PATIENT INFORMATION

Last Name: _____________________________ First Name: ____________________________ MI: ________
DOB: ____/____/_______Gender: M F Height: __________Weight: _________
Address: ____ City:______________ State:_______ ZIP: ___________
Home Phone: (___)______________ Cell Phone: (___)_________________ Work Phone: (___)________________
Preferred Contact Method: o Home o Cell o Work
Social Security#: ______/______/__________
Email: _________________________________ (Would you like to receive our email newsletter?) Y or N
Ethnicity (please select one):

○ American Indian/ Alaska Native	○ Hispanic	○ Native Hawaiian / Pacific Islander
○ Asian	○ White	○ Black / African American

Preferred Language: ____________________________

SOCIAL INFORMATION

__ Single __ Married __ Divorced__ Widowed
Occupation (Previous, If Retired): ______________________________ Employer: _______________________________
Cigarette/Tobacco: # of Packs _______ Day/Week/Month/Socially o Quit (How long ago): _______ o Never Smoked
Alcoholic Drinks: # of Glasses _______ Day/Week/Month/Socially Caffeine: # of cups _______ Day

REFERRAL INFORMATION

How did you hear about us?
Physician Referred (Name): ________________________ Friend/Family Member (Name): _________________________
Advertisement (Type): _________________________Other: _________________________

PRIMARY CARE INFORMATION

Primary Care Physician: ____________________________________ Phone: ____________________________________
Do you release authorization for us to send reports to your Physician? Y or N
Preferred Pharmacy: _______________________ Address: ______________________ Phone: ______________________

RESPONSIBLE PARTY

Last Name: _____________________________ First Name: ____________________________ MI: ________
Address: ____ City: ______________ State: _______ Zip: ___________
Phone: (___)______________ Relationship: ____Spouse ____ Parent ____ Other (Explain)____________________

Primary Insurance: ______________________________	**Secondary Insurance:** ______________________________
Policy Holder: __________________________________	**Policy Holder:** ____________________________________
SSN: ____	**SSN:** ____
DOB: ____	**DOB:** ____
Policy Number: _________________________________	**Policy Number:** ___________________________________
Group Number:_________________________________	**Group Number:** ____________________________________
Patient's Relationship to the Policy Holder:	**Patient's Relationship to the Policy Holder:**
____ Self ____ Spouse ____ Child ____ Other	**____ Self ____ Spouse ____ Child ____ Other**

I am authorizing Vein Specialists of Arizona to bill my Health Insurance Company(s) for services rendered. I understand that in order to obtain Authorization for treatment, my Health Insurance Company(s) must be billed for my Initial Office Visit and Diagnostic Ultrasound.Once services are billed Vein Specialists of Arizona will be unable to reverse the transaction(s) with my Health Insurance Company. Ifurther understand that in the situation that my Health Insurance Company(s) fails to pay for services rendered, I will be financially responsible to cover the bill.

Patient Signature (Printed): ____ Date: ___________

Responsible Party Signature (If under 18): ____ Date: ___________

Vein Specialists of Arizona
9515 W. Camelback RD. #108
Phoenix, AZ 85037
Office: (623) 428-0068
FAX: (623) 428-0069

CURRENT OR PAST MEDICAL HISTORY (Please check all that apply): ○ None

○ Anxiety	○ Fever	○ Mitral Valve Prolapse
○ Arthritis	○ Gout	○ Nausea/Vomiting/Belly Pain
○ Arrhythmias	○ Headache/Migraine	○ Pulmonary Embolus
○ Asthma	○ Heart Murmur	○ Rheumatoid Disease
○ Bleeding/Blood disorder	○ Hearing Difficulty	○ Seizures
○ Breathing Difficulty	○ Hepatitis/Liver Disease Type: ___________	○ Skin Rashes
○ Cancer	○ High Blood Pressure	○ Stroke
○ Chest Pain/Tightness	○ HIV/AIDS	○ Thyroid Disease
○ Depression	○ Inflammatory Bowel	○ Twitching/Paralysis
○ Diabetes	○ Kidney Disease	○ Visual Disturbances
○ Dizziness	○ Leg Trauma	○ Other: ________________ ______________________
○ Fatigue		

PLEASE EXPLAIN ABOVE ANSWERS:

____

____

ALL CURRENT MEDICATIONS (Prescription, Non-Prescriptions, Vitamins, and/or Herbal):

____

____ For what condition(s)/illness do you take the above medication(s)?

____

_____ **ALLERGIES** (List all Allergies and Reactions): ○ None Latex Allergy: Y or N Skin Tape Allergy: Y or N

____

_____ **SURGICAL HISTORY** (Please list any/all Surgeries and the year they were performed)**:** ○ None

____

____ **FOR WOMEN ONLY:**

○ Pregnant ○ Trying to become Pregnant	○ Number of Pregnancies: _________
○ Breast Feeding	○ Number of Stillbirths/Miscarriages: _____
○ Date of last Menstrual Period: ____/____/______	○ Pelvic Pain/Heaviness
	○ Veins: Upper Thighs, Vulva, or Labia Area

Patient Name (Printed): ____ DOB: _____________

Patient Signature: ____ Date: ____________

Responsible Party Signature (If under 18): ___________________________________ Date: _____________

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HIPAA Privacy Authorization Form

I, ____ authorize Vein Specialists of Arizona to disclose and/or release my Protected Health Information described below to:

Name(s): DOB: Relationship:

________________________________ ___________ ________________________________

________________________________ ___________ ________________________________

________________________________ ____

Health Information to be disclosed (Check all that apply):

□ My Complete Health Record (Including but not limited to Diagnosis, Results, Treatment, and Billing).

□ My Complete Health Record, with the Exception of the following:

____

□ Other (Please Specify):

____

This Medical/Health Information may be used by the persons I authorized above to know and understand my Diagnosis, Treatment, Claims Payment, and/or other related reasons.

This Authorization will remain in effect until______________________, at which time this authorization will expire.

I understand I have the right to revoke this authorization in writing at any time but any information given before that time is covered by this authorization.

Patient Name(Printed): ____ DOB: ___________

Patient Signature: ____ Date: ____________

Responsible Party Signature:
____ Date: ____________ (If under 18)

Witness Signature: ____ Date: ____________

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HIPAA Privacy Rule and Public Health Information and Liability Waiver

This form is to inform you (the patient) that there has been a new criteria established by The Centers for Medicare and Medicaid Services (CMS), in order to promote the communication of medical instructions/ information to all patients.

In the process of maintaining thorough communication of instructions, it is inevitable that Personal Health Information, deemed protected by the Health Insurance Portability and Accountability Act of 1996*, may be furnished to you in the course of a meaningful discussion.

This information, once released into your care will become your sole responsibility to protect.

By signing this form you acknowledge that you are accepting full responsibility for the security and use of your personal health information and that any third party distribution of the information in your care is not the fault or otherwise responsibility of Vein Specialists of Arizona, its physicians or staff.

Patient Name (Printed): ____DOB: ___________

Patient Signature: ____ Date: ____________

Responsible Party Signature:
____Date:_____________ (If under 18)

Witness Signature: ____ Date: ____________

Guidance from CDC and the U.S. Department of Health and Human Services

New national health information privacy standards have been issued by the U.S. Department of Health and Human Services (DHHS), pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The new regulations provide protection for the privacy of certain individually identifiable health data, referred to as protected health information (PHI).
http://www.hhs.gov/ocr/privacy/

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CONSENT TO PHOTOGRAPH AND RECORD FOR CHART AND/OR INSURANCE REQUIREMENT PURPOSES

Patient Name: ____DOB: _______________

I hereby authorize Vein Specialists of Arizona and/or attending physicians and staff to:

Take and Reproduce Photographs and/or Slides in connection with the Diagnosis, Treatment (including surgical procedures) or Functional capacity of the practice.Use of material as well as my information is also authorized for use in Insurance related dealings, such as: Filing claims, medical necessity, and appeals with the insurance company.

I release Vein Specialists of Arizona and its staff and consultants from any and all liability in conjunction with the use of stated materials. I also understand that this authorization as well as release of liability will remain effective unless revoked in writing.

Date: ___________________

Patient Signature: ____

Responsible Party Signature:
____ (If under 18)

Staff member taking photos: ________________________

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Venous HistoryQuestionnaire

Please explain the reason for you visit with us today: ____
____

How long have you been experiencing these symptoms? _________ Year(s)
Who in your family has suffered from varicose veins? ____

Previous Venous Treatment: ○ None

○ Cosmetic Injections: R L B	○ Radiofrequency Ablation (RF): R L B
○ Laser to Spider Veins: R L B	○ EndoVenous Laser (EVLT): R L B
○ Phlebectomy: R L B	○ Other: _____________________________
○ Stripping: R L B	When: _________________________________
○ Sclerotherapy: R L B	Where: ________________________________

Symptoms Occur:

○ Bilateral Legs	○ Right > Left
○ Right Leg Only	○ Left > Right
○ Left Leg Only	

Symptoms you suffer in your legs (Please check all that apply):

○ Visible Veins	○ Fatigue
○ Pain, Discomfort, Cramping	○ Skin Discoloration
On a scale from 0-10: ______	○ Ankle Ulcerations
○ Burning, Itching, Tingling	○ Blood Clots or Deep Vein Thrombosis (DVT)
○ Numbness	○ Heaviness
○ Restless Leg Syndrome	○ Bleeding of Veins
○ Swelling	○ Calf Pain with regular walks
○ Easily Bruise	○ Other:_________________________

At what time are your symptoms at their worse? ○ No Symptoms

○ During the day	○ When walking
○ During the night	○ When resting
○ After being on feet all day	○ No specific time
○ All the time	○ Other: _________________________

What daily activities are affected/interrupted by your symptoms?

○ Work (to walk or sit)	○ House hold chores
○ Exercise	○ Need to take frequent breaks
○ Daily living/Quality of life	○ Other: _________________________
○ Sleep	

What method(s) do you use/have you used in the past to alleviate your symptoms?

○ Graduated Compression Hose:	○ NSAIDs: Tylenol or Ibuprofen ______mg
>3m >6m >1yr Other________	>3m >6m >1yr Frequency ________
Knee High Thigh High Panty Hose	○ Leg elevations
20-30 mmHg 30-40mmHg	○ Other: _________________________

Patient Name (Printed): ____ DOB:____________

Patient Signature: ____ Date: ______________

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FINANCIAL POLICY

Thank you for choosing Vein Specialists of Arizona as your healthcare provider. We are committed to providing you with the best care possible. The following statement explains our financial policy. **It is the patient's responsibility to know their benefits and coverage prior to the first visit. Failure to do so may result in a higher out of pocket expense to the patient.**

- We accept Cash, Check, or Credit Cards (Visa, Master Card, Discover, and CareCredit)
- Co-Pays, Co-Insurance, and Deductibles must be paid at the time of service

Contracted Insurance: If we are contracted with your insurance company we must follow our contract and their requirements. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral you are responsible for obtaining one. Failure to obtain a referral may result in a denial of your claim.

Non-Contracted Insurance: If we are not contracted with your insurance company, we will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. **You agree to pay any portion of the charges not covered by your insurance.**

Transferring of Records: You will need to request in writing, and possibly pay a reasonable fee if you're requesting records for personal purposes. If you want copies of your record sent to another doctor or organization the fee will be waived. The amount of the fee is dependent on the number of copies made. You authorize us to include all relevant information.

Cancellation, Rescheduling, and Missing Appointments: Surgery (EndoVenous Ablation/RF) appointments must be cancelled or rescheduled 24hrs prior to your scheduled appointment date to avoid a cancellation/rescheduling fee of $200.00 (for the cost of instruments, supplies, and loss of revenue). All Office visits, Ultrasound appointments, or Sclerotherapy appointments must also be cancelled 24hrs prior to your appointment to avoid a $30.00 cancellation fee. These fees must be received before your next appointment will be rescheduled.

Re-Billing Fee: A Re-Billing fee of $**5.00** will be imposed on each service that is over (30) days past-due.

Payment: Full balance on your statement is due and payable when the statement is issued and is considered past due if not paid by the end of the month.

Returned Checks: If a check is returned to us unpaid by your bank, we will charge a $55.00 fee.

I hereby authorize assignee Vein Specialists of Arizona to release all medical information necessary to secure payment to my Insurance Company, Attending Physician, and/or Attorney. I hereby assign all medical and/or surgical benefits to include major benefits to which I am entitled, including medical private insurance and any other health plan to Vein Specialists of Arizona. I understand that I am fully responsible for any and all charges incurred whether or not paid by my said insurance company. I have been made aware of, read, fully understand, and agree to the terms and financial policy stated above.
If this account is sent to a collection agency, I agree that in addition to any amount left owing to Vein Specialists of Arizona I will be responsible for court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee equal to 40% of the past due balance.

Patient Name (Printed): ______________________________ **DOB:** ______________

Patient Signature: ______________________________ **Date:** ______________

Responsible Party Signature: ______________________________ **Date:** ______________
(If under 18)