Southern VEIN CARE

PATIENT REGISTRATION FORM

Name: _____ Preferred Name: _____
SSN: _____ SEX: _____ DOB: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone #: _____ Work Phone #: _____
Mobile Phone #: _____ Preferred Contact #: Home / Work / Mobile
Email Address: _____
Preferred Language: _____ Needs Interpreter: Y / N
Marital Status: _____ If Married, Spouse's Name: _____
Ethnicity: _____ Race: _____

Employer: _____ Employment Status: _____
Employer Address: _____
City: _____ State: _____ Zip Code: _____

Emergency Contacts:
Name: _____ Relationship: _____ Phone #: _____
Name: _____ Relationship: _____ Phone #: _____

Referring Physician's Name: _____ Phone #: _____
Primary Care Physician's Name: _____ Phone #: _____
Preferred Pharmacy: _____ Phone #: _____

Primary Insurance: _____ Policy ID #: _____ Group #: _____
Policy Holder: _____ Relationship to Policy Holder: _____

Secondary Insurance:_____ Policy ID #: _____ Group #: _____
Policy Holder: _____ Relationship to Policy Holder: _____

(If different from patient please provide the following information)
Policy Holder Employer: _____ Employment Status: _____
Policy Holder Employer Address: _____
City: _____ State: _____ Zip Code: _____

Patient Signature: _____ Date: _____

ASSIGNMENT AND RELEASE

I, the undersigned, authorize and assign the payment of my medical payments and benefits to Southern Vein Care otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not covered by insurance for services rendered on my behalf or my dependents. I authorize Southern Vein Care to release any information to complete and process my insurance claims and to secure payment of benefits. I further agree to pay all collection costs, attorney fees, and other collection costs that may be incurred to enforce the collection of any amounts that are outstanding and unpaid. I authorize the use of this signature on all insurance submissions.

Patient Signature: _____ Date: _____

MEDICARE AUTHORIZATION

I, the undersigned, request that payment of authorized Medicare benefits be made to Southern vein Care for any services rendered. I authorize the holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable to related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “the other health insurance” is indicated in box 9 of the HCFA-1500 form, or elsewhere on the approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient Signature: _____ Date: _____

Privacy Consent - For the Use and Disclosure of Protected Health Information

This consent is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to inform you of your rights for privacy with respect to your health care information.

I hereby give my consent to **Southern Vein Care** to use and disclose my protected health information for the purpose of treatment, payment, and operations of my healthcare and this practice.

Consent for treatment: I, with my signature, authorize **Southern Vein Care** and any employee working under the direction of the physician, for the purpose of evaluating my health, diagnosing medical conditions, and providing treatment.

Authorization to Pay Benefits to Physician: I hereby authorize payment of medical benefits directly to **Southern Vein Care** . I understand that co-pays, deductibles, out of pocket expenses and non-covered services are due at the time of service, unless prior arrangements have been made with the office administrator. **Southern Vein Care** will bill my insurance for services rendered. If my insurance does not pay within 30 days, I understand I am responsible for payment of the bill and/or contacting the insurance company to secure payment.

Authorization to Release Information: I hereby authorize **Southern Vein Care** to release any medical information necessary to process any insurance claim. This may be in the form of a copy of medical records or information conveyed via telephone or fax to my insurance company and/or any other necessary third party and/or its agents (collectively referred to as “the Plan”). I also authorize **Southern Vein Care** to disclose any medical information necessary to the Plan to verify services, conduct quality, chart site, or utilization reviews, investigate grievances. The Plan may review my medical chart in your office for proper documentation or for their studies as a measure of quality. My referring physician will receive a copy of your chart notes regarding my visit. This authorization also releases to the Health Care Financing Administration (HCFA) or its medical claims agencies any information referred to as “the Plan”. I hereby authorize **Southern Vein Care** to release any medical information needed to administer Title XVII (the Medicare Program) of the Social Security Act. This authorization is valid until revoked by me in writing.

Consent related to the Privacy Notice: I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand the terms of the Practice Notice may change and I may obtain these revised notes by contacting the Practice Privacy Officer by phone or writing. I understand I have the right to restrict how this information is disclosed, but **Southern Vein Care** is not required to agree to my restrictions.

Patient Name Printed: _____ DOB: _____

Guardian Name Printed: _____ Relationship to Patient: _____

Patient/Guardian Signature: _____ Date: _____

Billing and Financial Policy

The following sets forth the general Billing and Financial Policy of **Southern Vein Care**. Please review and sign below where indicated:

- I understand that it is my responsibility to provide the office of **Southern Vein Care** with current and accurate billing information at the time of check-in.
- I understand that my account balance should be paid, including my co-pay amount prior to services being rendered.
- I understand that this is a contractual agreement that I have with my health plan and that the practice rendering services also has a contractual agreement with my health plan to collect co-pays at the time of services, and they are required to report to the carrier any enrollees failing to make co-pay.
- I understand that if I present an insufficient check (NSF) for payment associated with my care, I will be charged a **$35** NSF fee. I further understand that to rectify my account, I will be required to pay with cash, money order, cashier's check, or credit card.
- I understand that there is a **$30** fee to complete disability paperwork associated with my care. I will be provided a standard form free of charge; however, if additional disability forms (such as FMLA) requires completion, I understand that the **$30** fee is required and must be paid prior to completion.
- I understand that the clinic will verify my insurance eligibility, deductible amounts, and coinsurance amounts prior to any elective surgery that I may have. I further understand that it is the policy to collect the deductible and/or coinsurance prior to scheduling my elective surgery. I further understand that the **FEE** that I am **QUOTED** is only an **ESTIMATE** that is based on: First, the anticipated surgery to be performed and second, the current information provided to the clinic by my insurance carrier.
- I understand that I will be billed for any amounts due by me and that I have a financial responsibility to pay these amounts in **FULL**. I understand that I will be provided with two statements for any balance due after the insurance payment is received. I further understand that if I have not made payment prior to the second statement being mailed, that the next statement will be marked **FINAL NOTICE** and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with collection efforts.
- I understand that the practice will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is **NOT** a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.
- I understand that the practice may also take a verbal request to use my credit card for payment on my account or they may also use the same listed credit card on my account should my account become delinquent or to cover an NSF check and the fee.

My signature below confirms that I have read these billing policies and my obligation as pertains to the physicians of **Southern Vein Care.**

_____ _____

Signature of Patient Date

HIPAA Privacy Act Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO
May we leave a message on your answering machine at home or on your cell phone? YES NO
May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

1. Individual Name: _____ Relationship to Patient: _____
2. Individual Name: _____ Relationship to Patient: _____

Patient Name Printed: _____ DOB: _____

Guardian Name Printed: _____ Relationship to Patient: _____

Patient/Guardian Signature: _____ Date: _____

Venous Health History Form

Patient Name: _____ **Date of Birth:** _____

Directions: Please answer all the following questions. Provide estimates for date of occurrence.

Past Medical History

1. Have you ever had vein stripping or ablation? ☐ Yes ☐ No
   If yes, when and which leg? _____
2. Have you ever had vein injections? ☐ Yes ☐ No
   If yes, which leg and where on the leg? _____
   What Solution(s) was used? _____
3. Have you ever had a blood clot? ☐ Yes ☐ No
   If yes, which leg and when? _____
4. Have you ever had phlebitis? ☐ Yes ☐ No
   If yes, which leg and when? _____

Family History

Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers or swollen legs?

Father	☐ Yes	☐ No
Mother	☐ Yes	☐ No
Brother(s)	☐ Yes	☐ No
Sister(s)	☐ Yes	☐ No
Other	☐ Yes	☐ No

1. Do you experience any of the following in your legs?

Aching/pain?	☐ Right leg	☐ Left leg
Heaviness?	☐ Right leg	☐ Left leg
Tiredness/fatigue?	☐ Right leg	☐ Left leg
Itching/burning?	☐ Right leg	☐ Left leg
Swollen ankles?	☐ Right leg	☐ Left leg
Leg Swelling?	☐ Right leg	☐ Left leg
Leg cramps?	☐ Right leg	☐ Left leg
Restless legs?	☐ Right leg	☐ Left leg
Throbbing?	☐ Right leg	☐ Left leg
Varicose veins?	☐ Right leg	☐ Left leg
Spider Veins?	☐ Right leg	☐ Left leg
Leg ulcer?	☐ Right leg	☐ Left leg

Females Only:
Do you have pelvic or vaginal varicose veins? ☐YES ☐ NO
Are you veins more painful during your menstrual cycle? ☐YES ☐ NO
Do you experience pain during intercourse? ☐YES ☐ NO
How many Pregnancies? _____
Any miscarriages? ☐YES ☐ NO

Venous Health History Form (cont.)

Please rate your pain: **No Pain** ☐ **Moderate Pain** ☐ **Severe Pain** ☐

Other? _____

Which leg is most painful? ☐ Right leg ☐ Left leg
Rate the pain. 1 (no pain)-10 (severe pain) ____

2. Have your veins gotten worse in recent months? ☐ Yes ☐ No

3. Do you take any medication for pain (i.e., Advil, Motrin) ☐ Yes ☐ No
If yes, what medication do you take and how many times/mgs per day? _____
_____

4. Do you elevate your legs to relieve discomfort? ☐ Yes ☐ No
If yes, how long per day do you elevate and does it provide relief? _____
_____

5. Do you exercise? ☐ Yes ☐ No
If yes, what kind of exercise and how often? _____
Have you had recent weight loss? _____ How much? _____
Height: _____ **Weight: _____**

6. Do you wear prescription compression stockings? ☐ Yes ☐ No
If yes, what type and gradient? 15-20__ 20-30__ 30-40__
How long have you worn them? _____

If yes, what is the name of the physician who prescribed your compression stockings and when were they prescribed? _____

8. Do you have any problem walking? ☐ Yes ☐ No
If yes, how does it affect you? _____

9. What type of work do you do? _____
How long do you stand (hours per day) at work? _____ At home? _____

10. Have you ever had any test(s) done on your veins? ☐ Yes ☐ No
If yes, when and what type of test and where on the leg? _____
_____

11. Were you diagnosed with saphenous vein reflux? ☐ Yes ☐ No

12. Current Physicians that you see: _____
_____

13. How did you hear about us? _____

Patient Signature: _____Date: _____

Thank you for choosing Southern Vein Care

Review of Systems

Name: _____ Date: _____ Ht:_____ Wt:_____

Please check the boxes that have applied to you for the past 6 months:

CONSTITUTIONAL:
- ☐ANOREXIA
- ☐CHILLS
- ☐FATIGUE
- ☐FEVERS
- ☐MALAISE (lack of energy)
- ☐NIGHT SWEATS
- ☐SWEATS
- ☐WEIGHT LOSS

EYES:
- ☐CATARACTS
- ☐COLOR BLINDNESS
- ☐CONTACTS/GLASSES
- ☐GLAUCOMA
- ☐IRRITATION
- ☐REDNESS
- ☐VISUAL DISTURBANCE

EARS/NOSE/MOUTH/ THROAT/FACE:
- ☐EPISTAXIS (bloody noses)
- ☐FACIAL TRAUMA
- ☐HEARING LOSS
- ☐HOARSENESS
- ☐SNORING
- ☐TINNITUS (ringing in ears)
- ☐VOICE CHANGES

RESPIRATORY:
- ☐ASTHMA
- ☐CHRONIC BRONCHITIS
- ☐COUGH
- ☐DYSPNEA ON EXERTION (shortness of breath)
- ☐EMPHYSEMA
- ☐HEMOPTYSIS (coughing up blood)
- ☐PLEURISY/CHEST PAIN
- ☐PNUEMONIA
- ☐WHEEZING

HEMATOLOGY/LYMPHATIC:
- ☐BLEEDING
- ☐CLOTTING HISTORY
- ☐EASY BRUISING
- ☐LYMPHADENOPATHY (swollen lymph nodes)
- ☐MISCARRIAGES
- ☐PETECHIAE (broken vessels)
- ☐SICKLE CELL ANEMIA

CARDIOVASCULAR:
- ☐CHEST PAIN
- ☐CHEST PRESSURE/DISCOMFORT
- ☐CLAUDICATION (leg pain w/exercise)
- ☐DYSPNEA (difficulty breathing)
- ☐EXERTIONAL CHEST PRESSURE/DISCOMFORT
- ☐FATIGUE
- ☐IRREGULAR HEARTBEAT
- ☐LOWER EXTREMITY EDEMA (leg swelling)
- ☐ORTHOPNEA (shortness of breath when lying flat)
- ☐PALPITATIONS
- ☐SYNCOPE (passing out)
- ☐VARICOSE VEINS

GASTROINTESTINAL:
- ☐ABDOMNAL PAIN
- ☐CHANGE IN BOWEL HABITS
- ☐CONSTIPATION
- ☐DIARRHEA
- ☐DYSPHAGIA (difficulty swallowing)
- ☐JAUNDICE (yellow skin)
- ☐MELENA (black stools)
- ☐NAUSEA
- ☐REFLUX SYMPTOMS
- ☐VOMITING

GENITOURINARY:
- ☐DECREASED STREAM
- ☐DYSURIA (pain with urination)
- ☐FREQUENCY
- ☐HEMATURIA (blood in urine)
- ☐HESITANCY
- ☐NOCTURIA (urinating at night)
- ☐URINARY INCONTINENCE

INTEGUMENTARY:
- ☐DRYNESS OF SKIN
- ☐PRURITIS (itching)
- ☐RASH
- ☐SKIN COLOR CHANGE
- ☐SKIN LESIONS
- ☐BLEEDING VEINS

MUSCULOSKELETAL:
- ☐ARTHRALGIAS
- ☐BACK PAIN
- ☐BONE PAIN
- ☐MUSCLE WEAKNESS
- ☐MYALGIAS (muscle pain)
- ☐NECK PAIN
- ☐STIFF JOINTS

NEUROLOGICAL:
- ☐COORDINATION PROBLEMS
- ☐DIZZINESS
- ☐GAIT PROBLEMS
- ☐HEADACHES
- ☐MEMORY PROBLEMS
- ☐PARESTHESIA (numbness)
- ☐SEIZURES
- ☐SPEECH PROBLEMS
- ☐STROKE/TIA
- ☐TREMORS
- ☐VERTIGO
- ☐WEAKNESS

BEHAVIORAL/PSYCH:
- ☐ABUSIVE RELATIONSHIP
- ☐ADHD (Attention Deficit)
- ☐AGGRESSIVE BEHAVIOR
- ☐ANOREXIA
- ☐ANXIETY
- ☐BEHAVIOR PROBLEMS
- ☐BIPOLAR
- ☐BORDERLINE PERSONALITY DISORDER
- ☐DEPRESSION
- ☐EXCESSICE ALCOHOL CONSUMPTION
- ☐ILLEGAL DRUG USE
- ☐LEARNING DIFFICULTY
- ☐MOOD SWINGS
- ☐OBESITY
- ☐OBSESSIVE COMPULSIVE DISORDER

ENDOCRINE:
- ☐DIABETIC SYMPTOMS
- ☐FERTILITY PROBLEMS
- ☐TEMPERATURE INTOLERANCE
- ☐THYROID DISEASE

ALLERGY/IMMUNE:
- ☐ANAPHYLAXIS
- ☐ANGIOEDEMA (swelling/hives)
- ☐HAY FEVER
- ☐URTICARIA (hives)