PALM VEIN CENTER®
EXCELLENCE IN VEIN CARE

Patient Name: _____
Nickname: _____
Guardian: _____
Date of Birth: _____
Sex: _____
_____
Address: _____
City: _____
State: _____
Zip Code: _____
Country: _____
2nd Address: _____
_____
Marital Status: _____
Spouse (If appl) _____
Pharmacy: _____

Home Phone: _____
Work Phone: _____
Cell Phone: _____
Best Number: _____
License / ID# _____
Contact Email: _____
Emergency Contact: _____
Emergency Phone: _____
Social Security#: _____
Primary Care MD: _____
2nd Physician _____
Referring Physician: _____
_____
How did you hear _____
about us? _____
_____

HIPAA Choices:

Did you receive a copy of the HIPAA Notice? Yes ___ No ___
Allow Postal Mail? Yes___ No___
Allow eMail? Yes___ No___
Allow Calls to Cell? Yes___ No___

Allow Voice Msg? Yes___No___
Who may we leave a message with? _____
Allow SMS (text message?) Yes___ No___

Occupation: _____
Employer: _____
(Leave blank if inapplicable)

Employer Address: _____
City / State: _____
Zip Code: _____

Language: _____
Race: _____
Ethnicity: _____

Need Interpreter: Yes:_____ No:_____
_____
Seasonal Resident: Yes:_____ No:_____

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Primary Insurance Provider: (Please provide a copy of your card)

Insurer: _____
Plan Name: _____
Effective Date: _____
Policy Number: _____
Group Number: _____
Co Pay: _____
Subscriber
Employer: _____
Address: _____
City: _____
State: _____
Zip Code: _____
Country: _____

Subscriber: _____
(If self - do not complete the following lines)
Relationship: _____
Date of Birth: _____
Soc. Sec. # _____
Sex: _____
Subscriber Address: _____
City: _____
State: _____
Zip Code: _____
Country: _____
Subscriber Tele# _____

Secondary Insurance Provider: (Please provide a copy of your card)

Insurer: _____
Plan Name: _____
Effective Date: _____
Policy Number: _____
Group Number: _____
Co Pay: _____
Subscriber
Employer: _____
Address: _____
City: _____
State: _____
Zip Code: _____
Country: _____

Subscriber: _____
(If self - do not complete the following lines)
Relationship: _____
Date of Birth: _____
Soc. Sec. # _____
Sex: _____
Subscriber Address: _____
City: _____
State: _____
Zip Code: _____
Country: _____
Subscriber Tele# _____

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Past Surgeries:

___ Coronary Atrtery Bypass
___ Angioplasty / Stenting
___ Peripheral Vascular Surgery

Other: _____

Past Medical History:

___ Coronary Artery Disease
___ High Cholesterol
___ High Blood Pressure
___ Diabetes
___ Peripheral Vascular Disease
___ Varicose Veins

Other: _____

Allergies:

Please List: _____

Family History:

___ Coronary Artery Disease Details: _____
___ High Cholesterol Details: _____
___ High Blood Pressure Details: _____
___ Diabetes Details: _____

Other: _____

Current Medications:

Please List: _____

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PATIENT HISTORY (continued)

Review of Systems: Please check all that apply.

Skin:
___ Itching
___ Hives
___ Bruising
___ Bleeding

Eyes:
___ Vision changes or loss
___ Double Vision

Ears:
___ Hearing aids
___ Hearing loss
___ Pain
___ Discharge
___ Ringing
___ Infections

Nose:
___ Nosebleeds
___ Discharge
___ Infections
___ Pain

Mouth/Throat:
___ Cavities
___ Dentures
___ Bleeding Gums
___ Sores / Lesions
___ Hoarseness

Respiratory:
___ Cough
___ Blood
___ Shortness of breath
___ Asthma
___ Emphysema
___ Tuberculosis
___ Pneumonia
___ Bronchitis

Cardiovascular:
___ Chest Pain
___ Palpitations
___ Shortness of breath
___ when sleeping
___ when walking
___ Legs swelling
___ Cramps
___ Varicose veins
___ Color changes
___ Legs/feet

Gastrointestinal:
___ Vomitting
___ Constipation
___ Diarrhea
___ Heartburn
___ Blood in stool
___ Changes in stool
___ Difficulty / pain
___ in swallowing
___ Jaundice
___ Liver Disease
___ Gallbladder Disease

Genitourinary:
___ Urine frequency
___ Pain
___ Bloody urine
___ Incontinence

Hematology / Lymphatic:
___ Anemia
___ Sickle Cell
___ Hemophilia
___ Swollen Glands
___ Night Sweats
___ Itching

Neurological:
___ Headaches
___ Dizziness
___ Numbness
___ Falls
___ Tremors
___ Stroke / TIA's
___ Loss of memory
___ Problems with gait

Psychiatric:
___ Depression
___ Anxiety
___ Bipolar

Endocrine:
___ Increased thirst
___ Increased urine
___ Intolerance to heat
___ Intolerance to cold
___ Diabetes
___ Hot flashes

Allergy / Immune:
___ AIDS
___ Hepatitis B
___ Hepatitis C

Musculoskeletal:
___ Weakness
___ Paralysis
___ Stiffness
___ Joint Pain
___ Swelling
___ Arthritis
___ Gout

Neck:
___ Goiter
___ Pain
___ Thyroid problems

Patient Signature: _____ Date: _____

Palm Vein Center

AGREEMENTS & AUTHORIZATIONS

CONSENT FOR TREATMENT

I hereby authorize and consent to treatment provided by ***Palm Vein Center***, employees or designees and authorize medical services, diagnostic procedures and medication as necessary or advisable by the caregiver(s) providing treatment. I understand that no guarantee has been made as to the results of the care, treatment, and/or medications which may be given to me.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize ***Palm Vein Center*** to release information required in the processing of application for financial coverage for services rendered. This authorization provides that my physician or my physician's staff may release objective clinical information related to my diagnosis and treatment, which may be requested by my insurance company or its designated agent to evaluate my claims or its liability under such policies or contracts or coordination of benefits pursuant to such policy or contract provisions. The information obtained will be treated as privileged and confidential and will not be released to any person without my expressed or written consent. Correspondence and test results will only be released to physicians involved in my case.

ASSIGNMENT OF INSURANCE BENEFITS/REFERRALS/PAYMENTS GUARANTEE/COLLECTION FEE/NSF FEE

I hereby authorize payment to be made directly to ***Palm Vein Center*** for insurance benefits payable to me. I understand that I am financially responsible to ***Palm Vein Center*** for any covered or non-covered services, as defined by my insurer, which are not paid by my insurer. I understand that I am financially responsible for payment in full if no required referral is received by this office. I understand payments are due when services are rendered. As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to us for health care services rendered. I understand that I am financially responsible for a collection fee of 30% of balance due and any reasonable attorney's fees and other costs incurred for collection including, but not limited to 1 ½ % interest per month on any outstanding amounts unpaid 90 days after insurance resolution. I understand that I am financially responsible for a returned check for any reason and a $35.00 NSF fee. A fee of $1 per page and $7 shipping will be charged for copy of records.

PAYMENT POLICY

The patient (or adult/guardian who brings in minor patient) will be responsible for all co-payments and deductibles. ***Palm Vein Center*** does not forward bills to other parties regardless of court rulings or divorce decrees.

MISSED APPOINTMENTS

I understand that in order for ***Palm Vein Center*** to best serve their patients, they ask for at least 24 hours' notice if I am unable to keep an appointment. This allows them to try to fill my scheduled appointment time with another patient. If they do not receive this notice, I will be charged a missed appointment fee of $25.00 for doctor's visits and $75.00 for procedures. My signature below signifies acceptance of the Missed Appointments terms.

IF MY INSURNACE CHANGES OR I HAVE NO CURRENT INSURANCE CARD AT THE TIME OF SERVICE

If I do not present my current insurance card for any date of service, I will be billed as a self-paying patient. ***Palm Vein Center*** may not be able to back date from the time of service to when I do present a valid insurance card. I may be asked to seek reimbursement from my insurance carrier(s).

MEDICARE

Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information that is needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf directly to ***Palm Vein Center***.

HIPAA NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I was offered and/or received the physician's HIPAA Notice of Privacy Practices. The Notice provides detailed information about how the practice may use and disclose my confidential information. I understand that ***Palm Vein Center*** has reserved the right to change their privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided or made available to me upon request.

PATIENT ACKNOWLEDGEMENT

I have read the Agreements & Authorizations form. I understand its contents, and that I have had an opportunity to discuss its contents with ***Palm Vein Center*** to my satisfaction. I understand that my signature represents agreement with the contents of the forms and that any statement may not amend the contents of the form. I understand that the records/information released will not be further disclosed for any purpose other than stated in this Authorization.

_____	_____
Patient Name (PRINT)	Date
_____	_____
Patient or Authorized Representative Signature	Relationship (if other than Patient)
_____	_____
Patient unable to sign: Verbal consent given to staff	Reason

VEIN SCREENING FORM

Please complete left side of form only.

Date:_____ Appt Time:_____

Name:_____ Primary Care Physician:_____

DOB: _____ Sex: ☐M ☐F Insurance Provider:_____

How did you hear about us?_____

1.) Vascular History

Do you have or have you ever been diagnosed with:

Varicose Vein Problems	☐Y ☐N	Leg: ☐R ☐L
Phlebitis (vein redness /tenderness)	☐Y ☐N	Leg: ☐R ☐L
Blood Clots	☐Y ☐N	Leg: ☐R ☐L
Deep Vein Thrombosis (DVT)	☐Y ☐N	Leg: ☐R ☐L
Saphenous vein reflux	☐Y ☐N	Leg: ☐R ☐L

Do you experience any of the following in your legs?

Aching/Pain	☐Y ☐N	Leg: ☐R ☐L
Heaviness	☐Y ☐N	Leg: ☐R ☐L
Tiredness/Fatigue	☐Y ☐N	Leg: ☐R ☐L
Itching/Burning	☐Y ☐N	Leg: ☐R ☐L
Swelling	☐Y ☐N	Leg: ☐R ☐L
Cramps	☐Y ☐N	Leg: ☐R ☐L
Restless Legs	☐Y ☐N	Leg: ☐R ☐L
Throbbing	☐Y ☐N	Leg: ☐R ☐L
Skin or ulcer problems	☐Y ☐N	Leg; ☐R ☐L
Numbness/Tingling	☐Y ☐N	Leg: ☐R ☐L

Which of the following do you currently do to improve your leg vein symptoms?

Medication for pain	☐Y ☐N	What?_____
Elevation of legs	☐Y ☐N	Which Leg?_____
Ever worn Support Hose	☐Y ☐N	Tolerated well?__Y __N

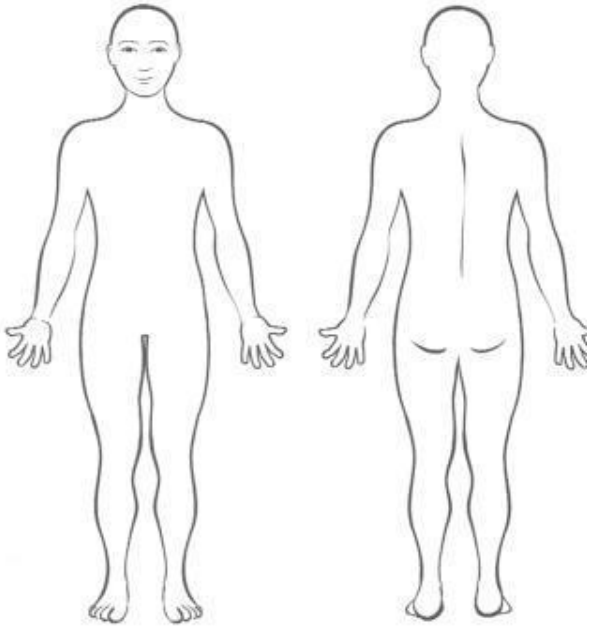
2.) Vein Treatment History

Have your ever been treated for varicose veins with:

Sclerotherapy	☐Y ☐N	Leg: R or L
Phlebectomy	☐Y ☐N	Leg: R or L
Vein Stripping	☐Y ☐N	Leg: R or L
RF Ablation	☐Y ☐N	Leg: R or L
Laser	☐Y ☐N	Leg: R or L

3.) Personal Activities

Prolonged Standing	☐Y ☐N	
Prolonged Sitting Periods	☐Y ☐N	
Do you exercise regularly	☐Y ☐N	
Do you smoke?	☐Y ☐N	
Pregnancies	☐Y ☐N	How many?_____



Physical Exam:

CEAP Clinical Signs:

RIGHT LEG (check all that apply)

☐No Signs of venous disease ☐Spider Veins
☐Visible Varicose Veins ☐Edema
☐Pigmentation ☐Active Ulcers
☐Healed ulcers

LEFT LEG (check all that apply)

☐No Signs of venous disease ☐Spider Veins
☐Visible Varicose Veins ☐Edema
☐Pigmentation ☐Active Ulcers
☐Healed ulcers

Clinical Assessment:

☐Chronic venous insufficiency ☐R ☐L
☐Other: _____ ☐R ☐L

Treatment Plan:

☐Duplex ultrasound ☐R ☐L
☐Sclerotherapy ☐R ☐L
☐EVLA ☐R ☐L
☐Medical compression stockings ☐R ☐L
☐Other:_____ ☐R ☐L