



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: _____ Advance Directive: Yes ___ No ___ If "yes", provide details: _____

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 ____/____/____



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



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): _____

Please list all persons who you authorize to work with UVC regarding your care (i.e. schedule an appointment, make a payment, discuss follow up care, etc.):



Prescription History Consent Form

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 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 my questions have been answered to my satisfaction.

_____ **Print Name** _____ **Patient DOB**

_____ **Signature Patient/Guardian** _____ **Today's Date**

_____ **Relationship to Patient**



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:

- | | |
|---|---|
| <ul style="list-style-type: none"><input type="checkbox"/> Pain (check <u>ALL</u> that apply)<ul style="list-style-type: none"><input type="radio"/> Dull<input type="radio"/> Sharp<input type="radio"/> Aching<input type="radio"/> Throbbing<input type="radio"/> Shooting<input type="radio"/> Burning<input type="checkbox"/> Pain with standing<input type="checkbox"/> Swelling<input type="checkbox"/> Restless legs<input type="checkbox"/> Soreness<input type="checkbox"/> Heaviness<input type="checkbox"/> Fatigue and/or tiredness | <ul style="list-style-type: none"><input type="checkbox"/> Skin rash and/or discoloration<input type="checkbox"/> Calf and/or foot cramps at night (“Charlie Horse”)<input type="checkbox"/> Varicose veins and/or spider veins<input type="checkbox"/> Leg Ulcer (“an open sore”)<input type="checkbox"/> Inflammation<input type="checkbox"/> Itching<input type="checkbox"/> Dry, flaking skin<input type="checkbox"/> Tenderness and/or warm to touch<input type="checkbox"/> Bleeding varicose and/or spider veins<input type="checkbox"/> Numbness and/or tingling in legs/feet<input type="checkbox"/> 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)

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

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



Previous Surgeries:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History: (check ALL that apply)

- | | |
|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Blood Clots (DVT or Pulmonary Embolism) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood clotting disorder |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Cancer (type) _____ |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Peripheral Arterial Disease (PAD) |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Restless Leg Syndrome |

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

- | | | |
|-----------------------------------|---|---|
| <input type="checkbox"/> Father | <input type="checkbox"/> Maternal Grandfather | <input type="checkbox"/> Maternal Aunt |
| <input type="checkbox"/> Mother | <input type="checkbox"/> Maternal Grandmother | <input type="checkbox"/> Paternal Aunt |
| <input type="checkbox"/> Sister | <input type="checkbox"/> Paternal Grandfather | <input type="checkbox"/> Maternal Uncle |
| <input type="checkbox"/> Brother | <input type="checkbox"/> Paternal Grandmother | <input type="checkbox"/> Paternal Uncle |
| <input type="checkbox"/> Children | | |

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