The Vein Institute of Phoenix

HEALTH & HISTORY FORM

Today's Date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐	
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F	
Street address:		Social Security no.:		Home phone no.: ( )		
P.O. box:	City:	State:	ZIP Code:			
Occupation:	Employer:	Employer phone no.: ( )				
PCP:	Office Name:	Phone:				
How did you hear about us?						
☐ PCP (listed above)	☐ Cardiologist / Vascular:	☐ Dermatologist:	☐ Orthopedist/ Podiatrist:	☐ Other:		
MAY WE SEND A REPORT? YES / NO	Other family members seen here:					

SYMPTOMS

Reason for your visit today: _____ **Years with Spider Veins or Varicose Veins:** _____

Please check if you have had or currently have any of the following in your legs or ankles:

☐ Hurt/Pain/Throb/Ache/Burn ☐ Tired/ Heavy Feeling ☐ Cramping ☐ Other: _____

☐ Leg Swelling ☐ Itch ☐ Restless Legs _____

Please check if you have had or currently have any of the following:

☐ Leg Swelling ☐ Skin Color Changes Below Knee ☐ Bleeding from the Visible Veins ☐ Other: _____

☐ Visible Veins ☐ Sores/ Ulcers Below Knee ☐ Blood Clots in your legs _____

Please tell us how your signs and symptoms **Negatively** affect your **daily life and activities**: (Please give us at least **TWO** examples) *Ex: Pain in legs while shopping, cooking, walking, running, working etc…*

Example: _____

Example: _____

Example: _____

Please tell us about any and all methods you have used to help with the discomfort in your legs:

☐ Elevation of Legs

☐ Exercise: Walking or running

☐ Use of: Tylenol / Ibuprofen / Advil *

Duration: ☐ 3-5 months ☐ 6-12 months ☐ Years: _____

☐ Other: _____

☐ Use of Support / Compression Stockings: * (Medical Grade)

☐ Given by Physician: _____ ☐ Over the counter

Duration: ☐ 3-5 months ☐ 6-12 months ☐ Years: _____

Type: ☐ Panty Hose ☐ Thigh High ☐ Knee High

Results: _____

PT Signature: _____

PAST MEDICAL HISTORY

Please tell us about an PREVIOUS VEIN TREATMENTS:

☐ Treatment done by: _____ ☐ What Clinic: _____

Treatment Method:

☐ Injections (Sclerotherapy) ☐ EVLT (laser procedure for Varicose Veins) ☐ Plebectomy (removal of veins)

☐ Laser for Spider Veins ☐ Stripping / Surgery ☐ Stents/ Filters: _____

☐ Other: _____

HISTORY OF SYMPTOMS

☐ Allergies	☐ Easy bruising	☐ Migraine Headaches
☐ Anemia	☐ Heart disease	☐ Mitral valve prolapse
☐ Ankle skin changes	☐ Heart murmur	☐ Pulmonary embolus
☐ Asthma	☐ Hepatitis	☐ Rupture of a vein
☐ Atherosclerosis	☐ HIV	☐Seizures
☐ Bleeding/ blood disorder	☐ Hypertension	☐Stomach ulcer
☐ Chest pain discomfort	☐ Kidney disease	☐ Superficial thrombophlebitis
☐ Crohn's disease, IBS	☐ Leg ulcers	☐ Trauma to legs
☐ Deep vein thrombosis/clot	☐ Liver Disease	☐Thyroid problem
☐Diabetes	☐ Lupus	☐ Other: _____

REVIEW OF SYMTOMS YOU ARE CURRENTLY EXPERIENCING

☐Abdominal pain	☐Fever	☐Pacemaker
☐Anxiety	☐Headaches/Migraines	☐Pelvic Pain
☐Arthritis	☐High Blood Pressure	☐Nausea/ Vomiting
☐Blood Clot	☐Hepatitis	☐Numbness
☐Blood in Urine	☐Insomnia	☐Pacemaker
☐Chest Pain/ Tightness	☐Joint Pain	☐Thyroid
☐Depression	☐Leg ulcers	☐Weakness
☐Diabetes	☐Leg Trauma	☐Visual disturbances
☐Difficulty Breathing	☐Lung Disease	
☐Fatigue		

FAMILY VASCULAR MEDICAL HISTORY

☐History of DVT (Deep Vein Thrombosis or Clotting disorder)
☐History of Varicose Veins

MEDICATIONS / ALLERGIES / SURGICAL HISTORY

Please list all **MEDICATIONS** that you are currently taking with dosage: (☐ SEE LIST)

_____
_____
_____
_____

ALLERGIES:

☐ No Known Drug Allergies (NKDA) ☐ PCN **Skin Allergies:** ☐ Latex ☐ Skin Tape
☐ Drug Allergies: _____
_____

SURGERIES: (List with dates)

_____ _____
_____ _____
_____ _____
_____ _____

PT Signature :_____

SOCIAL HITORY

- ☐ Professional Occupation: _____
- ☐ Employer: _____
- ☐ Tobacco/Cigarette: Per pack usage: #_____/ Day Week Month
- ☐ Alcohol: Per Glass usage: #_____/ Day Week Month
- ☐ Number of Children: _____

FOR WOMEN ONLY

- ☐ Date of last menstrual cycle: _____
- ☐ Trying to become pregnant
- ☐ Currently Pregnant (please inform medical staff)
- ☐ Breast Feeding
- ☐ Number of Pregnancies: _____
- ☐ Number of Miscarriages/ Stillbirths: _____
- ☐ Veins on Vulva or Labia
- ☐ Pelvic Pain or Heaviness / Pelvic Congestion Syndrome

ACKNOWLEDGEMENT

The above information is true to the best of my knowledge.

signature *Date*

Vein Institute of Phoenix

HEALTH INSURANCE INFORMATION

Today's Date:

PATIENT INFORMATION

Patient's last name: First: Middle:			☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐	
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):		Birth date:	Age:	Sex: ☐ M ☐ F
Street address:		Social Security no.:		Home phone no.: ( )		
P.O. box:	City:		State:		ZIP Code:	
Occupation:	Employer:			Employer phone no.: ( )		
PCP:	Office Name:			Phone:		

PRIMARY INSURANCE:		Policy holder:	DOB:
Subscriber ID:	Group ID:	Phone:	
PT Relationship to policy Holder	☐ Self ☐ Spouse ☐ Child ☐ Other: _____		
SECONDARY INSURANCE:		Policy Holder:	
Subscriber ID:	Group ID:	Phone:	
PT Relationship to Policy Holder	☐ Self ☐ Spouse ☐ Child ☐ Other: _____		

DISCLAMER

V.I.P. WILL VARIFY YOUR HEALTH INSURANCE BENEFITS BUT PLEASE UNDERSTAND THAT YOU ARE ULTIMATELY RESPONSIBVLE FOR KNOWING YOUR OWN HEALTH INSURANCE BENEFITS. PAYMENTS NOT COVERED BY YOUR HEALTH INSURANCE COMPANY WILL BE BILLED TO YOU.

ACKNOWLEDGEMENT

I have read and understand the above disclaimer and the above information is true to the best of my knowledge.

signature *Date*

THE VEIN INSITUTE OF PHOENIX

ASSIGNMENT OF BENEFITS & PROMISE TO PAY

I AUTHORIZE The Vein Institute of Phoenix and its Providers to perform medical treatment. I certify that the signature below shall serve as Signature on File for Medicare, Medicaid, and All Health Insurance companies for claims filed on my behalf by The Vein Institute of Phoenix. I assign the benefit payable for physician services and authorize The Vein Institute of Phoenix to submit a claim to Medicare, Medicaid, and all insurance companies for payment. I understand that by signing this agreement, I am authorizing the provision of therapy for varicose veins which may include the following; Consultation, Endovenous Laser Therapy, Ambulatory Phlebectomy, Sclerotherapy and Venous Duplex Ultrasounds while under the care and supervision of my attending physician. I authorize direct payment of any insurance benefits to The Vein Institute of Phoenix, their billing agent, or to any provider of these services. I also authorize my insurance company to furnish to The Vein Institute of Phoenix with any and all information pertaining to my insurance benefits and status of claims submitted for therapy rendered.

AGREEMENT TO PAY

The Vein Institute of Phoenix participates with many insurance plans as a convenience to our patients. Your co-payment and / or deductibles are determined by your insurance company. We are required to collect these fees, to ensure the insurance policy is enforced. Please understand that payment of your bill is considered in part the responsibility of the patient. Payment, according to the policies below, is due at the time of service. "Bounced Checks" will be charged a $25 fee. It is your responsibility to contact us as soon as you are aware that your check has been rejected for payment. All co-pays and / or deductibles, and services not covered by insurance will be collected up front on the day services are rendered. I acknowledge that reasonable efforts will be made to have my insurance pay for this therapy, and that I will be responsible for my deductibles and other fees specific to my insurance plan. In the event that my insurance will not cover this therapy, I agree to be responsible for the full amount of the charges or any remaining balances due after insurance has paid, including any costs or expenses incurred, including a reasonable attorney's fee in collecting such payment. This consent shall be valid for whatever period of time is reasonable, necessary, or until I revoke this consent in writing.

PATIENT WITHOUT INSURANCE: Payment in full is due at the time of service. We will not do any procedures/surgeries without having full payment. Sclerotherapy for Spider Vein Treatment that is cosmetic and is not covered by insurance companies and a claim will not be file with your insurance company. Payment in full will be collected prior to any treatment being rendered. The undersigned certifies the following: that the foregoing text has been read, and that the undersigned is the patient or a duly authorized representative of the patient and as such as is responsible to execute the above and accept its items.

_____ _____

Patient's Signature Date

_____

Staff

Vein Institute of Phoenix

HIPPA CONSENT

Today's Date:

PATIENT INFORMATION

PT Name: _____ DOB: _____/_____/ _____

I hereby authorize the use or disclosure of my personal health information as described below. I understand the information I authorize a person or entity to receive may be re-disclosed and is no longer protected by federal regulations.

Persons within the physicians practice authorized to use or make disclosure of the information: **All EMPLOYEES OF THE VEIN INSTITUTE OF PHOENIX.**

Persons or organizations authorized to revive the information:

- Spouse: ☐ YES ☐ NO Name: _____
- Parent: ☐ YES ☐ NO Name: _____
- Other (Boyfriend/Girlfriend/brother/sister…) Name & Relation:

  _____

Specific description of information disclosed: Any pertinent Medical information, i.e.: Test Results, Referrals, Samples, Prescriptions, Paperwork and Your entire Medical Record.

This information will be used/ disclosed for the following purposes:

- To inform me of my medical conditions(s) by phone, mail email or in person.
- To give information/ referrals/ medical records/ samples/ prescription/ paperwork and test results to you or the person(s) named on this form by phone, mail, email or in person.
- For treatment, payment and health care operations.

This authorization expires on: _____. ☐ N/A

I understand that I may revoke this authorization at any time by notifying the physician's office providing the information in writing. However, the revocation will not be valid, if:

- The physician has taken action in reliance of the authorization.
- This authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

ACKNOWLEDGEMENT SIGNATURE

I have read and understand the above information and with my signature give consent.

signature *Date*

Vein Institute of Phoenix

BEFORE & AFTER PHOTOGRAPH CONSENT

Today's Date:

PATIENT INFORMATION

PT Name: _____ DOB: _____/_____/ _____

Before and after photographs are an important of proof as to the success of your vein procedure(s). V.I.P. does not use these photographs for any other purpose without your consent.
However in many cases patients are contemplating having their vein procedures done, and having the option to look at Before and After photos is very helpful to their decision. For that reason we would like to ask for your permission take photographs and to use these photographs for patient education. Occasionally the photos could be used for medical lectures, some marketing material and on the V.I.P. website.

VIP understands the sensitive nature of these photographs and keeps your identity completely protected at all times.

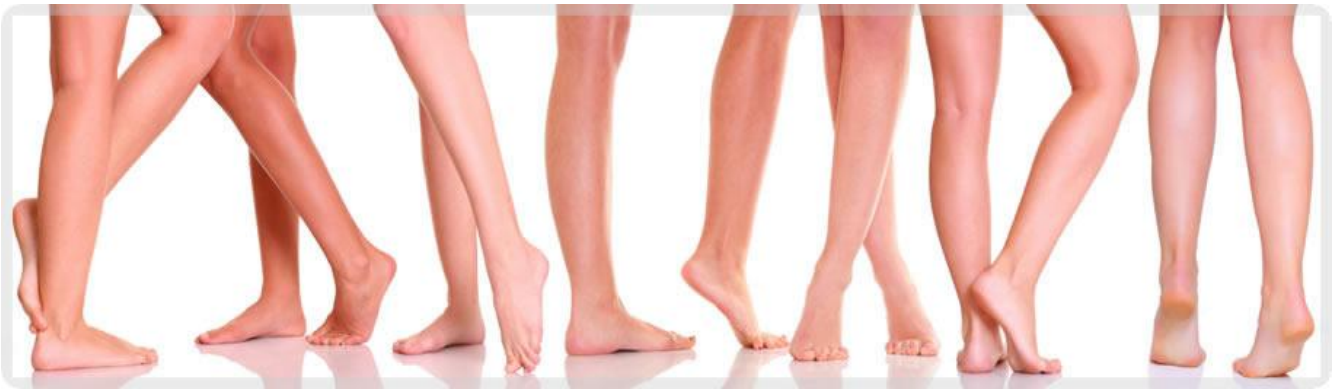
☐ I allow V.I.P. to utilize my photographs for Educational purposes and to help other patients contemplating having venous procedures done.

☐ I allow my photographs to be used on V.I.P.'s website and marketing materials.

☐ I do not want my photographs used for any purpose other than my own treatment process.

☐ I do not want to have any photographs taken.

The photos are also available for you to copy for your own personal collection.



ACKNOWLEDGEMENT SIGNATURE

I have read and understand the above information and with my signature give consent.

signature *Date*

The Vein Institute of Phoenix

Today's Date:						
PATIENT INFORMATION						
Patient's last name:	First:	Middle:	Mr. Mrs.	Miss Ms.	Marital status: Single Mar Div Sep Wid	
Is this your legal name? Yes No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: M F	
Street address:	Social Security no.:	Home phone no.: ( )				
P.O. box:	City:	State:	ZIP Code:			
Records Release From:	**Name:**	**Address:**	**City:**			
Ph:	Fax:	Web:				
Authorized Recipient:	**Name:** The Vein Institute of Phoenix	**Address:** 3200 S. Alma School Rd Suite 204	**City:** Chandler			
Ph: 480-496-2655	Fax: 480-258-6111	Web: www.vipveinsaz.com				
Information Requested:						
Demographics	Procedure Reports	Lab Reports	H&P			
Ultra Sound Report	Progress Notes	X Ray	ANY and ALL			
Reason For Release:						
Transfer of Care	New Insurance	Consult	Referral	Moving		
Other: (Please Explain)						

DISCLAIMER

THIS CONSENT WILL EXPIRE IN 60 DAYS FROM THE DATE IT WAS SIGNED. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME PROVIDING I NOTIFY THE VEIN INSTITUTE OF PHOENIX (V.I.P.) IN WRITING TO THAT EFFECT. I UNDERSTAND THAT ANY RELEASE MADE PRIOR TO MY REVOCATION IS IN COMPLIANCE WITH THIS AUTHORIZATION AND SHALL NOT CONTRIBUTE TO MY RIGHTS OF CONFIDENTIALITY.
I HEREBY RELEASE THE VEIN INSTITUTE OF PHOENIX (V.I.P.) FROM ALL LEGAL RESPOINSIBILITY OF LIABILITY THAT MAY ARISE FROM THE ACT THAT I HAVE AUTHORIZED ABOVE.

ACKNOWLEDGEMENT

I have read and understand the above disclaimer and the above information is true to the best of my knowledge.

signature

Date