



2169 SE Ocean Blvd Stuart FL 34996 (Tel) 772-286-5501 (fax) 772-781-7767

S Scott Tapper M.D., FACS

Please present your insurance card & photo ID at check in

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_

DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_ Social Security# \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home # \_\_\_\_\_ Cell# \_\_\_\_\_ Work# \_\_\_\_\_

E-mail Address \_\_\_\_\_

Patient's Employer \_\_\_\_\_

Address \_\_\_\_\_ Phone# \_\_\_\_\_

IN CASE OF EMERGENCY NOTIFY

RELATIONSHIP \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

How were you referred to our office?

- Physician Dr. Family/Friend
Newspaper other Yellow Pages Insurance Directory Mailer Postcard

I HEREBY ASSIGN PAYMENT DIRECTLY TO SYMMETRY LASER VEIN CENTER FOR THE AMOUNT DUE FOR MEDICAL/ SURGICAL EXPENSES INCURRED AND PAYABLE UNDER TERMS OF MY BASIC INSURANCE AS WELL AS MAJOR MEDICAL BENEFITS. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS ASSIGNMENT. PHOTOCOPIES OF THIS FORM WILL BE VALID. I AUTHORIZE ANY PHYSICIAN, HOSPITAL, OR CLINIC TO PROVIDE FULL DETAILS OF MY MEDICAL HISTORY AND TREATMENT TO SYMMETRY LASER VEIN CENTER

Dear Patients:

Under Florida law, physicians are generally required to carry malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law. Florida Statutes Section 458.320 (5) (6) (4).

Sincerely, S.Scott Tapper, M.D. FACS

I \_\_\_\_\_ have read and understand this notice provided with respect to malpractice insurance. I herby consent to treatment by S. Scott Tapper M.D., FACS who has informed me of his lack of medical malpractice coverage. I have chosen Dr. Tapper (initials) \_\_\_\_\_ and his staff to provide care regarding my veins.

Effective: January 01 2002 Revised: July 01, 2006

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Symmetry Laser Vein Center

## Medical and Venous History

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Primary Physician \_\_\_\_\_

**How were you referred to our office?**

- Primary Physician     OB/GYN     Other Physician (Specify) \_\_\_\_\_  
 Newspaper     Magazine     Mailbox Mailer  
 Other \_\_\_\_\_

**Reason for Today's Visit:**

- Spider Veins     Varicose Veins     Medical     Cosmetic

**Please check symptoms that you have or have had in the past:**

- Ache     Burning     Heaviness     Throbbing     Itching/Tingling  
 Swelling/Edema     Pain     Inflammation     Phlebitis     Dermatitis (rash)  
 Ulceration     Bleeding     Fatigue     Restless Legs     DVT  
 Night Cramps     Unsightly Appearance

**Do these symptoms impair your mobility and/or cause inability to perform daily activities?**

- YES     NO

Have you ever worked or currently work on your feet?  YES  NO What is your Profession: \_\_\_\_\_

How long have your veins been a concern to you?  Months \_\_\_\_\_  Years \_\_\_\_\_

Did your veins develop during pregnancy?     YES     NO     N/A

**What have you tried in order to make your legs feel better?**

- Compression Hose (worn for \_\_\_\_\_ weeks/months/years)  
 Elevate Legs     Soak Legs     Pain Relievers     Nothing

**Have you been previously treated by:**

- Ligation Surgery     Vein Stripping     Sclerotherapy (Injections)     Laser Therapy

Family History:     Varicose Veins     Spider Vein     Leg Ulcers

**Please check any health issues that you have or have had:**

- High Blood Pressure     Heart Disease     Heart Attack     Diabetes  
 High Cholesterol     Heart Murmur     Asthma/Emphysema     Bleeding Disorder  
 Superficial Blood Clots     Stroke     Hepatitis     HIV  
 Deep Blood Clots     Migraine Headaches     Cancer     Other \_\_\_\_\_

**Please list any surgeries that you have had:**

\_\_\_\_\_

**Please list medications including vitamins/herbal supplements:**

\_\_\_\_\_

**Please list allergies:**

\_\_\_\_\_

Do you currently smoke?     YES     NO    If yes, How Much per day \_\_\_\_\_    Age you started \_\_\_\_\_  
How often do you consume alcohol?     Never     Occasionally     Frequently

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Symmetry Laser Vein Center**  
2169 SE Ocean Boulevard  
Stuart, FL 34996  
Phone 772-286-5501  
Fax 772-781-7767

*Notice of Privacy Practices, Payment, and Healthcare Operations*

*Signature Required*

I consent to the use or disclosure of my protected health information by **Symmetry Laser Vein Center** for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of **Symmetry Laser Vein Center**. I understand that diagnosis or treatment of me by Dr. \_\_\_\_\_ or any other physician of **Symmetry Laser Vein Center** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Symmetry Laser Vein Center** is not required to agree to the restrictions that I may request. \*Reverse side\*

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. \_\_\_\_\_, or any other physician of **Symmetry Laser Vein Center** has taken action in reliance on this consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health care information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review **Symmetry Laser Vein Center's** Notice of Privacy Practices prior to signing this document. The **Symmetry Laser Vein Center's** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **Symmetry Laser Vein Center**. The Notice of Privacy Practices for **Symmetry Laser Vein Center** is also provided in the patient waiting room. This Notice of Privacy Practices also describes my rights and **Symmetry Laser Vein Center's** duties with respect to my protected health information.

**Symmetry Laser Vein Center** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practice by calling and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

*Please initial where applicable*

\_\_\_\_\_ I may request a copy or read a displayed copy of the **Notice of Privacy Practices for Symmetry Laser Vein Center**.

\_\_\_\_\_ **Symmetry Laser Vein Center** may leave messages on my answering machine to confirm appointments.

\_\_\_\_\_ **Symmetry Laser Vein Center** may speak to family members in my house and leave me a message with them regarding my healthcare or billing arrangements.

\_\_\_\_\_ **Symmetry Laser Vein Center** may call me at my place of employment to confirm an appointment.

\_\_\_\_\_ **Symmetry Laser Vein Center** may leave minimal medical data on my answering machine regarding medications, treatments, and or test results.

\_\_\_\_\_ **I authorize payment of medical benefits to be paid directly to Symmetry Laser Vein Center for services provided to me. I understand that I am responsible for all charges regardless of insurance status as well as any associated cost for collection. I agree that this authorization shall be valid until rescinded in writing.**

I authorize **Symmetry Laser Vein Center** to be my personal representative, which allows **Symmetry Laser Vein Center** to:  
(1) Submit any and all appeals when my insurance company denies my benefits to which I am entitled. (2) Submit any and all requests for benefit information from my insurance company, and (3) Initiate formal complaints to any state or federal agency that has jurisdiction over my benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100% of my benefits within 90 days of any appeals or request for information. I also agree that any fines levied against my insurance company will be paid to **Symmetry Laser Vein Center** for acting as my personal representative.

\_\_\_\_\_  
**Signature of Patient or Personal Representative**

\_\_\_\_\_  
**Printed Name of Patient or Personal Representative**

**DATE:** \_\_\_\_\_