New Patient Registration Form ***Today Date*** ___/___/___ **MD**

Patient Name: (Last, First, Middle)		Age	Date of Birth / /
Social Security #	Sex M F *Please circle one*	Marital Status S M D W *Please circle one*	
Preferred Language: English Spanish Other: *Please circle one*	Race: Amer.Indian, Asian, Black, Caucasian, Other, Declined *Please circle one*		
	Ethnicity: Hispanic, Non-Hispanic, Declined *Please circle one*		
Street Address			
City	State	Zip	
Home #	Work #	Cell #	

Employment Information

Employer Name	Occupation
Employer Address	Phone #

City	State	Zip

Key Medical And Lifestyle Information

Major Complaint (*describe pain or concern*)	Family History of Varicose Veins?
Hobbies	

City	State	Zip

Emergency Contact-Residing at Different Address

Name	Phone #	Relationship

Patient e-mail address:

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New Patient Medical History

Patient Name: _____

Office Visit Date: _____ ***DOB:***_____ ***Gender:*** **Male / Female**

Age:_____ ***Height:*** _____ ***Weight:***_____

Reason for Visit:_____

CHECK ALL APPLICABLE SYMPTOMS:

	Right Leg	Left Leg
Varicose Veins Present	☐	☐
Spider Veins Present	☐	☐
Pain in Thigh and/or Calf	☐	☐
Swelling in Leg and/or Foot	☐	☐
Fatigue and/or Heaviness in Leg	☐	☐
Burning and/or Itching	☐	☐
Night Cramping/Restless Leg	☐	☐
Severe Discoloration/Ulcer Present	☐	☐
Bleeding from Varicose Vein	☐	☐

Do Any of Your Symptoms Interfere with… **Occupation?** **Yes / No**
Daily Activities? **Yes / No**
Sleep Habits? **Yes / No**

Do Any of Your Symptoms Improve with... **Medical Stockings?** **Yes / No**
Exercise/Walking? **Yes / No**
Medication? **Yes / No**
Leg Elevation? **Yes / No**

Do You Have a Family History of Spider/Varicose Veins? **Yes / No**

Have You Had a Previous Ultrasound of Your Leg Veins? **Yes / No**
Date: Location:

Have You Had Any Previous Treatment to Your Leg Veins? **Yes / No**
Date: Location:
List Treatment Type(s):

Have You Worn Medical-Grade Compression Stockings? **Yes / No**
If So, Circle Type of Stockings: Prescription Grade / Self-Purchase
Estimated Date & Duration Worn:

CHECK ALL APPLICABLE MEDICAL CONDITIONS:

Deep Vein Thrombosis (DVT)	----------	☐
Superficial Thrombophlebitis	----------	☐
Pulmonary Embolism	----------	☐
Hypercholesterolemia	----------	☐
Hypertension	----------	☐
Cardiac Disease	----------	☐
Peripheral Vascular Disease	----------	☐
Fainting/Syncope	----------	☐
Diabetes Mellitus (Type I/Type II)	----------	☐
Kidney Disease	----------	☐
Arthritis	----------	☐
Lumbar Spine/Disk Degeneration	----------	☐
Cancer	----------	☐
Auto-Immune Disorder	----------	☐
HIV/AIDS	----------	☐
Hepatitis	----------	☐
Other		☐

Do You Smoke? **Yes / No** Amount:
Do You Drink Alcohol? **Yes / No** Amount:
Do You Exercise Regularly? **Yes / No** Amount:

Known Allergies: ___

Prior Surgical History:

Current Medications:

Any Past History of Significant Leg Trauma or Injury? **Yes / No**

If So, Did You Sustain Bone Fracture and/or Require Surgery? **Yes / No**

Circle Type of Trauma/Injury Fall / Motor Vehicle Accident / Impact / Other

Estimated Date of Trauma/Injury: _____

FEMALES ONLY:

Currently Pregnant: **Yes / No**
Currently Breastfeeding: **Yes / No**
Current Hormone Therapy: **Yes / No**
Post-Pregnancy Varicose/Spider Veins: **Yes / No**
Planning Additional Childbirths: **Yes / No**
Total Number of Full-Term Pregnancies: _____

CLINICAL STAFF ONLY: ***VITAL SIGNS*** Blood Pressure: _____ Pulse: _____

PHOTOS OBTAINED Date: _____

MGCS RX ISSUED Duration: _____ Insurer: _____

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Authorization for Release of Information to Primary Care Physician

Patient Name:_____ DOB:_____

*I authorize **VEIN**INNOVATIONS to release records to my:*

☐ Primary Physician: _____

Name

_____

Address

_____

City, State, Zip

_____ _____

Phone number **Fax number**

☐ I do ☐ I do not ☐ N/A… Authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)

This authorization will expire one year after it is signed

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA privacy rule. I have the right to revoke this authorization in writing except to the extent that Vein Innovations has acted in reliance upon this authorization. My written revocation must be submitted to Vein Innovations Privacy Officer at 5673 Peachtree Dunwoody Rd #340, Atlanta, Ga. 30342 Phone #678-731-9815

By signing this authorization, I authorize Vein Innovations to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed above.

***Signature*: _____ *Date*: _____**

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Authorization for Release of Information to Referring Physician

Did your primary care refer you to our practice? ☐ **Yes** ☐ **No**

Did a specialist refer you to our practice? ☐ **Yes** ☐ **No**

If yes, please complete the entire form:

Patient Name_____ DOB_____

*I authorize **VEIN**INNOVATIONS to release records to my:*

☐ Referring Physician: _____

Name

_____

Practice Name

_____

Address

_____

City, State, Zip

_____ _____

Phone number **Fax number**

☐ I do ☐ I do not ☐ N/A… Authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)

This authorization will expire one year after it is signed

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA privacy rule. I have the right to revoke this authorization in writing except to the extent that Vein Innovations has acted in reliance upon this authorization. My written revocation must be submitted to Vein Innovations Privacy Officer at 5673 Peachtree Dunwoody Rd #340, Atlanta, Ga. 30342 Phone #678-731-9815

By signing this authorization, I authorize to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed above.

***Signature*: _____ *Date*: _____**

VEININNOVATIONS

Financial Information

Please bring insurance cards and referral form

Primary Insurance		***Secondary Insurance***	
Insurance Company Name:		Insurance Company Name:	
Address to Mail Claim:		Address to Mail Claim:	
City: State: Zip:		City: State: Zip:	
Name of Policy Holder		Name of Policy Holder	
Policy Holder SS#:	DOB	Policy Holder SS#	DOB
Group # or Name:	Policy #	Group # or Name:	Policy #
Is this a HMO, POS or PPO		Is this a HMO, POS or PPO	

Financial Agreement

I hereby assume full responsibility for all charges incurred for professional services rendered by VeinInnovations, unless the service is deemed "paid in full" as a result of a contractual agreement between VeinInnovations and my insurer. I understand that all charges not covered by my insurer, including copay, deductibles and any charges for which I have failed to secure prior authorization, are due at the time of service. I understand that my insurance benefits are verified and claims billed as a courtesy and I am responsible for payment of balance in full if not paid by the insurance within 30 days. I understand that if VeinInnovations does not participate with my insurance plan, I will be responsible for payment in full at the time services are rendered.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner: I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Signature of Responsible Party:_____ Date:_____

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Assignment of Benefits / Release of Information

I authorize my health insurance benefit plan to pay directly to VeinInnovations, medical benefits if any, otherwise payable to me for their services as described on attached claim but not to exceed the charges for those services. I understand I am financially responsible to VeinInnovations for charges not covered by this assignment. I authorize Vein Innovations to release all information necessary, including medical records, to secure payment.

***Signature of Responsible Party*: _____ *Date:* _____**

Consent for Care & Treatment

I, the undersigned, do hereby agree and give my consent for VeinInnovations to furnish medical care and treatment to _____, considered necessary and proper in diagnosing or treating his/her Medical condition.

***Signature of Responsible Party*: _____ *Date:*_____**

Appointment Cancellation Financial Agreement

I understand that the time reserved for my appointments is valuable and I agree to give at least 24-hour notice (one full business day) for a Sclerotherapy appointment and a 48-hour notice (two full business days) for a Closure procedure appointment.

I further understand and agree that failure to provide this notice will result in a charge of $300.00 for a missed Sclerotherapy appointment and $500.00 for a missed Closure procedure appointment.

***Signature of Responsible Party*: _____ *Date:*_____**

***Facility Representative:* _____ *Date:*_____**

NOTICE REGARDING PRIVACY OF MEDICAL INFORMATION AND CONSENT TO DISCLOSURE

Pursuant to the Health Insurance Portability and Accountability Act of 1999 ("HIPPA"), medical providers and health plans are required to give patients a clear written explanation of allowable uses and disclosures of medical information and patient rights. This notice is being provided to you in order to comply with this requirement.

It is the policy of **VEIN**INNOVATIONS (VI) that any protected health information ("PHI") obtained with respect to a patient relating to the diagnosis or treatment of that patient will be held in strict confidence, and will not be disclosed to other parties without the consent of the patient, or as otherwise required or permitted by law. Patients will be permitted to view and obtain a copy of their medical information, and obtain a history of authorized disclosures. Inquiries or complaints regarding privacy and disclosure of medical information should be directed to VI's privacy official, David Martin.

For this and subsequent episodes of treatment, I understand that I may revoke this consent at any time. Such revocation should be in writing. As a patient of VI, I hereby consent to the disclosure of medical and other information as follows:

1. PHI may be disclosed to other parties involved in providing medical treatment to me, including hospitals, laboratories, pharmacists, physicians and other parties where VI reasonably believes that such party has a need to know such PHI in order to provide treatment or diagnosis or assist me in obtaining treatment or diagnosis.

2. VI may disclose PHI to insurance companies, HMOs, PPO's, employers, government agencies and other parties where necessary in order to obtain payment for services.

3. VI may use PHI for quality assurance, internal controls, and peer review and in other circumstances where the use of such information is reasonable necessary in order to improve the standards or quality of service of VI.

4. VI may disclose PHI to third party billing, accounting, and practice management services in order to enable such party to provide billing, practice management and other similar services to VI. In such event, VI will take reasonable precautions to prevent further disclosure of such information by such parties.

5. Disclosure of PHI may be made where specifically authorized or requested by me.
6. PHI may be disclosed where specifically permitted or required by HIPAA or other federal or state law.

7. PHI may be used for the purpose of sending newsletters or other marketing communications by VI to its patients. However, VI does not sell mailing lists or any other patient information to third parties, nor does VI use its patient list for the purpose of mailing or transmitting information on behalf of third parties.

8. PHI may be de-identified with the patient and used for medical research, including the publication of scholarly articles.

9. PHI may be disclosed to immediate family members or close friends who VI reasonably believes to be actively involved in my care and treatment where VI believes I am unable to make an informed decision as to who should receive disclosure of PHI.

It is intent of VI to comply with all applicable laws and regulations governing disclosure of PHI, and such laws and regulation may change from time to time. In the event any such laws or regulations prohibit the disclosure of PHI even if such disclosure has been consented by the patient, VI will comply with applicable legal requirements.

I, as a patient of VI, acknowledge receipt of a copy of this Notice Regarding Privacy of Medical Information and Consent to Disclosure, and consent to the disclosure of PHI under the circumstances set forth and herein.

This _____day of_____ 20____.

Patient Signature: _____

Print: _____

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PATIENT RIGHTS AND RESPONSIBILITIES

The patient has the right to:

- Be treated with respect and dignity and to be provided with courteous, considerate care.
- Be informed about the diagnosis, treatment and prognosis of the health problems in terms that can be understood.
- Know the chances that the treatment will be effective and to know the possible risk, side effects and alternative methods to treatment.
- Receive confidential treatment of his or her disclosures and medical records and except when required by law, to be afforded the opportunity to approve or disapprove of their release.
- Know who is responsible for providing treatment.
- Have access to a second medical opinion before making any decision.
- Decide not to be treated but to be informed of the medical consequences of refusal.
- Participate in the decisions involving the health problem.
- Be informed of the personal responsibilities involved in seeking medical treatment and maintaining health and well-being thereafter.
- Privacy.
- Have access to resource persons and information concerning health, education, self care and prevention of illness.

The patient has the responsibility to:

- Inform the provider of any changes in his or her health status that could affect treatment.
- Adhere to a prescribed treatment plan and to discuss any desired change.
- Act in a considerate and cooperative manner with the office staff.
- Ask questions and seek clarification regarding areas of concern.
- Weigh the consequences of refusing to comply with instructions and recommendations.
- Assist the providers in compiling a complete record by authorizing the provider to obtain necessary medical information from the appropriate sources.
- Keep appointments on time and understand that you will be charged for appointments not canceled within 24 hours.
- Cancel appointments only when absolutely necessary and far enough in advance so that the other patients might utilize the time.

Patient Signature*:**_____ ***Date:_____

VEININNOVATIONS

I understand that my visit today for a New Patient Office Visit and Complete Venous Duplex Ultrasound exam will be billed to my insurance company.

Any amount of my deductible that I have not met during my current benefit year will be applied to the cost of this visit, along with my co-pay.

If you have any questions regarding your visit today, please ask a staff member for assistance.

Signed _____

Date_____

Received by _____