United Vein CENTERS

Consent

By signing this consent form you are agreeing that your provider at United Vein Centers request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to United Vein Centers, to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____Print Name _____Patient DOB

_____Signature of Patient or Guardian _____Today's Date

_____Relationship to Patient

United Vein CENTERS

Thank you for choosing United Vein Centers. We are please to welcome you to our practice and look forward to providing you the most up to date technology in varicose vein treatment.

Patient Consent Form

Consent for Medical and Diagnostic Treatment: I wish to be evaluated by United Vein Centers. I hereby agree and give my consent to the providers and staff of United Vein Centers to provide diagnostic and medical treatment to me to appropriately diagnose my medical condition. I understand my insurance company will be billed for services rendered today. I will be responsible for any deductible, co-insurance and/or co-pays that may apply.

_____ _____

Patient/Responsible Party *Date*

Telephone: 813.961.1331 Fax: 813.961.6336

PATIENT INFORMATION *(Please Print)* Today's Date_____

Name_____
Last First M.I.

Mailing Address _____
City State Zip

Home Phone_____ Work/Cell Phone _____ SS #_____
Area Code Area Code

Date of Birth ____ / ____ /____ Age _____ Sex____ Marital Status: S M W D

Occupation:_____

E-mail Address _____

Primary Care Physician_____ Phone_____

Address_____

INSURANCE INFORMATION (Please complete if different than above.)

Primary Insurance Name_____ Secondary Insurance Name _____
Name of Insured _____ Name of Insured _____
Address of Insured _____ Address of Insured _____
Date of Birth of Insured _____ Date of Birth of Insured _____
Relationship to the insured _____ Relationship to the insured _____

RESPONSIBLE PARTY (If different from patient)

Name _____
Last First M.I.

Mailing Address _____
City State Zip

Home Phone_____ Work Phone _____ SS#_____
Area Code Area Code

Date of Birth ____ / ____ /____ Age _____ Sex____ Martial Status _____

Other family members that are patients _____

Pharmacy of Choice _____ Phone _____

In case of Emergency, who should be notified? _____ Phone _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services render on my behalf or my dependents.

Patient or Responsible Party Signature _____ Date ____ / ____ / ____

United Vein CENTERS

Physical/Health Information

Name: _____ **Date:** _____

How did you hear about us?

- ☐ **TV**
- ☐ **Radio**
- ☐ **Internet**
- ☐ **Family/Friend referral**
- ☐ **Event/Show, name of event/show:** _____
- ☐ **Physician Referral, name of physician:** _____

Please explain the reason for your Doctor visit: (painful varicose veins, swelling, ulcer, etc.)

_____
_____
_____
_____

Please check ALL symptoms and/or signs that apply:

- ☐ **Pain (check ALL that apply)**
  - o **Dull**
  - o **Sharp**
  - o **Aching**
  - o **Throbbing**
  - o **Shooting**
  - o **Burning**
- ☐ **Pain with standing**
- ☐ **Swelling**
- ☐ **Restless legs**
- ☐ **Soreness**
- ☐ **Heaviness**
- ☐ **Fatigue and/or tiredness**
- ☐ **Skin rash and/or discoloration**
- ☐ **Calf and/or foot cramps at night ("Charlie Horse")**
- ☐ **Varicose veins and/or spider veins**
- ☐ **Leg Ulcer ("an open sore")**
- ☐ **Inflammation**
- ☐ **Itching**
- ☐ **Dry, flaking skin**
- ☐ **Tenderness and/or warm to touch**
- ☐ **Bleeding varicose and/or spider veins**
- ☐ **Numbness and/or tingling in legs/feet**
- ☐ **Reddened and/or knot in vein(s)**

When did you first notice your problems? _____

Does anything make your symptoms worse? (standing for more than 30 min, sitting, traveling, etc.)

_____
_____
_____

Does anything help relieve your symptoms? **(rest with your legs up, ibuprofen, compression stockings, exercise, etc.)**

_____
_____
_____

Have you ever been treated for a vein problem? If 'yes" by whom and what type of treatment? **(injection sclerotherapy, surgery, etc.)**

_____
_____

Medications: **(include over the counter products like aspirin, vitamins, etc.)**

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies and allergic response to medication(s): ☐ **No Known Allergies**

_____ _____
_____ _____

Number of pregnancies: _____ | **Deliveries:** _____ | **Miscarriages:** _____

Past Medical History: **(check ALL that apply)**

- ☐ **Arthritis**
- ☐ **Diabetes**
- ☐ **High Blood Pressure**
- ☐ **High Cholesterol**
- ☐ **Hypothyroidism**
- ☐ **Cancer (type)** _____
- ☐ **Leukemia**
- ☐ **Psoriasis**
- ☐ **Angina**
- ☐ **Heart Attack**
- ☐ **Irregular Heart Beat**
- ☐ **Heart Disease**
- ☐ **Pneumonia**
- ☐ **Asthma**
- ☐ **Peripheral Arterial Disease (PAD)**
- ☐ **Emphysema/COPD**
- ☐ **Stroke**
- ☐ **Epilepsy (seizures)**
- ☐ **Kidney disease**
- ☐ **Migraines with Aura**
- ☐ **Anemia**
- ☐ **Hepatitis**
- ☐ **Heart Failure**
- ☐ **Stomach or Peptic Ulcer**
- ☐ **Tuberculosis**
- ☐ **HIV/AIDS**
- ☐ **Patent Foramen Ovale (PFO)**
- ☐ **Clotting disorder of blood**

Have you ever had a blood clot or pulmonary embolism? _____

Previous Surgeries:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History: (check ALL that apply)

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Stroke
- ☐ Blood Clots (DVT or Pulmonary Embolism)
- ☐ Blood clotting disorder
- ☐ Cancer (type) _____
- ☐ Peripheral Arterial Disease (PAD)
- ☐ Restless Leg Syndrome

Do you have a family history of vein disease? If "yes" select which family members:

- ☐ Father
- ☐ Mother
- ☐ Sister
- ☐ Brother
- ☐ Children
- ☐ Maternal Grandfather
- ☐ Maternal Grandmother
- ☐ Paternal Grandfather
- ☐ Paternal Grandmother
- ☐ Maternal Aunt
- ☐ Paternal Aunt
- ☐ Maternal Uncle
- ☐ Paternal Uncle

Social History:

Tobacco use:

- ☐ Nonsmoker
- ☐ Former smoker, quit? _____ (approximate date or months/years)
- ☐ Current smoker, how long? _____ Amount: _____packs/day

Alcohol use:

- Have you had a drink containing alcohol in the past year? Yes No
- If "yes" how often did you have a drink containing alcohol in the past year?
  - ☐ Monthly or less
  - ☐ 2 to 4 times/month
  - ☐ 2 to 3 times/week
  - ☐ 4 or more times /week
- How many drinks did you have on a typical day when you were drinking in the past year?
  - ☐ 1 or 2 drinks
  - ☐ 3 or 4 drinks
  - ☐ 5 or 6 drinks
  - ☐ 7 or 9 drinks
  - ☐ 10 or more drinks
- How often did you have 6 or more drinks on one occasion in the past year?
  - ☐ Never
  - ☐ Less than monthly
  - ☐ Monthly
  - ☐ Weekly
  - ☐ Daily or almost

Please list your *height*: _____ ft _____ in and *weight* _____ lbs.

Review of systems: (circle "Yes" or "No")

General		
Change in appetite	**Yes**	**No**
Chills	**Yes**	**No**
Fever	**Yes**	**No**
Eyes		
Blurred vision	**Yes**	**No**
Floaters in vision	**Yes**	**No**
Eye pain	**Yes**	**No**
ENT		
Sore throat	**Yes**	**No**
Swollen glands	**Yes**	**No**
Endocrine		
Cold intolerance	**Yes**	**No**
Excessive thirst	**Yes**	**No**
Heat intolerance	**Yes**	**No**
Respiratory		
Cough	**Yes**	**No**
Short of breath	**Yes**	**No**
Wheezing	**Yes**	**No**
Cardiovascular		
Chest pain at rest	**Yes**	**No**
Exertion chest pain	**Yes**	**No**
Irregular heartbeat	**Yes**	**No**

Gastrointestinal		
Abdominal pain	**Yes**	**No**
Diarrhea	**Yes**	**No**
Nausea	**Yes**	**No**
Genitourinary		
Blood in urine	**Yes**	**No**
Difficulty urinating	**Yes**	**No**
Musculoskeletal		
Painful joints	**Yes**	**No**
Swollen joints	**Yes**	**No**
Skin		
Rash	**Yes**	**No**
Sun sensitivity	**Yes**	**No**
Neurologic		
Balance difficulty	**Yes**	**No**
Difficulty speaking	**Yes**	**No**
Headache	**Yes**	**No**
Tingling/numbness	**Yes**	**No**
Psychiatric		
Anxiety	**Yes**	**No**
Depression	**Yes**	**No**

HIPAA PATIENT CONSENT FORM

I understand that I have certain Rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent, I authorize **United Vein Centers** to use and disclose my protected health information (PHI) to carry out the following:

- Treatment (including direct and indirect treatment by others healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of **United Vein Centers**

I have also been informed of, and given the right to review and secure a copy of the **United Vein Centers** Privacy Statement, which contain a more complete description of the uses and disclosures of my PHI and my rights under HIPPA. I understand that **United Vein Centers** reserves the right to change the terms of this notice at any time and that I may contact **united vein Centers** at any time to obtain the most current copy of this notice.

I understand that I may revoke this consent at any time. However, any use or disclosure that occurred prior to the revocation date is not affected.

_____ _____

Patient's Signature Date

PHONE CONSENT

I wish to be contacted in the following manner (check all that apply), be sure to fill in phone numbers.

- □ Home Telephone#: _____
  - □ Can leave a message with detailed information.
  - □ Leave a message with a call back number only
- □ Work Telephone #: _____
  - □ Can leave a message with detailed information.
  - □ Leave a message with a call back number only
- □ Written Communication
  - □ Okay to mail to my home address.
  - □ Okay to fax to this number(s): _____

Other Requests:

_____

_____

_____

Financial/Cancellation Policy

We would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office and notifying the office if you are unable to make your scheduled appointment.

FINANCIAL POLICY

Insurance Patients:
As a courtesy to you, we will file a claim with your primary and secondary plans. When each has paid their portion of the charge the remainder becomes your balance and is indicated on the statement you will receive from United Veins. While our billing professionals will do all they can to help you in communicating/negotiating with your insurance plan, we must remind you that you are responsible for all charges until they are fully paid.

At the time of visit, we will collect co-payments as well as charges for non-covered procedures prior to meeting with the physician.

If we do not have a contractual relationship with your insurance carrier, you have the option to continue care as a self-pay patient. (See self-pay patient policy below) Please understand that if we do not have a contract with your plan, we are not obligated to adjust our charges based on your plan's coverage or benefits.

Self-pay Patients:

We expect patients who have no insurance coverage to pay for all services prior to scheduling services. We will do our best to give you an estimate of the charges prior to your visit. If you have questions regarding financial matters, you may contact the billing department at 800-952-5954.

Medicare Patients:

We are Medicare participating providers. We will bill Medicare and Medigap carriers. You will be asked to sign an Advance Beneficiary Notice (ABN) form if a service is provided which we know is not covered by Medicare.

If you have Medicare as well as secondary coverage with a commercial plan that is not Medigap or is an insurance company with which we have no contract, we will file a claim to your secondary/supplemental carrier. If no payment is received from your secondary/supplemental carrier within 45 days after we file

a claim, you will be sent a bill and will be responsible for the balance.

Most insurance companies generally will not give a specific amount that they will pay until a claim is submitted, but we will obtain insurance benefits before the patient's initial visit. Upon request we will provide an estimate of what the patient responsibility will be. If you have any questions about this policy, please contact our patient responsibility department at 800-952-5954.

CANCELLATION POLICY

Late Patients:

Patients are required to be on time to their appointment. If possible, patients should arrive a few minutes early to check in and fill out any required paperwork. If a patient is more than 15 minutes late for an appointment, the appointment may be cancelled. It will be at the discretion of the provider and the office staff to determine if there will be enough time to see the patient without making other patients wait. A cancellation fee of $50.00 may be charged if your appointment must be cancelled.

Cancellation/ No Shows:

Prior to an appointment our office will attempt to contact you with a reminder call/text. These reminder efforts occur approximately 4 days prior to your appointment. If the patient is unable to make the appointment, they are required to give a 48-hour (2-day) notice. If this notice is not given in time, or not at all, then the patient will be charged the $50.00 cancellation fee.

(Note: Please be aware that charges for missed or cancelled appointments and procedures are not covered by insurance)

Your signature below signifies that you understand and agree to our financial policy, our cancellation policy, and your responsibility regarding charges incurred in this office.

_____ _____/_____/_____

Patient or Responsible Party Signature Date