Elite Vein Institute
Intelligent Medicine at Work

Patient Information

Last Name: _____ First Name: _____ M.I:_____

Date of Birth: _____ Age: _____ Sex: _____ Email address: _____

Street Address: _____ City: _____ State: _____

Home phone #:_____ Cell Phone #:_____
Preferred Method of contact: Home Cell Email (choose one)

Occupation: _____ Employer: _____ Work Phone #:_____

Primary Care Physician: _____ Phys. Phone #:_____

Emergency Contact: _____ Phone #:_____ Relationship: _____

Insurance Information

PLEASE HAVE ALL INSURANCE CARDS AVAILABLE FOR PHOTOCOPYING

Primary Insurance

Company : _____ Policy or ID #:_____ Group #_____

Policy Holder's Name: _____ DOB: _____ Relationship :_____

Employer's name: _____

Secondary Insurance

Company : _____ Policy or ID #:_____ Group #_____

Policy Holder's Name: _____ DOB: _____ Relationship :_____

Employer's name: _____

How did you hear about Elite Vein Institute? □Doctor referral □Family/Friend referral □ Internet Search
□ Chamber of Commerce □ Other : _____

Payment Policy Statement: Payment at the time of our services is necessary unless you are insured by a PPO, Medicare PPO, or an approved insurance carrier that we bill directly. All deductibles, co-insurance, co-pays, and services that are not covered by your plan are your responsibility. Elite Vein Institute accepts cash, checks, Visa, Mastercard, American Express, Discover Cards, Care Credit and FSA/HSA spending cards. Refer to page 5 of this packet for further financial policies.

Authorization and Assignment: I hereby consent to any necessary medical treatment/physical examination required by myself or the minor above for whom I am legally responsible. I permit payment directly to Elite Vein Institute for any benefits due for the services rendered. I understand that I am financially responsible for all charges, whether or not covered by my insurance company.

Medical Records: Authorization is hereby granted for release of any information required to process my insurance claims. Regardless of any claim pending, you will receive periodic statements if your account has an outstanding balance. We cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.

Patient or Legal Guardian Signature: _____ Date : _____

Personal Health History

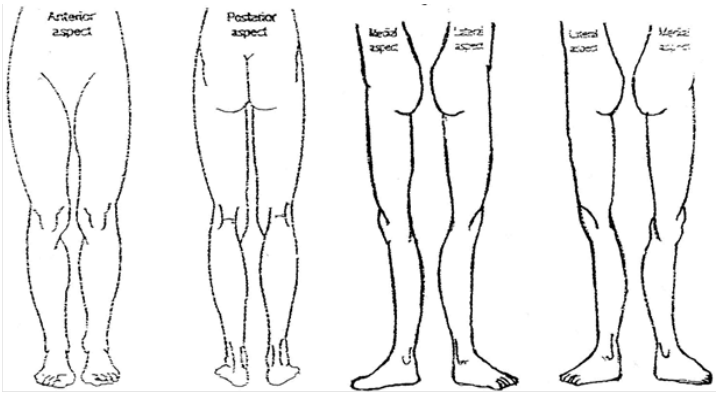
Patient Name: _____ DOB: _____ Age: _____

What is the reason for your visit today? □ Spider Veins □ Varicose Veins □ Both □ Other : _____

When did you first notice this problem? _____

Are you consulting for: □ Medical purposes □ Cosmetic purposes □ Both

In the picture below please draw or shade the bothersome areas



Please indicate if you have experienced:

Leg pain	□ Right	□ Left
Leg heaviness	□ Right	□ Left
Leg Fatigue	□ Right	□ Left
Ankle/Leg Swelling	□ Right	□ Left
Restless Legs	□ Right	□ Left
Ankle Skin Discoloration	□ Right	□ Left
Itching	□ Right	□ Left
Leg Ulceration	□ Right	□ Left
Phlebitis	□Right	□ Left
Varicose Vein ruptured or bleeding	□ Right	□ Left
DVT (blood clot)	□ Right	□ Left

When are your symptoms the worst?

□ At the end of the day □ After prolonged sitting
□ After prolonged standing □ During menstruation
□ When walking □ When heat is applied

What brings/has brought relief to your symptoms?

□ Leg elevation □ Hot / Cold Pack □ Exercise □ Weight Loss
□ Compression stockings □ Supplements □ Medication □ Other:_____

Do your symptoms interfere with your lifestyle or work? □ YES □ NO

-What is your occupation? _____
- Does your occupation require long periods of sitting or standing? □ YES □ NO

Do you presently wear compression stockings? □ YES □ NO

- If yes, how long? _____
- Were they doctor prescribed? □ YES □ NO

Personal Health History Cont'd

Have you had any prior vein treatments? *If so, what year?*

□ Sclerotherapy : _____ □ Foam Sclerotherapy : _____ □ Vein Stripping Surgery : _____

□ Phlebectomy : _____ □ EVLT : _____ □ Laser (spider veins) : _____

□ Radiofrequency Ablation : _____ □ Clarivein MOCA Ablation : _____ □ Other : _____

Height _____ Weight_____LBS

Please list ALL Health Conditions / Medical Problems and the year which they presented:

1) _____ , began in _____
2) _____, began in _____
3) _____ , began in _____
4) _____, began in _____

Please list ALL Surgeries or Major Hospitalizations and the year which they occurred:

1) _____ , occurred in _____
2) _____, occurred in _____
3) _____ , occurred in _____
4) _____, occurred in _____

Please list all Allergies you have (include Medications, Foods, Detergents, etc.) and the type of reaction you have:

1) _____ Reaction : _____
2) _____ Reaction : _____
3) _____ Reaction : _____
4) _____ Reaction : _____

Are you allergic to latex? □ YES □ NO
Are you allergic to adhesive tapes? □ YES □ NO
Are you allergic to Lidocaine? □ YES □ NO
Are you allergic/sensitive to iodine? □ YES □ NO

Please list all prescribed drugs and over-the-counter drugs (such as vitamins and supplements) you currently take:

1) _____ Strength: _____ Frequency Taken: _____
2) _____ Strength: _____ Frequency Taken: _____
3) _____ Strength: _____ Frequency Taken: _____
4) _____ Strength: _____ Frequency Taken: _____

(Please use blank back of page to list any additional medications and their strength/frequency)

Are you currently taking aspirin as part of a health regimen? □YES □ NO
Are you taking Plavix, Aggrenox, Lovenox, or Coumadin? □ YES □ NO
Are you taking any over-the-counter blood thinning agents such as Vitamin E or Gingko Biloba? □YES □ NO

Personal Health History Cont'd

Have you received your Influenza vaccination (Flu Shot) for this season? □ YES □ NO

*If yes, when?*_____

Have you received your Pneumonia vaccination? □ YES □ NO

*If yes, when?*_____

What type of exercise do you regularly engage in?

□ Mild Exercise (climbing stairs, walking small distances, golf) □ Occasional exercise (less than 4x per week for 30 min)

□ Regular vigorous exercise (4x per week or more for 30 min) □ Sedentary (No exercise)

Do you use tobacco products? (Ie. Cigarettes, Vaporizors, Hookah, Cigars, Dip) □ YES □ NO

If yes, in what frequency/amount: _____ per day/week/month (circle one)

Do you drink alcohol? □ YES □ NO If yes, how many drinks per week? _____

Family Health History

Do you have a FAMILY history of spider or varicose veins? □ YES □ NO

Do you have a FAMILY history of Deep Vein Thrombosis or any other blood clotting disorders? □ YES □ NO

Do you have a FAMILY history of leg ulcers relating to leg pain? □ YES □ NO

NOTICE OF PRIVACY PRACTICES

This notice is required by the Privacy Regulations created as a result of the Health Information Portability and Accountability Act of 1996 (HIPAA). The Department of Health and Human Services established a "Privacy Rule" to help insure that personal health information is protected for privacy. The Privacy Rule was also created to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate, the law allows us to provide the minimum necessary information to those we feel in need of your health care information for your treatment, payment or healthcare operations. Authorization will be required from you to disclose your healthcare information to any other third party other than those just described. You have the right to inspect and copy your personal medical and billing records. If you request copies, a fee may be charged for printing and mailing. If you believe information is incorrect or incomplete in your records you may ask for a correction. All requests for correction must be submitted in writing and signed by the patient. We will consider your request but are not required to accept it.

You have the right to ask for a list of instances when we have disclosed your medical information for reasons other than your treatment, payment, or health operations. Your request must be in writing and must state the time period from which you want to receive a list of disclosures. The time period may not exceed six years and may not include dates prior to April 13 2003. A fee may be charged if you ask for this information more than once every twelve months.

We reserve the right to change privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and a copy will be made available to you.

I hereby acknowledge that I have read and understand Elite Vein Institute's Notice of Privacy Practices

Print Name : _____ DATE : _____

Signature : _____ DATE : _____

Cancellation Policy

If you are scheduled for a procedure (RF Ablation, MOCA Ablation, Foam Closure, Venaseal) we require any cancellations to be made *AT LEAST 72 hours in advance*. If you cancel without 72-hour notice or do not show up for a surgery appointment you will be subject to a $200 surgical fee.

If you are scheduled for sclerotherapy or an ultrasound we require any cancellations to be made *AT LEAST 24 hours prior to the appointment*. If you cancel less than 24 hours before your appointment, or do not show at all, you will be subject to a $50 missed appointment fee.

If you schedule and do not show up for more than three appointments Elite Vein Institute reserves the right to refuse services and may refer you to another provider for treatment.

I understand Elite Vein Institute's cancellation policy for both surgical and regular appointments. I further understand that failure to show up for any appointment may result in cancellation fees being charged. I consent to scheduling appointments with Elite Vein Institute under these guidelines.

Patient or Legal Guardian Printed Name: _____ DATE : _____

Patient or Legal Guardian Signature: _____ DATE : _____

Financial Agreement

(Please note: All blank spaces must be initialed and bottom signed by patient or legal guardian.)

_____ I understand it is MY responsibility to check my benefits and eligibility with my insurance company prior to any appointments. Although Elite Vein Institute staff performs regular insurance checks for each patient, I understand I may not hold them responsible for any information given to me regarding my personal insurance plan and that Elite Vein Institute cannot guarantee payment from my insurance company for any service or procedure.

_____ I understand that it is MY responsibility to notify Elite Vein Institute staff if I have made any changes to my health insurance.

_____ I understand that my deductible, co-pay, and co-insurance will be due at the time of my appointments.

_____ I understand that if my insurance claim has not been paid to Elite Vein Institute within 45 days of my date of service, I will be notified and asked to help in contacting my insurance company to arrange and/or facilitate timely payment.

_____ I understand that if my insurance claim has not been paid to Elite Vein Institute within 90 days of my date of service, I will be held responsible for the payment of the appointment. I further understand that once my insurance company finalizes payment to Elite Vein Institute for the date of service, I will be compensated or credited for any overpayment.

_____ I understand that any amount owed by me on my account for more than 30 days must be paid prior to booking any additional appointments.

_____ I understand that any amount owed by me on my account for more than 60 days is subject to a one-time $20 late payment fee.

_____ I understand that I will be charged $35 for any returned checks.

In signing this document I acknowledge that I have read, initialed, and understand Elite Vein Institute's Financial policy. All my questions have been answered to my satisfaction and I agree to the terms outlined above.

Patient or Legal Guardian Printed Name: _____ DATE : _____

Patient or Legal Guardian Signature: _____ DATE : _____