Name:_____

Date:_____Date of Birth:_____Age:_____

Vein Clinics of Tristate

Patient History

Symptoms: ***(Please check if yes)***	**R**	**L**
Aching / pain in legs	☐	☐
Heaviness	☐	☐
Tiredness / fatigue	☐	☐
Itching / burning / warmth	☐	☐
Leg cramping	☐	☐
Leg restlessness	☐	☐
Throbbing	☐	☐
Swelling	☐	☐

Check if you've had any of the following:	
Heart disease	☐
Peripheral arterial disease	☐
HIV	☐
Hepatitis	☐
High blood pressure	☐
Diabetes	☐
Cancer	☐
Leg trauma / surgery	☐
Asthma/COPD	☐
Major surgery / hospitalizations:	☐

Do your symptoms interfere with your sleep? ☐

Are your symptoms worse later in the day? ☐

Are your symptoms worse with or after activity? ☐ _____

Do your symptoms keep you from doing anything? ☐ _____

Do you have an Advanced Directive? ☐ Yes ☐ No

Do you have any Peripheral Arterial Disease (PAD) Symptoms? *Check all that apply:*

☐ Was diagnosed with PAD in past

☐ Have/had cramping leg pain that worsens with walking, forcing me to stop walking

☐ Feet/toes become pale and painful with exercise or when elevating them

☐ Have/had ulcers on feet or toes

Conservative Measures Used *Currently* or *Previously*: *(please check those measures that you have tried)*

☐ Exercise ☐ Weight loss **Have you worn compression stockings or leg wraps? ☐ Yes ☐ No**

☐ Leg elevation ☐ Job change If yes, what was the strength of the stockings?_____mmHg

☐ Pain medication If yes, how long did you wear compression stockings? _____ months____years

Restless Legs Syndrome: ***(Please check box if yes)***

Do you find the need to move your leg(s) to relieve an uncomfortable feeling? ☐

Do(es) your leg(s) feel better when moving it (them) or walking? ☐

Are your leg symptoms worse when sitting or resting, without elevating your leg(s)? ☐

Are your leg symptoms worse later in the day or night? ☐

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

☐ A prior evaluation for your veins:_____*(yr)*

☐ Previous vein surgery or laser treatments:_____*(yr)*_____*R* ___ *L*

☐ Previous vein injections:_____*(yr)*_____*R*_____*L*

☐ Bleeding from a vein:_*(yr)*_____*R*_____*L*

☐ A leg ulceration:_____*(yr)*_____*R*_____*L*

☐ Superficial thrombophlebitis or an inflammation of a vein: *(yr)* *R*_____*L*_____*(Location)*

☐ Any type of blood clot:_____*(yr)*___*R*___*L*_ *(Location)*

☐ Any type of clotting disorder: _ _____ *(Diagnosis)*

☐ Migraines with aura

☐ Diagnosed with a PFO (patent foramen ovale)

☐ A family history of vein disease

☐ A family history of leg ulceration

☐ A family history of blood clots

☐ A family history of a clotting disorder

Women Only: ***(Please check box if yes)***

Are you pregnant or considering a pregnancy sometime in the future? ☐

Are you breast-feeding? ☐ Are your legs more painful associated with menstruation? ☐

Have you been diagnosed with Pelvic Congestion Syndrome and/or had bulging veins during pregnancy? ☐

Number of Pregnancies:____Deliveries:_____Miscarriages:__Children's ages:_____

Today's Date:_____ Appointment Time_____a.m. / p.m. Date of Birth:_____

Race	**Ethnicity**
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to State
Preferred Primary Language: ☐English ☐Other:_____ ☐ Decline to State	
Weight:_____lbs. and **height:** _____ ft._____in	

Annual Influenza Immunization: Did you receive a flu shot during the 'Flu Season' (August – March)?

Date of Last Flu Shot_____/ ☐ No/Refused ☐Decline for Medical Reason → ☐ Allergy ☐ Other Medical Reason
(Month/Year)

Social History:

Tobacco Use History ☐ Never smoked or used tobacco ☐ Former smoker but quit on _____ (approx. date)

☐ Current Smoker → Started_____(approx. date) Amount of cigarettes:___per day

☐ Use tobacco in other forms → _____Amount:____per day

Alcohol Use History: Did you have a drink containing alcohol in the past year? ☐ NO ☐ YES

If Yes: → How often? ☐ monthly or less_____drinks per month_____drinks per week_____drinks per day

How often >6 drinks on one occasion in past year? ☐Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐Daily

Allergies and Your Allergic Response: or ☐ *No Known Allergies*

_____☐Rash ☐Nausea/Vomiting ☐Diarrhea ☐Shortness of Breath ☐Anaphylaxis ☐Other:_____

_____☐Rash ☐Nausea/Vomiting ☐Diarrhea ☐Shortness of Breath ☐Anaphylaxis ☐Other:_____

_____☐Rash ☐Nausea/Vomiting ☐Diarrhea ☐Shortness of Breath ☐Anaphylaxis ☐Other: _____

Current Medications: Include prescription drugs, Over-the-Counter drugs, vitamins, minerals, herbals, dietary (nutritional) supplements

#	Medication Name	Dose	Frequency	Route
1				☐Oral ☐
2				☐Oral ☐
3				☐Oral ☐
4				☐Oral ☐
5				☐Oral ☐
6				☐Oral ☐
7				☐Oral ☐

Patient Signature_____ **Date:**_____

OFFICE USE ONLY

Blood Pressure:_____/_____ R L MRN:_____

Staff Signature:_____Date:_____

Patient Education from Healthwise: ☐Tobacco Cessation <24 months ☐H>140/90 or pre-hypertension 120/80 to 139/89

Provider Signature:_____

Patient Information

Name (First)_____(MI) (Last) _____

Address_____

City_____State_____Zip Code _____

Home Phone_____Cell Phone_____

Email Address_____DOB__/__/___Social Security_____

Sex ☐ Male ☐ Female Marital Status ☐ S ☐ M ☐ D ☐ W

Occupation_____Employer_____

Work Phone_____City_____State _____

Insurance Information: ☐ Patient ☐ Spouse (If neither patient or spouse policy holder DOB /_ /__) Primary

_____Group_____ID #_____Insured's Name _____

Secondary_____Group_____ID #_____Insured's Name _____

Spouse Information:

Name_____DOB / / Social Security _____

Occupation_____Employer_____

Work Phone_____City_____State _____

How did you find out about us?

☐ Referral from Physician_____ ☐ Friend/Family Member_____
(Name) (Name)

☐ Radio_____ ☐ TV_____ ☐ Internet_____ ☐ Other_____
(Station) (Station) (Website) (List)

Physician That Referred You

Name_____Specialty_____City_____State_____

Primary Care Physician (if other than referring physician)

Name_____City_____State_____

OB/GYN Physician (if other than referring physician)

Name_____City_____State_____

In Case of Emergency, Contact_____**Phone** _____

I authorize Vein Clinics of Tristate to execute any documents necessary, and release to my health insurance carrier, or other organization as required, any pertinent medical information about myself as may be required to process claims for reimbursement of fees charged to me for medical treatment at Vein Clinics of America.

Signature_____Date_____

Authorization for Communication of Protected Health Information

Patient Name (print) **Date of Birth** **Medical Record Number**

I understand Vein Clinics of Tristate personnel often need to communicate with patients, either directly or through a third party business associate acting on their behalf. This communication may involve information, or ask for feedback, about appointments, treatment, instructions, lab results, payment, or other items related to care at Vein Clinics of Tristate, and may contain or reference protected health information. I also understand speaking personally with each patient is not always possible to communicate this information. By executing this authorization, I hereby authorize Vein Clinics of Tristate personnel, or business associates acting on their behalf, to use all the contact information I have provided, including information on my Patient Information form, to contact me for the purposes described in this document.

I understand that texting is not a secure method of electronic communication, and there is a possibility that texts can be read by someone other than the intended recipient. If I have provided my cell phone number as a means of contacting me, I still wish to receive text reminders for upcoming appointments and other messages from Vein Clinics of Tristate or business associates acting on its behalf.

By providing their name and contact information below, in addition to informal authorization I previously made, I authorize Vein Clinics of Tristate to share information about my care or treatments at Vein Clinics of Tristate (that may include Protected Health Information) with the following people:

Name _____@ _____

Name _____@ _____

I hereby release, discharge and agree to hold harmless Vein Clinics of Tristate and all third parties acting on its behalf for the purposes described herein from any liability that may arise from the release of information authorized above. I understand that I may revoke this consent in writing at any time. This authorization does not expire unless otherwise revoked in writing.

_____

Signature of Patient or Patient/Guardian Date

_____

Relationship to Patient if Minor

CONSENT TO TREATMENT, ASSIGNMENT
OF BENEFITS AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

This CONSENT TO TREATMENT, ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE HEALTH INFORMATION (this "Agreement") pertains to the diagnosis and treatment of the patient identified below (the "Patient") by Vein Clinics of Tri-state ("Clinic"), Dr. Anjari / Dr. Foruhari ("My Doctor"), other doctors employed or under contract with the Clinic ("Clinic Doctors) and Clinic nurses and other care providers ("Care Providers"). The Patient and/or the individual signing this Agreement on the Patient's behalf (the "Legal Representative") hereby agree to comply with all requirements of this Agreement. For purposes of this Agreement, "I," "my" and "myself" refer to the Patient and/or the Patient's Legal Representative, as appropriate.

Consent to Treatment:

As part of the course of the diagnosis and treatment of my medical condition, I voluntarily consent to the provision of all diagnostic tests, physical examinations, medical procedures, medications and other items and services (collectively, "Services") that Clinic, My Doctor, Other Clinic Doctors and Care Providers deem appropriate to diagnose and treat the conditions that I discuss with Clinic Doctors or Care Providers. I acknowledge that no guarantees have been made to me about the outcome of any Services provided by Clinic, My Doctor, other Clinic Doctors or Care Providers.

Assignment of Benefits, Agreement to Pay for Services and Designation of Authorized Representatives:

I acknowledge that I may be entitled to receive payment for Services that I receive from Clinic, My Doctor, Other Clinic Doctors and Care Providers under (i) any employee health benefit plan, any insurance plan, the Medicare program or any other governmental or private third party source of payment ("Third-Party Coverage") or (ii) any judgment, settlement, cause of action or other claim I might assert against a third party because of my injuries or illness ("Claim"). In considerate f Services, I hereby assign, authorize and transfer to the Clinic [**and My Doctor**] all right, title and interest in any insurance benefits, judgments, settlements and other monies otherwise payable to me under Third-Party Coverage of a Claim as a result of Services that I receive from Clinic, Clinic Doctors and Care Providers, and I authorize payment directly to Clinic [**and My Doctor**] of such payments. Further, I authorize Clinic and My Doctor to exercise any applicable remedies that I may have under my employee health plan or other source of Third-Party Coverage. I agree to execute all forms that Clinic [**and My Doctor**] deems necessary or beneficial in order to enable Clinic [**and My Doctor**] to apply for and obtain such payments. I agree to cooperate with Clinic [**and My Doctor**] regarding the foregoing.

I designate the Clinic [**and My Doctor**] as an authorized representative to act on my behalf in regard to claims submitted to any employee health plan or other source of Third-Party Coverage for Services rendered by Clinic [**and My Doctor, respectively**]. This designation includes, but is not limited to, initial determinations, request for documents, requests for additional information and appeals. I further authorize Clinic [**and My Doctor**] to execute any documents necessary to process claims for reimbursement of charges for Services received by Patient.

I hereby authorize my plan administrator (or party to whom the plan administrator has designated its health plan responsibilities), employer, insurer, other source of Third-Party Coverage and my attorney to release to Clinic, My Doctor and any other Clinic Doctors, any and all Protected Health Information (as defined by the privacy regulations adopted pursuant to the Health Insurance Portability and Accountability Act of 1996), plan documents, insurance policies, claim denial information and/or settlement information upon written request form Clinic [**and My Doctor**] in order for Clinic [**and My Doctor**] to act as my authorized representative in claiming such medical benefits, reimbursement, authorizing an appeal of my benefit claim or exercising any applicable remedies I may have under my employee health plan or other source of Third-Party Coverage.

I understand that I am financially responsible for Clinic's [**and My Doctor's**] charges for Services regardless of the existence of any source of Third-Party Coverage or Claim and understand that payment of charges for Services is due within forty-five (45) days from the date on which Patient incurred the charges. In consideration of Services that Patient will receive from Clinic, My Doctor, Other Clinic Doctors and Care Providers, I hereby agree to pay Clinic [**and My Doctor**] for any charges incurred for Services, which are not paid by a source of

Vein Clinics of Tristate – Financial Policy

Thank you for choosing Vein Clinics of Tristate (VCT). We are committed to providing you with the highest quality medical care in an efficient and cost effective manner. To keep you informed of our current office and financial policies, we ask that you please read and sign our financial acknowledgement prior to any treatment.

1. All charges, regardless of insurance coverage, are ultimately the patient's responsibility. Insurance benefits were verified as a courtesy based on the insurance policy number provided to VCT. Benefits and eligibility were obtained from the patient's insurance provider. At VCT, we encourage every patient to contact their insurance company to verify coverage.
2. The patient is responsible for any service not covered by insurance carriers. Patients are responsible for knowing what services are covered under their insurance plan. VCT must bill the visit according to the services provided. To verify coverage and benefits, please provide the following Common Procedure Types (CPT codes):
   - Endovenous Laser Ablation – 36478
   - Sclerotherapy – 36471
   - Ultrasound Guided Needle Placement – 76942
   - Ultrasound Scan – 93971
   - Compression Stockings A6534
   - Radiofrequency Ablation – 36475
   - Puncture Aspiration – 10160
   - Endovenous Adhesive Ablation – 36482
3. Patients will be asked to provide their current insurance card and patient's current mailing address and phone number at the initial and each subsequent visit. It is the patient's obligation to inform our office of any insurance, address or telephone number changes; failure to do so, will result in the balance being patient's responsibility.
4. Once your insurance has processed your claim any remaining balance is your financial responsibility under the terms of the contract with your insurance company. We expect prompt payment of any co-insurance, deductibles or any other monies due. We are required under our contract with your insurance company to collect this money from you. All balances are to be paid in full prior to your next appointment. Please be aware that some of the treatments or tests performed may not be covered by your insurance and may not be considered by your insurance to be reasonable and medically necessary.
5. Patients will receive monthly statements. Sixty days following the initial statement, if the account remains delinquent, it may be referred to outside collections and patient may be responsible for collection fees. Patient care could be terminated if account continues to remain delinquent.
6. Co-Payment: If your plan has a co-payment you will be expected to pay at each visit. We are required under agreement with your insurance company to collect this from you.
7. For patients without insurance, full payment is expected at the time of service. We do not offer payment plans for this. Cancellation Policy: To ensure your quality of care and the quality of care of all other scheduled patients, we require a minimum of 48 hours notification in the event that your appointment must be rescheduled. Any patient canceling an appointment without 48-hours' notice will be charged a fifty ($50.00) cancellation fee.

I have read, understand, and agree to the above Financial Policy. I understand that charges are to be paid in full at the time of service. I understand that all applicable coinsurance, copayments, deductibles and non-covered services are my responsibility. I authorize my insurance benefits to be paid directly to VCT. I authorize the Practice to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Name: (please print)_____

Signature:_____

Third-Party. Coverage or as a result of a Claim, at Clinic's [**and My Doctor's**] regular rates, except where a law or an applicable contract with a source of Third-Party Coverage establishes a different payment rate and/or patient cost-sharing obligation. The amount due for Services is referred to as an "Account" in this Agreement. I agree to pay reasonable attorney's fees and all cost of collection in the event my Account is turned over to an attorney or collection agency.

I agree that if payment for Services under this Agreement results in a credit balance, the credit amount will be applied to amounts due on any other outstanding Accounts I have with Clinic [**or My Doctor, as applicable**], whether current or delinquent Accounts. If there are any credit balances related to prior agreements between me and Clinic [**or My Doctor, as applicable**] I authorize Clinic [**and My Doctor, as applicable**], to transfer such credit balances to this Account. If there is an overpayment in my Accounts, after the completion of treatment, I understand that I will receive a refund check in that amount from Clinic [**and My Doctor, as applicable**].

Use and Disclosure of Health Information:

I understand that Clinic's, Clinic Doctors' and Care Providers' uses and disclosures of information about the Patient for treatment, billing and collection, and other purposes are described in Clinic's "Notice of Privacy Practices." By this authorization, I specifically authorize Clinic [**and My Doctor**] to disclose medical and financial information about the Patient for billing and collection purposes to sources of Third-Party Coverage and other third-parties that Clinic [**and My Doctor**] believes to be responsible for the payment of the charges for Services received by Patient.

In the unlikely event that I need to be admitted to a hospital or seen in an emergency room, I give permission for My Doctor to request a copy of my discharge summary records for collaborative health care purposes and the provision of appropriate follow-up care, as needed.

I authorize Vein Clinics of Tristate to obtain my health information, including external prescription history, from all available databases. This includes medication that can be used to treat sexually transmitted diseases (including HIV/AIDS), mental health conditions, or other sensitive medical conditions. I understand that my prescription history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers will be viewable by Vein Clinics of Tristate providers and staff, and the information may include prescription I had filled over the past several years.

My signature below certifies that I have read and understand the scope of my consent and that I authorize the access.

General Provisions:

1. I certify that all information given to Clinic is complete and accurate to the best of my knowledge.
2. I agree that an electronic or paper copy of this Agreement is as valid as the original bearing my signature.
3. I have read and fully understand this assignment.

Name of Patient: _____

Signature of Patient/Legal Representative: _____

Print Name: _____ Date: _____

Relationship of Legal Representative To Patient: _____

OFFICE POLICIES

Cancelling Appointments- Failure to cancel your appointment without a **48 HOUR NOTICE** will result in a $50 Cancellation Fee.

No Show Appointment- No Call No Show appointments will result in a $50 No Show Fee.

Late Appointment- 10 minute window for late patients. If you are more than 10 minutes late the office will do the following:

1. We will check the schedule to see if there is an opening for you to be seen immediately or another time later in the same day.
2. If no availability, we will reschedule your missed appointment for the next available opening.

We understand that sometimes being late is out of your control due to traffic, accidents, family obligations, etc. We will do our best to accommodate you. Reminder calls are a courtesy of VCT. However, it is ultimately your responsibility to ensure you know when your appointments are scheduled for and the time of the appointment.