____
Subscriber (if other than patient) _____ Subscriber's DOB _____

In Netwk _____ Out of Network _____ Spec. Office Visit Co-Pay _____ Verified By _____ Date _____
Ded Amt _____ Amt Ded Met _____ Ded Remaining _____ Pays at _____ % after deductible is met.
If Secondary to Medicare: Pays Medicare Ded Y N Pays Medicare Co-Ins Y N
Pre-Cert Req'd Outpatient Y N Inpatient Y N Spoke With _____
Confirmation number _____ PRE-CERT Phone _____

ASSIGNMENT AND RELEASE OF INFORMATION

I, the undersigned, certify that I (or my dependent) have insurance coverage as stated above, and assign directly to **Dr. Samuel Bundz** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for copays and deductibles if Dr. Bundz is a participating provider with my insurance company. If Dr. Bundz is NOT a participating provider with my insurance company, I understand that I am financially responsible for all charges whether or not paid by insurance. If my insurance denies payment, I am personally and fully responsible for payment. I hereby authorize the doctor to release all information necessary to secure the payment of benefits and to use this signature on all insurance submissions. I also authorize release of my medical records to physicians or facilities when pertinent to my care.

Patient or Guardian Signature Date

VEIN MEDICAL HISTORY

Date _____

Patient _____ Birthdate _____ Age _____

Please answer the following questions **in as much detail** as you can. This information will help the doctor plan your care. Please answer each question **completely**, answers should pertain **only** to your vein problem.

How long has your vein problem been present? _____

Make a check (✓) by each of the following that describes your present or past symptoms:

____ sharp ____ dull ____ ache ____ sting ____ cramps ____ night cramps ____ burning ____ swelling

Other symptoms, (please describe) _____

What makes the symptoms better: _____

What makes the symptoms worse: _____

Do you have or ever had swelling of the ankle or leg? ____ Yes ____ No

Do you now or have you ever worn vascular compression hose: ____ Yes How long? _____ No ____

Do you use any OTC (ie. Tylenol, Advil, Motrin) pain relievers? ____ Yes ____ No

Do you use any prescription pain relievers for vein symptoms? ____ Yes ____ No

Have you had any previous stripping or ligation of veins? ____ Yes ____ No ____ When? _____

Do you take antibiotics before dental or invasive procedures: ____ Yes ____ No

List **Current** Medications: _____

Drug Allergies: _____ Other Allergies (tape, latex, etc): _____

List Major Surgeries: _____

Check any conditions that you have had or are currently being treated for:

| | | | |
|----------------------------|-----------------------|---------------------------|-----------------------|
| ____ None | ____ DVT | ____ Heart Attack | ____ Angina |
| ____ Diverticulitis | ____ COPD | ____ High Blood Pressure | ____ Stroke |
| ____ Crohn's Disease | ____ TIA's | ____ Low Blood Pressure | ____ Asthma |
| ____ Cancer | ____ Blood Clots | ____ Ulcerative Colitis | ____ Hepatitis |
| ____ Depression | ____ Tuberculosis | ____ Bleeding Disorder | ____ Cirrhosis |
| ____ Seizures | ____ Heart Murmur | ____ Type I Diabetes | ____ Type II Diabetes |
| ____ Mitral Valve Prolapse | ____ Stomach Problems | ____ Venous Stasis Ulcers | |

Other Conditions _____

SOCIAL HISTORY

____ Reg ____ Decaf Coffee ____ Cups per day ____ Reg ____ Decaf Soft Drinks ____ Cans per day

Alcohol _____ Amt _____

Smoke _____ packs per day for ____ years. Quit _____ years ago.

Hobbies/Interests/Recreational activities: _____

FAMILY HISTORY

Include any history of vein disease please.

Father: _____ Mother: _____

Brothers: _____

Sisters: _____

PHARMACY

Pharmacy _____

Address _____

Phone Number _____

Notice of Privacy Practices

Patient Acknowledgment

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. A copy is located in the waiting area, or a personal copy may be obtained from our office staff. By signing this form, you acknowledge the opportunity to read and/or receive a copy of the Notice of Privacy Practices of Samuel Bundz, M.D., P.A.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by calling our office at 352-787-9111 or by making the request in person at our office, 8112 Centralia Court Ste 101, Leesburg, Florida 34788. If you have any questions about the Notice of Privacy Practices, please contact our office at 352-787-9111.

Please list any family members or significant others, that we may inform of your medical condition (including treatment, payment, and health care information) with:

Name: _____ Relationship _____

Phone: _____

Name: _____ Relationship: _____

Phone _____

Name: _____ Relationship: _____

Phone: _____



Signature of Patient/Parent/Guardian

Date

FOR OFFICE USE ONLY

INABILITY TO OBTAIN ACKNOWLEDGMENT

I was unable to obtain the patient's signature.

Reason _____

Signature

Date

Samuel Bundz, MD, PA
General, Vascular, and Thoracic Surgery
Advanced Laparoscopic Surgery
And
Laser Vein Treatment

Financial Policy

Thank you for choosing our office for your surgical healthcare needs. We are committed to giving you quality healthcare while minimizing administrative costs. This Financial Policy has been established with these goals, and to avoid any misunderstanding or disagreement concerning payment for professional services.

- **Medicare** We accept Medicare assignment. We have agreed in contract to accept the fees and to bill according to Medicare's allowed amount. All Medicare patients are responsible for their annual deductible and 20% coinsurance at the time of service. If you have a Medicare Supplement that covers the deductible and coinsurance we will accept payment from that insurance carrier. All other Medicare Supplements will be filed as a courtesy to you; however you will be responsible for any deductibles, coinsurance, copayments or any portion of the charges as specified by the plan at the time of service. Any medical service not covered by your insurance plan is the patient's responsibility and payment is due in full at the time of service.
- **Other Insurance** We are happy to file your insurance claim as a courtesy. Our office participates with many insurance carriers. Members of these plans are responsible for copayments, deductibles, coinsurance and noncovered items at the time of your visit. If we are not a participating provider for your insurance and you have out of network benefits, we will gladly file your claim. You will be responsible for any deductible, copayment, coinsurance or non covered service at the time of your visit. Be aware that your portion could be higher than if you were using a network provider. We have no control over this it is determined by your carrier.
- Our staff makes every effort to verify your insurance coverage before services are provided. Please be advised that your insurance carrier has a disclaimer that verification of coverage is not a guarantee of payment. Any medical services not covered by your plan are the patient's responsibility and payment is due in full at the time of your visit.
- **Payments can be made by cash, check, Visa, MasterCard, Discover, American Express or a Debit Card with Visa or MasterCard logo.**
- Patients that are uninsured are required to pay for professional services at the time of service.
- It is the patient's responsibility to provide our office with current information. Please advise us of any changes in carriers and bring your insurance cards to each visit.
- Remember your insurance is a contract between you and your insurance carrier. Ultimately it is your responsibility to know and understand your policy coverage. If you have specific questions concerning your benefits or coverage contact your Member Services (number is on your card). Our staff is happy to help with questions concerning how a claim was filed, or regarding additional information needed to process a claim.

Please sign that you have read and understand this Financial Policy. Please return this signed document at your visit.

Patient's Printed Name

Signature of Patient or Responsible Party

Date