VARICOSE TO PERFECT

Date: _____

Dear _____,

Welcome to Varicose to Perfect. Dr. Sinnathamby and staff look forward to meeting with you to discuss your concerns and will strive to meet your needs.

Your consultation is scheduled with _____.

Your appointment scheduled on _____ on _____ at

___ 572 N. Main Street, Springboro, Ohio 45066

___ 5538 Philadelphia Drive, Dayton, Ohio 45424

Please review the enclosed information and complete the registration forms ***prior*** to your scheduled appointment. Please bring the following information with you to your appointment:

- ❑ Completed Registration and Medical History Forms
- ❑ Insurance Cards
- ❑ Co-Pay
- ❑ Photo ID
- ❑ Medication List

Please contact our office if you should have any questions regarding your appointment. If you are unable to keep your scheduled appointment, please contact our office immediately, so we can reschedule to a time that will better serve you.

Thank You.

572 N. MAIN ST., SPRINGBORO, OH 45066
(937) 748-8905 • (800) 716-VEIN (8346) • FAX (937) 748-8906
VARICOSETOPERFECT.COM

Varicose to Perfect

572 N. Main Street, Springboro, Ohio 45066 5538 Philadelphia Drive, Dayton, Ohio 45415

Phone: 937/748-8905 Fax: 937/748-8906

PERSONAL INFORMATION

First Name:	**MI:**	**Last Name:**
SSN:	**Date of Birth:**	**Gender:**
Marital Status:	**Email Address:**	
Address:		
City:	**State:**	**Zip Code:**
Primary Phone:	**Secondary Phone:**	
Employer:	**Employer Phone:**	
Preferred Language:	**Pharmacy:**	
Primary Care Physician:		
Referral Source:		

EMERGENCY CONTACT

Name (someone living outside your home):	
Relationship:	**Primary Phone:**

RACE

	American Indian		**Alaska Native**		**Asian**		**Hispanic or Latino**
	Black or African American		**Caucasian**		**Native Hawaiian**		**Not Hispanic or Latino**
	Pacific Islander		**Other**		**I Decline to Answer**		**I Decline to Answer**

ETHNICITY

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Varicose to Perfect to release any medical information to process a medical claim. I understand that I am financially responsible for any and all charges rendered at the time of my office visit, testing or procedure and that fees may be collected on the day services are received. If for any reason it becomes necessary to initiate collection proceedings, I understand that I am responsible for the cost of all treatments received, as well as any and all legal or collection fees that occur at Varicose to Perfect.

Patient Signature		**Date**	

PRIMARY INSURANCE

PLAN NAME:	
POLICY #:	GROUP#:
POLICY HOLDER NAME:	
POLICY HOLDER DATE OF BIRTH:	SSN:
POLICY HOLDER RELATIONSHIP TO PATIENT:	
POLICY HOLDER EMPLOYER:	

SECONDARY INSURANCE

PLAN NAME:	
POLICY #:	GROUP#:
POLICY HOLDER NAME:	
POLICY HOLDER DATE OF BIRTH:	SSN:
POLICY HOLDER RELATIONSHIP TO PATIENT:	
POLICY HOLDER EMPLOYER:	

FINANCIAL POLICY

We are committed to providing you with the best possible medical care. If you have special needs, we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

1). Varicose to Perfect participates with a variety of insurance plans. It is your responsibility to:

- ❑ Bring your insurance card to every visit;
- ❑ Be prepared to pay your co-pay at each visit. Payment may be made by cash, check or credit card;
- ❑ For medical care NOT COVERED under your insurance , payment in full is due at the time of service.

2). If you have insurance that we do not participate in, our office is happy to file the claim upon request; however, payment in full is due at the time of service.

3). If you are unable to pay for necessary medical care, you may be eligible for financial assistance. It is ***your*** responsibility to inform us ***prior*** to receiving services.

4). It is your responsibility to bring any required referrals for treatment at, or prior to the visit. If you do not have a referral, your visit may be rescheduled, ,or you may be held financially responsible.

5). If you have questions about your insurance, we are happy to assist you. Specific coverage questions or issues should be directed to your insurance company member services department (the phone number is generally listed on the back of your card).
6). If you fail to make payment in full for the services that are rendered to you, your outstanding balance will be sent to a collection agency. You will be held responsible for the fees assessed by the collection agency.

Varicose to Perfect firmly believes that a good physician/patient relationship is based upon understanding and good communication. Questions about financial arrangements should be directed to our billing department.

Your signature below indicates that you have read, fully understand and agree to this Financial Policy.

Patient Signature		**Date**	

CANCELLATION & NO SHOW POLICY

There will be a $25.00 charge for "NO SHOW" office or ultrasound appointments or appointments that are not cancelled within 24 hours prior to appointment time. We require that you notify the office 24 HOURS PRIOR TO YOUR SCHEDULED APPOINTMENT TIME in the event you will be unable to keep an appointment. Otherwise a $25.00 charge will be assessed to you, the patient.

Your signature below indicates that you have read, fully understand and agree to this Cancellation & No Show Policy.

Patient Signature		**Date**	

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- ❑ Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- ❑ Obtain payment from third party payers.
- ❑ Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received Varicose to Perfect's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Varicose to Perfect has the right to change its *Notice of Privacy Practices* from time to time and that I may contact

Varicose to Perfect at any time at the address listed to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that Varicose to Perfect restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that Varicose to Perfect is not required to agree to my requested restrictions, but if Varicose to Perfect does agree then such restrictions are binding and must be honored.

On occasion, it may be necessary to release clinical information to outside physicians, radiological institutions, laboratories, etc that you have been referred to by, Varicose to Perfect, to aide in your coordination of care. We will not release your information to any third parties.

DESIGNATION OF CERTAIN RELATIVES, CLOSE FRIENDS AND OTHER CAREGIVERS AS MY PERSONAL REPRESENTATIVE

I agree that Varicose to Perfect may disclose certain pieces of my health information to a Personal Representative f my choosing, since such person is involved with the healthcare or payment relating to my healthcare. In that case, Varicose to perfect will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare.

Name		**Relationship**	
Date of Birth		**Primary Phone #**	

Name		**Relationship**	
Date of Birth		**Primary Phone #**	

The following person(s) **ARE NOT AUTHORIZED** to received by Patient Health Information

Print Name:
Print Name:

Patient Signature:	
Patient Name Printed:	**Date:**
Relationship to Patient (if not self):	

SUMMARY NOTICE OF PRIVACY PRACTICES

Varicose to Perfect
572 N. Main Street, Springboro, Ohio 45066
5538 Philadelphia Drive, Dayton, Ohio 45415
Phone: 937/748-8905 Fax: 937/748-8906
Privacy Officer: Jodi Jacobs

Effective Date: January 20, 2015

This Notice describes how medical information about you may be used and disclosed and how you can gain access to this information. ***Please review it carefully.***

We understand that the health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office, whether made by your personal physician or others working in this office. This Notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that the health information that identifies you is kept private;
- Provide you with this Notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the Notice that is currently in effect.

How we may use and disclose health information about you:

- For treatment
- For Payment
- For health care operations
- For appointment reminders
- As required by Law
- To avert a serious threat to health and safety
- As required by the Military, Veterans Administration and/or Workers Compensation
- Public Health Risks
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- Coroners, health examiners and funeral directors
- National Security and Intelligence activities
- Security Officials for Inmates

- Organ and Tissue Donation
- Business Associates
- Judicial and Administrative Proceedings

Your rights regarding Health Information about you:

- Right to Request Restrictions
- Right to Request Confidential Communications
- Right to Inspect and Copy
- Right to a Summary of PHI
- Right to an Electronic Copy of PHI
- Right to Breach Notification
- Right to Request Amendment
- Right to an Accounting of Disclosures
- Right to a Paper or Electronic Copy of this Notice

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We reserve the right to change this Notice. You have the right to obtain a copy of our most recent Notice in effect. Please ask a Front Office staff member if you wish to receive a full copy of our current Notice of Privacy Practices. It is made available to you in our waiting area.

Acknowledgement of Receipt of this Notice

We will request that you sign a separate form acknowledging you have received a copy of this notice. This acknowledgment will become part of your record. This acknowledgement provides that you have declined to accept the Complete Notice and instead requested the Summarized Notice.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact the Privacy Officer to file a complaint.

Varicose To Perfect
Aberdeen Varicose Veins Questionnaire (AVVQ)

The AVVQ form must be completed at baseline, 6 weeks, 6 months and 12 months.

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

Date Questionnaire Completed: _____

Please check one of the following:

- ❑ Baseline
- ❑ 6 Week Follow Up
- ❑ 6 Month Follow Up
- ❑ 12 Month Follow Up

**** Please answer ALL 13 Questions****

1). Please see chart for review of digital images.

2). In the last 2 weeks, how many days did your veins cause pain or aching?

	Right Leg	Left Leg
None at All	_____	_____
Between 1 and 5 Days	_____	_____
Between 6 and 10 Days	_____	_____
For more than 10 Days	_____	_____

3). During the last 2 weeks, on how many days did you take pain killing medication for your varicose veins?

	Right Leg	Left Leg
None at All	_____	_____
Between 1 and 5 Days	_____	_____
Between 6 and 10 Days	_____	_____
For more than 10 Days	_____	_____

4). In the last 2 weeks, how much ankle swelling have you had?

	Right Leg	Left Leg
None at All	_____	_____
Between 1 and 5 Days	_____	_____
Between 6 and 10 Days	_____	_____
For more than 10 Days	_____	_____

5). In the last 2 weeks, have your worn support stockings or tights?

	Right Leg	Left Leg
None at All	_____	_____
Between 1 and 5 Days	_____	_____
Between 6 and 10 Days	_____	_____
For more than 10 Days	_____	_____

6). In the past 2 weeks, have you had any itching in association with your varicose veins?

	Right Leg	Left Leg
None at All	_____	_____
Between 1 and 5 Days	_____	_____
Between 6 and 10 Days	_____	_____
For more than 10 Days	_____	_____

7). Do you have purple discoloration caused by tiny blood vessels in the skin, in association with your varicose veins?

	Right Leg	Left Leg
None at All	_____	_____
Between 1 and 5 Days	_____	_____
Between 6 and 10 Days	_____	_____
For more than 10 Days	_____	_____

8). Do you have a rash in the ankle area?

	Right Leg	Left Leg
None at All	_____	_____
Between 1 and 5 Days	_____	_____
Between 6 and 10 Days	_____	_____
For more than 10 Days	_____	_____

9). Do you have a skin ulcer associated with your varicose veins?

	Right Leg	Left Leg
None at All	_____	_____
Between 1 and 5 Days	_____	_____
Between 6 and 10 Days	_____	_____
For more than 10 Days	_____	_____

10). Does the appearance of your varicose veins cause you concern?

- ❑ No
- ❑ Yes, their appearance causes me slight concern
- ❑ Yes, their appearance causes me moderate concern
- ❑ Yes, their appearance causes me a great deal of concern

11). Does the appearance of your varicose veins influence your choice of clothing including tights?

- ❑ No
- ❑ Occasionally
- ❑ Often
- ❑ Always

12). During the last 2 weeks, have your varicose veins interfered with your work/housework or other activities?

- ❑ No
- ❑ I have been able to work but my work has suffered to a slight extent
- ❑ I have been able to work but my work has suffered to a moderate extent
- ❑ My veins have prevented me from working on day or more

13). During the last 2 weeks, have your varicose veins interfered with your leisure activities (including sports, hobbies and social life)?

- ❑ No
- ❑ Yes, my enjoyment has suffered to a slight extent
- ❑ Yes, my enjoyment has suffered to a moderate extent
- ❑ Yes, my veins have prevented me from taking part in any leisure activities

Thank You for your participation!!!

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

Medical History (Symptoms & Conditions)

Please check the appropriate box(es) below if you have (or have had in the past) **ANY** of the following:

CARDIAC/VASCULAR

___ Aortic Stenosis
___ Abnormal EKG
___ Cardiac Arrest
___ Congestive Heart Failure
___ Coronary Artery Disease
___ Heart Attack: Date: _____
___ Heart Murmur
___ Pericardial Effusion
___ Pericarditis
___ Arrhythmia

___ Aneurysm
___ Carotid Stenosis
___ TIA/CVA
___ DVT
___ Gangrene
___ Claudication
___ Ulceration: Location: _____
___ PAD/PVD
___ Raynaud's Disease
___ Renal Artery Stenosis
___ Subclavian Stenosis
___ Thoracic Outlet Syndrome
___ Thrombophlebitis
___ Varicose Veins
___ Venous Insufficiency

GENERAL

___ Alzheimers
___ Anemia
___ Asthma
___ Blood Thinners
___ Cancer
Type _____
___ COPD
___ Depression
___ Diabetes
___ Dyspnea
___ Edema/Swelling
___ GERD
___ GI Bleed
___ Hemorrhage
___ Hepatitis
Type _____
___ HIV
___ Hyperlipidemia
___ Hypertension
___ Hypotension
___ Liver Disease
___ Lymphedema
___ Erectile Disorder
___ Menopause
___ Obesity
___ Palpitations
___ Neuropathy
___ Pleural Effusion
___ Pregnancy
___ Pulmonary Embolism
___ Renal Disease
___ Seizure Disorder
___ Shortness of Breath
___ Sleep Apnea
___ Syncope
___ Thyroid Disorder
___ Vertigo
___ Other
___ No Significant Medical History

SOCIAL HISTORY

___ Alcohol Use
___ Drug Use
Type: _____
___ Tobacco Use

FAMILY HISTORY

___ Aneurysm
___ Coronary Artery Disease
___ Cancer
___ Diabetes
___ Pulmonary Disease
___ Premature Heart Disease
___ Stroke
___ Rhythm Disorder
___ Sudden Cardiac Death
___ Varicose Veins

Surgical History

___ No Significant Surgical History

GENERAL

___ Advanced Reaction to Anesthesia
___ Easy Bruising Tendancy
___ Easy Bruising

FEMALE

___ Breast Surgery
___ Hysterectomy
___ Tubal Ligation
___ Cesarean Section

MALE

___ Prostate Surgery

GASTRO

___ Appendectomy
___ Gallbladder Surgery
___ Hernia Repair
___ Upper EGD
___ Colonoscopy
___ Sigmoidoscopy
___ Colectomy
___ Ileostomy
___ Hemorrhoidectomy
___ Small Bowel Resection
___ Colostomy

VENOUS PROCEDURES

___ Cosmetic Injections ___Right ___ Left
___ Vein Stripping ___ Right ___ Left
___ Ambulatory Phlebectomy ___ Right ___ Left
___ Vein Ligation ___ Right ___ Left
___ Endovenous Radiofrequency Ablation
___ Right ___ Left
___ Endovenous Laser Ablation
___ Right ___ Left

MUSCULOSKELETAL

___ Back Surgery
___ Hip Replacement
___ Knee Replacement
___ Rotator Cuff Repair

OTHER

___ Lung Surgery
___ Tonsils/Adenoids
___ Nephrectomy
___ Lithotripsy
___ Cataract Surgery
___ Chemotherapy

CARDIOVASCULAR

___ Cardiac Cath
___ PTCA/stent
___ CABG
___ Valve Replacement
___ Pacemaker Implant
___ ICD (Defibrillator) Implant
___ AAA/TAA Stent Placement
___ Aneurysm Repair
___ Carotid Stent
___ Carotid Endarterectomy
___ Renal Angiogram/PTA/stent
___ Lower Extremity Angiogram/PTA/stent
___ Lower Extremity Bypass
___ Amputation