VARICOSE TO PERFECT

572 N. MAIN STREET SPRINGBORO, OH 45066   5538 PHILADELPHIA DRIVE DAYTON, OH 45415
PHONE: 937-748-8905   FAX: 937-748-8906

First Name: ______________________________ MI:_____ Last Name: __________________________________

Address: ____

City: ____ State: _________ Zip Code:_________________

SSN: ____________________________________ Date of Birth: _________________ Gender: M   F

Primary Phone: ____________________________________ Cell: ______________________________________

Preferred Pharmacy: ____

Primary Care Physician: ____

How did you hear about us? ____

Preferred Language:____

Emergency Contact: ___________________________ Relationship: _____________ Phone: _________________

INSURANCE INFORMATION

Primary Insurance: ____

Subscriber Name (if other than self): ____

Subscriber Date of Birth (if other than self): ____

Secondary Insurance: ____

Subscriber Name (if other than self): ____

Subscriber Date of Birth (if other than self): ____

Authorization to release information:

I hereby authorize Varicose To Perfect to release any medical information to process all medical claims. I understand that I am financially responsible for any and all charges incurred at the time of my office visit, testing or procedure and that fees may be collected on the day services are rendered. 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 fees that occur at Varicose To Perfect.

Patient SIgnature: ____ Date: ______________

Patient Name: ____ Date of Birth: ___________

MEDICAL AND SURGICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

CARDIAC/VASCULAR

___NO SIGNIFICANT HISTORY
___aortic stenosis
___abnormal EKG
___cardiac arrest
___congestive heart failure
___heart attack
___heart murmur
___pericardial effusion
___pericarditis
___arrhythmia
___aneurysm
___carotid stenosis
___TIA/CVA
___DVT
___gangrene
___claudication
___ulceration
___PAD/PVD
___raynauds disease
___subclavian stenosis
___thoracic outlet syndrome
___varicose veins
___venous insufficiency
___A-Fib

GENERAL

___alzheimers
___anemia
___asthma
___blood thinner
___cancer
___COPD
___depression
___diabetes
___dyspnea
___edema/swelling
___GI bleed
___GERD
___hepititis - type___
___hyperlipidema
___hypotension
___lymphodema
___menopause
___palpitations

___ pleural effusion
___pregnancy
___pulmonary embolism
___renal disease
___seizure disorder
___sleep apnea
___syncope
___thyroid disorder
___vertigo
___hemorrhage
___HIV
___hypertension
___liver disease
___liver disease
___erectile disorder
___obesity
___neuropathy

SOCIAL HISTORY

___ alcohol use
___tobacco use
___drug use __________

FAMILY HISTORY

___varicose veins
___coronary artery disease
___diabetes
___pulmonary disease
___stroke
___cancer
___aneurysm
___rhythm disorder

SURGICAL HISTORY

___no significant surgical history
___breast surgery
___hysterectomy
___c-section
___prostate surgery
___appendectomy
___gallbladder surgery
___hernia repair
___colonoscopy

___cardiac cath
___PTCA/stent
___CABG
___valve replacement
___pacemaker
___ICD implant
___AAA stent/repair
___carotid stent/endarterectomy
___lower extremity angiogram

___back surgery
___knee replacement
___rotator cuff repair
___lung surgery
___nephrectomy
___lithotripsy
___amputation
___renal angiogram/stent
___lower extremity bypass

NAME ____

Venous History

Past Medical History:

1. Have you ever had vein procedures? Yes ___ No ___ Type of procedures/Dates__________________

____

2. Have you ever had vein injections? Yes ___ No ___ Cosmetic or non-cosmetic/Dates_______________
3. Have you ever had a blood clot? Yes ___ No ___ When/Location _____________________________
4. Have you ever had a pulmonary embolism? Yes ___ No ___ When ____________________________
5. Have you ever had phlebitis? Yes ___ No ___ When/Location _______________________________
6. Have you ever had bleeding varicose veins? Yes ___ No ___ When/Location ___________________
7. Have you ever had migraines? Yes ___ No ___ When/How often _____________________________

Family History: (M) mother (F) father (S) sister (B) brother (CM) child male (CF) child female

Varicose veins ____ Spider veins ____ Deep vein clot ____ Stroke ____ Blood clotting disorder ____

Pulmonary Embolism ____

Current Vein History: Do you experience any of the following symptoms in your legs?

Pain/aching	Right ____	Left ____
Heaviness	Right ____	Left ____
Tiredness/fatigue	Right ____	Left ____
Cramping	Right ____	Left ____
Itching/burning	Right ____	Left ____
Swelling/edema	Right ____	Left ____
Restless legs	Right ____	Left ____
Skin discoloration	Right ____	Left ____
Bleeding	Right ____	Left ____
Sores/Ulcers	Right ____	Left ____
Slow healing wounds	Right ____	Left ____
Which leg bothers you the most	Right ____	Left ____

Have you taken any pain medication for relief of symptoms in your legs?

Aspirin ____ Ibuprofen ____ Aleve ___ Tylenol ___ Other ______________________________

Do you elevate your legs to relieve your leg symptoms? Yes ____ No ____

Do your vein/leg symptoms interfere in your daily activities? Yes ____No ____

Have you ever worn compression stockings? Yes ___ **For how long?** _______________ No ____

Have you done any of the following to help with your symptoms? Exercise _____ Weight loss _____

PATIENT NAME____ DATE OF BIRTH_____________

PLEASE FILL THIS QUESTIONNAIRE OUT COMPLETELY

CHOOSE ONE:

___BASELINE ___3 MONTHS ___6 MONTHS ___12 MONTHS

1. In the past 2 weeks, how many days did your veins cause you pain or itching?

	LEFT LEG	RIGHT LEG
None at all	_________	_________
Between 1-5 days	_________	_________
Between 6-10 days	_________	_________
More than 10 days	_________	_________

2. During the last 2 weeks, how many days did you take pain meds for your veins?

	LEFT LEG	RIGHT LEG
None at all	_________	_________
Between 1-5 days	_________	_________
Between 6-10 days	_________	_________
More than 10 days	_________	_________

3. In the last 2 weeks did you have any ankle swelling?

	LEFT LEG	RIGHT LEG
None at all	_________	_________
Between 1-5 days	_________	_________
Between 6-10 days	_________	_________
More than 10 days	_________	_________

4. In the last 2 weeks have you worn compression stockings?

	LEFT LEG	RIGHT LEG
None at all	_________	_________
Between 1-5 days	_________	_________
Between 6-10 days	_________	_________
More than 10 days	_________	_________

5. In the past 2 weeks have you had any itching associated with your varicose veins?

	LEFT LEG	RIGHT LEG
None at all	_________	_________
Between 1-5 days	_________	_________
Between 6-10 days	_________	_________
More than 10 days	_________	_________

6. Do you have any spider veins?

	LEFT LEG	RIGHT LEG
None at all	_________	__________
Between 1-5 days	_________	__________
Between 6-10 days	_________	__________
More than 10 days	_________	__________

7. Have you experienced any rash at your ankles?

	LEFT LEG	RIGHT LEG
None at all	_________	__________
Between 1-5 days	_________	__________
Between 6-10 days	_________	__________
More than 10 days	_________	__________

8. Do you have any ulcerations?

	LEFT LEG	RIGHT LEG
None at all	_________	__________
Between 1-5 days	_________	__________
Between 6-10 days	_________	__________
More than 10 days	_________	__________

9. Does the appearance of your varicose veins concern you?
   ___No ___Yes slightly ___Yes moderately ___Yes greatly

10. Does the appearance of your varicose veins influence your clothing choice?
    ___No ___ occasionally ___often ___always

11. During the last 2 weeks have your varicose veins interfered in your activities of daily living, such as work, chores or travel?
    ___No ___Yes slightly ___Yes moderately ___Yes greatly

12. Do you have migraines?
    ____No ____Yes If Yes, please answer the following questions.

    When was the last time you had a migraine? ___________________________________
    Do you experience an aura with your migraines? ________________________________
    Do you take medication for your migraines? _____________________________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and 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 them at a 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 healthcare 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 aid in your coordination of care. We will not release your information to any third parties.

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

I agree that Varicose To Perfect may disclose certain pieces of my PHI to a personal representative of my choosing since that 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 personal involvement with my healthcare or payment relating to my healthcare.

Name:________________________________ Relationship: _____________ Phone: ____________________

Name: _______________________________ Relationship:______________ Phone: ____________________

THE FOLLOWING PERSON(S) ARE NOT AUTHORIZED TO RECEIVE MY PHI

Name: ____

Name: ____

Patient Signature: ____

Patient Name Printed: ____Date: __________

FINANCIAL POLICY

Thank you for choosing Varicose To Perfect as your healthcare provider. We are committed to building a successful physician - patient relationship with you. Your clear understanding of our patient financial policy is important to our professional relationship. Please understand that payment for services is part of that relationship. Please ask if you have any questions about our fees, our policies or your responsibilities. It is your responsibility to notify our office of any patient information changes such as address, name, and insurance information.

Copays:

All copayments and past due balances are due at the time of check-in unless previous arrangements have been made with our billing coordinator. We accept cash checks or credit cards. No post dated checks will be accepted.

Insurance Claims:

Insurance is a contract between you and your insurance company. In some cases we may not be a party to this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all accurate and current information including primary and secondary coverage at the time any services are rendered. Failure to provide complete and accurate insurance information may result in patient responsibility for the entire bill. Although we may estimate that your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company does not pay for any of your services performed at Varicose To Perfect, you will be responsible for the complete balance. If we are out of network with your insurance company and your insurance company pays you directly, you are responsible for payment and agree to forward the payment to Varicose To Perfect within 15 days of receipt.

Missed Appointments:

We require a 24-hour notice appointment cancellation. Appointments missed or canceled with less than 24 hours notice may be charged the following fees:

- Office visit $25
- Ultrasound $50
- Procedure $200

Returned Checks

The charge for a return check is $25 payable by cash, money order or credit card. You will owe this in addition to the original amount that was owed.

Outstanding Balance Policy

It is our office policy that all past due accounts are sent three statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency which may result in discharge from our practice. In the event an account is turned over for collection the person financially responsible for the account will be responsible for all collection costs including any associated fees. Regardless of any personal arrangements that a patient made or might have outside of Varicose To Perfect if you are over 18 years of age and received treatment you are ultimately responsible for payment of services. Our office will not bill a secondary party.

I, ____ have read and understand the above Financial Policy and understand my financial responsibility to Varicose To Perfect.

Patient SIgnature: ____ Date: ____________