metro Vein centers

PATIENT INFORMATION

Name: _____
Last Name First Name M.I.

Mailing Address: _____
Street City State Zip

Home Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____

Date of Birth: _____ /_____ /_____ Age: _____ Sex: _____ SS #_____

Marital Status: ☐ Single ☐ Married Occupation: _____

Race: _____ Primary Language: _____ Ethnicity: _____

Email Address: _____

Were you referred by your doctor: ☐ Yes ☐ No Referring Doctor Name: _____

If not, how did you hear about us?

☐ TV ☐ Radio
☐ Newspaper
☐ Brochure
☐ Online Ad ☐ Facebook ☐ Google
☐ Friend/Family:_____
☐ Other_____

Primary Care Physician: _____ Phone: (_____)_____

Address: _____
Street City State Zip

Pharmacy of Choice: _____ Phone: (_____)_____

In an of emergency, who should be notified? _____ Phone: (_____)_____

Other family members that are patients: _____

Responsible Party (If different from patient)

Name: _____
Last Name First Name M.I.

Mailing Address: _____
Street City State Zip

Home Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____

Date of Birth: _____ /_____ /_____ Age: _____ Sex: _____ SS #_____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

_____ _____ /_____ /_____
Patient or Responsible Party Signature Date

PHYSICAL & HEALTH INFORMATION

Name: _____
Last Name First Name M.I.

Please explain reason for Doctor visit (painful varicose veins, swelling, ulcers, etc.): _____

_____

Please check ALL that apply:

- ☐ Aching Sensation
- ☐ Heaviness
- ☐ Pain while standing
- ☐ Swelling
- ☐ Redness
- ☐ Tender/warm to touch
- ☐ Skin discoloration
- ☐ Varicose/Spider veins
- ☐ Ulcer (an "open sore")
- ☐ Itching
- ☐ Dry, flaky skin over varicose veins
- ☐ Burning
- ☐ Restless legs
- ☐ Calf and/or foot cramps at night ("Charlie horse")

When did your vein problems first appear, and when did you notice the symptoms? (days, months, years)

_____

Does anything make your symptoms worse? (standing for more than 30 min, sitting, traveling, etc.)

_____

Does anything help relieve your symptoms? (resting with your legs up, compression hose, ibuprofen, etc.)

_____

Do you travel frequently? ☐ Yes ☐ No Do you wear compression hose? ☐ Yes ☐ No,

Alcohol Use (beer/wine/liquor) ☐ Yes ☐ No Drinks per week: ____

Smoking History: ____ Packs per week ____ Years smoked ____ and/or, years since you quit ____

Women Only

Number of pregnancies ____ Number of deliveries ____

Last Mammogram ____ /____ /____ Were there any abnormalities? ☐ Yes ☐ No

Last menstrual period ____ /____ /____ Is there any chance you could be pregnant? ☐ Yes ☐ No

Hospitalizations and Surgeries (when and type): _____

_____

_____

PHYSICAL & HEALTH INFORMATION (cont.)

Past Medical History

Check if you have any of the following:

- ☐ Arthritis
- ☐ Hypertension
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Heart Palpitations
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Asthma
- ☐ Stroke (Recovered)
- ☐ Diabetes
- ☐ Kidney disease
- ☐ Liver Disease/Cirrhosis
- ☐ Bleeding/Bruising
- ☐ Cancer/Tumors
- ☐ Thyroid Disease
- ☐ Epilepsy
- ☐ Mental Illness
- ☐ Other medical issues_____

Have you ever had a blood clot? ☐ Yes ☐ No

Have you ever sustained an injury from a fall? ☐ Yes ☐ No If so, when _____ /_____ /_____

Have you ever been treated for your vein problem? ☐ Yes ☐ No

If yes, by whom and type of treatment? (injections, sclerotherapy, surgery, etc.): _____

_____

Do you have foot and/or ankle pain? ☐ Yes ☐ No

If yes, please describe the pain: _____

Are you seeing a podiatrist? ☐ Yes ☐ No Podiatrist Name: _____

Medication Allergies (please include the reaction you had): _____

_____

Do you have a family history of vein disease? (Parents, Grandparents, Relatives, etc.) ☐ Yes ☐ No

Current Medications— please include over-the-counter products (aspirin, vitamins, etc.)

_____

_____

_____

Please indicate your: Height (Feet & Inches): _____ Weight (lbs.): _____

REVIEW OF SYSTEMS

Name: _____
Last Name First Name M.I.

Do you have any of the following (please check all applicable)?

Constitutional
- ☐ Fever
- ☐ Chills
- ☐ Significant Weight Loss
- ☐ Other: _____

Eyes
- ☐ Double Vision
- ☐ Blurred Vision
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Glasses or Contacts
- ☐ Other: _____

Cardiac
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Orthopnea (difficulty breathing while lying down)
- ☐ Swelling of Extremities
- ☐ Other: _____

Respiratory
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Wheezing
- ☐ Other: _____

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Vomiting
- ☐ Heartburn
- ☐ Jaundice
- ☐ Other: _____

Genitourinary
- ☐ Hematuria (blood in urine)
- ☐ Polyuria (frequent urination)
- ☐ Incontinence
- ☐ Other: _____

Musculoskeletal
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Muscle Pain
- ☐ Back Pain
- ☐ Other: _____

Neurologic
- ☐ Seizures
- ☐ Headache/Migraine
- ☐ Memory Loss
- ☐ Dizziness/Fainting
- ☐ Other: _____

Psychosocial
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Other: _____

Skin
- ☐ Rash/Sores
- ☐ Lesions/Open Wounds
- ☐ Itching
- ☐ Burning
- ☐ Bruising
- ☐ Other: _____

_____ _____/_____/_____
Patient or Responsible Party Signature Date

_____ _____/_____/_____
Provider Signature Date

HIPAA CONSENT FORM

I understand that I have certain Rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize Metro Vein Centers to use and disclose my protected health information (PHI) to carry out the following:

- Treatment, including direct and indirect treatment by others healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of Metro Vein Centers I have also been informed of, and given the right to review and secure a copy of the Metro Vein Centers Privacy Statement, which contain a more complete description of the uses and disclosures of my PHI and my rights under HIPAA. I understand that Metro Vein Centers reserves the right to change the terms of this notice at any time and that I may contact Metro Vein Centers at any time to obtain the most current copy of this notice.

I understand that I may revoke this consent at any time. However, any use or disclosure that occurred prior to the revocation date is not affected.

_____ _____ /_____ /_____

Patient or Responsible Party Signature Date

Appointment Cancellation Policy

I have read and agree to the cancellation Policy of the practice that states I may be assessed a fee if I do not give proper notice of cancellation of an appointment or procedure.

_____ _____ /_____ /_____

Patient or Responsible Party Signature Date

Communcation Consent

I wish to be contacted in the following manner (check all that apply and fill in the best number that you can be reached):

☐ Home Phone: (_____)_____
☐ Cell Phone: (_____)_____
☐ Other Requests: _____
☐ Work Phone: (_____)_____
☐ Fax Phone: (_____)_____

PATIENT FINANCIAL POLICY

Thank you for choosing us as your Healthcare Provider. We are committed to providing excellent service and quality care. In order to reduce confusion and misunderstanding we have adopted the following financial policy. If you have any questions pertaining to this policy, please discuss them with our Billing Department Manager.

Insurance Claims: It is important for you to understand that health insurance is an agreement between you and your insurance company. Our practice has contracts with most local health insurance companies, including Medicare and BCBSM. As a courtesy, we will file your insurance claims for you to your primary and secondary carriers. We will collect co-payments when you are here for your appointment. If you have a deductible or co-insurance you will receive a statement from our West Bloomfield office after your insurance company responds to your claims. Payment is expected when you receive our statement or we encourage you to call our billing department for payment arrangements. If you have insurance coverage with a plan that we do not have a contract with, we will also bill that plan, although you may have a higher co-payment or deductible for which you will be responsible. If your insurance company does not pay the practice within 90 days, we will look to you for payment.

Referrals: It is your responsibility to obtain referrals if your insurance requires them. Your primary care physician is responsible for sending the referral to your insurance company.

Pre-Authorization/Pre-Determination: Most insurance companies cover the treatment of veins as long as medical necessity is established. We will need to perform a diagnostic ultrasound to determine if you have venous disease. If your insurance company requires approval prior to any procedure, our office will do the necessary paper work to obtain their approval. Upon your request, our billing department will check your insurance benefits and provide you with an estimate of any dollar amount you may owe due to deductible or co-insurance.

Self-Pay Patients: We expect payment at the time of treatment for patients who have no insurance coverage. We will do our best to give you an estimate of the charges prior to your visit. If a surgical procedure is necessary, we will collect 50% of the cost prior to the procedure being done. Prior to the procedure, or on the date of the procedure, you will be asked to guarantee payment for the remaining cost by providing Metro Vein Centers with a credit card number. If financial arrangements are needed, please arrange this with our billing department.

Copy Of Medical Records: If you would like a copy of your medical records, please submit a written request to our West Bloomfield office. Once request is received, your records will be mailed to the address we have on file for you or you may pick them up in person (valid ID is required). There is a fee of $20.00 for a complete copy of your medical records. This fee must be paid at the time of your request. Please allow 5 business days from-date written request is received for records to be mailed or available for pick up.

Cancellations: In order to provide the best possible service and availability to all our patients, please call us as early as possible if you know you will need to reschedule your appointment. Unless cancelled 24 hours in advance, $50.00 will be charged for missed appointments. For no show procedure appointments, $150.00 will be charged.

I have read and understand the financial policy of Metro Vein Centers and I agree to be bound by its terms.
I also understand and agree that such terms may be amended from time-to-time by the practice.

_____ _____ /_____ /_____

Patient or Responsible Party Signature Date