The Vu Center for Plastic and Hand Surgery, PC | Dr. Kim-Chi Vu
15390 NW Cornell Road Suite 225, Beaverton OR 97006 | P: 503-601-2910 | F: 503-601-2914 | www.thevucenter.com

PATIENT INFORMATION

Name________________________________ **MI**_____ **DOB**___________ **Age**_______

S.S #____________________ **Male**_____ **Female**______ **Single**_____ **Married**_______

Address______________________________ **City**_____________ **State**_____ **Zip**_________

Phone#_______________________________ **Cell #**_______________________________

Parent/Guardian if patient is a minor ____

Email ____

***Would you like to correspond by email and receive our e-newsletter (circle) YES / NO**

CARETAKER/EMERGENCY CONTACT INFORMATION

Name:____ **Relationship to Patient:** ______________________

Phone#: ____

Do you allow The Vu Center to disclose medical information regarding your care?** *(circle)* ***YES / NO

Insured's Employer__________________________________ Work#__________________

Date of Injury ___________ Motor Vehicle accident _______ Work Related _________

Primary Insured's Name _____________________________________ D.O.B. ___________

Insurance ___________________________________ Phone # ______________________

Address ____

I.D. # _________________ Policy/Group # _____________ Co-Pay $ ______ Deductable $ ______

Self _______ Spouse _______ Child _______ Coinsurance (circle) YES / NO

Secondary Insured's Name ___________________________________ D.O.B. ____________

Insurance _____________________________________ Phone # __________________

Address ____

I.D. # _________________________ Policy/Group # ___________________________

Workman's Compensation Insurance ______________________ Claim #__________________

Adjuster Name ______________________ Ph # ___________________ Fax # __________________

***** WE CANNOT PROCESS YOUR CLAIM W/O THIS INFORMATION! *****

Referred By ______________________________________ Phone ______________________

PCP ____ Phone ______________________

PLEASE READ AND SIGN BELOW: AUTHORIZATION FOR RELEASE OF INFORMATION:
I herby authorize The Vu Center for Plastic and Hand Surgery, PC to release any information requested by my insurance company, or to release information to any hospital or physician I may be referred to by this office. I also acknowledge that I have received a copy of the privacy practices.

ASSIGNMENT OF BENEFITS:
I authorize assignment of payment of medical benefits due me to The Vu Center for Plastic and Hand Surgery, P.C. for professional services she may render in the course of my treatment. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. **I HERBY AGREE TO PAY ALL CHARGES THAT EXCEED OR ARE NOT COVERED BY INSURANCE.**

Signature ____ **Date** ________________

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PATIENT HISTORY

Patient Name: ______________________________ **Date of Birth**:____________
Date of Visit:__________ **Describe Reason for Visit/Injury**: _____________________

ARE YOU ALLERGIC TO ANY MEDICATIONS, IF SO WHAT?

____

ARE YOU TAKING ANY MEDICATION? *PLEASE LIST MEDICATION NAMES AND DOSAGES*

1. _________________________ **3.** _________________________
2. _________________________ **4.** _________________________

CURRENT HEIGHT: _____________ **WEIGHT:** _________________

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS?

	Yes	No		Yes	No
Anxiety/depression	___	___	HIV/AIDS	___	___
Bleeding disorder/clots	___	___	Hypertension	___	___
Cancer	___	___	Kidney disease	___	___
Diabetes	___	___	Liver disease	___	___
GI bleeding	___	___	Lung disease/Asthma/COPD	___	___
Hepatitis	___	___	Seizures	___	___
Sleep apnea	___	___	Stroke	___	___
Heart disease/attack	___	___			

If you have any **heart conditions**, who is your cardiologist? ________________________
Any recent **EKG** performed? Date and location: ______________________________
Any other medical conditions? ______________________________________
If female: date of last menstrual period____________ Any possibility of pregnancy?_____

HAVE YOU HAD ANY SURGERY IN THE PAST? *PLEASE LIST SURGERY TYPE AND DATE*

1. _________________________ **3.** _________________________
2. _________________________ **4.** _________________________

ANY PROBLEMS WITH ANESTHESIA IN THE PAST? Yes or No
If yes, explain: ____

DO ANY OF YOUR FAMILY MEMBERS HAVE ANY OF THE FOLLOWING?

PLEASE INDICATE WHICH FAMILY MEMBER & IF MATERNAL OR PATERNAL RELATIVE

1. Bleeding disorder/clots____________ **4.** Heart disease___________________
2. Cancer_______________________ **5.** Hypertension___________________
3. Diabetes______________________ **6.** Kidney disease__________________
Any other medical conditions? ____

SOCIAL HISTORY

Smoke? How much?______________ Type of work you do:___________________
Alcohol? How much? ______________ Hobbies: __________________________
Recreational drug use? ____________ Married or single:_____________________
(marijuana, methamphetamines, etc.)

DO YOU HAVE ANY RECENT SYMPTOMS OF THE FOLLOWING?

1. Fever/chills	yes/no	8. Heartburn	yes/no
2. Rashes/sores	yes/no	9. GI bleeding	yes/no
3. Nasal congestion/sore throat	yes/no	10. Body/joint pain	yes/no
4. Chest pain	yes/no	11. Headache	yes/no
5. Cough/shortness of breath	yes/no	12. Dizziness/fainting	yes/no
6. Swollen lymph nodes	yes/no	13. Anxiety/depression	yes/no
7. Nausea/vomiting	yes/no		

MUTUAL AGREEMENT TO MAINTAIN PRIVACY

Kim-Chi Vu, MD, PC agree to maintain Privacy of ________________________(patient name) as outlined in the HIPAA form. The Physician takes pride in being able to extend a greater degree of privacy than is required by HIPAA, state confidentiality mandates, and common law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, HIPAA forbids physicians from receiving money for selling lists of patients or protected health information to companies to market their products or services directly to patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Physician believes this is improper and may not be in the patients' best interest. Accordingly, Physician agrees not to provide any list for marketing or be paid for selling patient lists or protected health information to any party for the purpose of marketing directly to patients. Regardless of legal privacy loopholes, Physician will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

In consideration for treatment and the above noted patient protection, Patient agrees to refrain from directly or indirectly publishing or airing commentary upon Physician and his practice, expertise and/or treatment unless explicitly mandated by law. Publishing is intended to include attribution by name, by pseudonym, or anonymously. Physician has invested significant financial and marketing resources in developing the practice. In addition, Patient will not denigrate, defame, disparage, or cast aspersions upon the Physician; and (ii) will use all reasonable efforts to prevent any member of their immediate family or acquaintance from engaging in any such activity. Published comments on web pages, blogs, and/or mass correspondence, however well intended, could severely damage Physician's practice.

Physician feels strongly about Patients' privacy as well as the practices' right to control its public image and privacy. Both Physician and Patient will work to prevent the publishing or airing of commentary about the other party from being accessed via Internet, blogs, or other electronic, print, or broadcast media without prior written consent. Finally, this Agreement shall be in force and enforceable for a period of five years from Physician's last date of service to Patient. As a matter of office policy, Physician is requiring all patients in its practice sign the Mutual Agreement to Maintain Privacy so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Physician's patients. Further, this Agreement will survive for a minimum of three years beyond any termination of the Physician-Patient relationship.

Patient and Physician acknowledge that breach of this Agreement may result in serious, irreparable harm. In addition to compensation for consequential damages, Patient and Physician agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

** SIGN ELECTRONICALLY AT THE TIME OF YOUR APPOINTMENT**

AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean ___________________(patient name)

"Physician" shall be understood to mean Kim-Chi Vu, MD.

I understand that I am entering into a contractual relationship with the physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against the Physician.

Should I, initiate or pursue a meritorious medical malpractice claim against Physician, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Medical Specialties in the same specialty as the Physician. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the American Society of Plastic Surgeons.

I agree the expert will be obligated to adhere to the guidelines or code of conduct defined by the American Society of Plastic Surgeons.

I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions.

In further consideration, Physician also agrees to exactly the same above-referenced stipulations.

Each party agrees that his/her counsel shall have the right and be free to depose the other party's expert witness(es) at least 120 days before any scheduled trial date.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or meritless claim.

Patient/guardian and physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.

Physician and patient/guardian agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.

Patient/guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

**** SIGN ELECTRONICALLY AT THE TIME OF YOUR APPOINTMENT****

PAYMENT POLICY

Your services have been provided for you by the staff of The Vu Center for Plastic and Hand Surgery, PC. Please note that we make every effort to assist you with your billing and submit your billing accordingly based on financial status relating to your injury. Following is our guidelines of how the billing is process and submitted.

1. WORKERS COMPENSATION/PERSONAL INJURY PROTECTION:

- If your date of services is related to workman's comp injury, we will submit the HCFA billing form as soon as we receive a claim number from your WC insurance. To expedite the process, we encourage you to remind you employer to submit the work injury incident report to your insurance carrier as soon as possible in order for them to issue you a claim number. Without a claim number we cannot submit your bill and may further delay the process.
- It is your responsibility to fill out the 827 form when you come to our office for your first visit. We need your employer's name, phone number, and insurance carrier.
- You are responsible for contacting your employer and informing them immediately of your injury.
- We are not responsible for contacting your insurance carrier. It is your responsibility as a patient to find out if your claim is or is not approved. If your claim is approved then you are not responsible for the bill unless otherwise said by your adjuster.
- You will not be financially responsible for any outstanding bill, as long as the workman's comp insurance accepted your claim. If your claim is denied, then you are financially responsible for the bill. We will then send you a billing statement.
- If your worker's compensation claim or personal injury claim is denied then you are responsible for providing your health insurance information if you do have coverage. In a situation where you don't have medical insurance you are responsible for all charges.
- *There will also be an additional $25.00 collection fee if account gets transferred into collection agency.*

2. INSURANCE PATIENTS/NON WORKERS COMP:

- Please note that we may not be a provider for your insurance.
  A. In an **EMERGENCY** basis: If you were seen in the emergency room or in the hospital and services were provided for you in an emergency basis, we will bill your insurance first, whether or not we are a provider for your insurance. We do not know what insurance status you have in an emergency situation. Dr. Vu was asked to see you for your emergency situation, and services were provided based on your injury.
  B. If we are not a provider for your insurance, then we will submit the billing to your insurance first, then any amount that is **NOT COVERED** by your insurance will be your financial responsibility. After we receive any payment from your insurance then you will receive a billing statement The Vu Center for Plastic and Hand Surgery, PC for the remainder of your billing.
- If you disagree with any of your billing, we will help you to resolve any matter possible. However, you should also be proactive and dispute with your insurance as well regarding your coverage.
- If we are a provider for your insurance, the claim will be submitted and you will be responsible for all **co-pays, co-insurance, or deductible that have not been met, in addition for any denied or uncovered procedures that is not paid by your insurance it will be your responsibility.**
- If you were referred to see us or wish to be seen in an elective basis and we are not a provider for your insurance, please note that we will submit the bill to your insurance but there is no guarantee that your bill will be covered, depending on what kind of insurance you have and whether or not you have an out of network provider coverage. You should always check with your insurance carrier regarding your benefits. Any portion not covered by your insurance will be billed to you and you will then receive a billing statement from us.
- If you have primary and / or secondary insurances, please provide us with all the appropriate information from your insurance card, so we can process your claim as smoothly as possible.
- If you do not pay the patient balance within 30 days after receiving the initial statement or been contacted about payments, your bill will be submitted to a collection agency or small claims court depending on the amount due.
- We do ask for the insurance co-pay at the time of your visit.
- If you need to cancel any future appointments please give us at least 24 hours notice.
- *There will also be an additional $25.00 collection fee if account gets transferred into collection agency.*

3. UNISURED/SELF PAY-PATIENTS:

- You are financially responsible for any services provided to you by Dr. Vu, whether it was performed in the hospital, emergency room or in the clinic.
- If you require a surgical procedure, you must pay half of the charge in advance (for example, if Dr. Vu's fee for a particular surgery is $1,200.00, you are expected to pay $600.00 before surgery is scheduled).
- You will be directly billed for all services provided. If you do not pay the patient balance within 30 days after receiving the initial statement or been contacted about payments, your bill will be submitted to a collection agency or small claims court, depending on the amount due.
- If you need to cancel any future appointments please give us at least 24 hours notice.
- *There will also be an additional $25.00 collection fee if account gets transferred into collection agency.*

4. ALL PATIENTS (INSURED/WORKMAN'S COMP/PERSONAL INJURY/SELF-PAY/NON INSURED)

- If we have not receive any payment from you within ONE MONTH of your FIRST STATEMENT, your account will be submitted to our accelerator and profit recovery agency who will attempt to call you and send you additional statements. If no payments have been made after 120 days, your account will be submitted to a **COLLECTIONS AGENCY**, small claims court, or referred to an attorney for collections. The undersigned or representative responsible for patient shall be responsible for paying any attorney's fees and collection expenses accrued during the process.
- We have a payment plan available to assist you with your billing. We try to make every effort to help ease some of your financial burden.
- If you have any change of address or change in phone numbers, you are responsible to notify us immediately, so we do not have any confusion with your billing to avoid sending to collections.
- **You are able to dispute the charges after the entire principal balance is paid in full, but it is on a case by case basis. Please speak to your billing representative for further questions.**

ALL OUTSTANDING BALANCE (ALL PATIENTS):

- You will be directly billed for all services provided. If you do not pay the patient balance within 30 days after receiving the initial statement, we will contact you to establish a payment plan.
- After 90 days, if we have not received payment form you or been contacted about payments, your bill will be submitted to a collection agency or small claims court, depending on the amount due.
- All outstanding balances will have a reoccurring administrative fee of $25.00 per month. You are able to dispute the charges after the entire principal balance is paid in full, but it is on a case by case basis. Please speak to your billing representative for further questions.
- *There will also be an additional $25.00 collection fee if account gets transferred into collection agency.*

I,________________________ **(patient name)** have read the above billing guidelines and acknowledge the financial responsibility as outlined above ***based on my medical coverage***, and will assume any financial responsibilities and consequences for services provided by the staff The Vu Center for Plastic and Hand Surgery., P.C.

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