Richmond Vein Center

RVC-A1.1

Patient Information

Name:_____ **Social Security Number:**_____

Gender: ☐Male ☐Female **Date of birth:**_____

Mailing Address:_____

City:_____ **State:**_____ **Zip:**_____

Home phone: (____)_____ **Work phone:** (____)_____

Race: ☐American Indian or Alaska Native ☐Asian ☐African American ☐Native Hawaiian or other Pacific Islander ☐White ☐Not Provided

Ethnicity: ☐Hispanic or Latino ☐**Not** Hispanic or Latino ☐Not Provided

Language: ☐English ☐French ☐German ☐Japanese ☐Mandarin ☐Russian ☐Spanish ☐Not Provided

Insurance Information

Name of policyholder:_____ **Date of birth:**_____

Patient relationship to policy holder: ☐Self ☐Spouse ☐Parent/Guardian ☐Other

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Emergency Contact

Name:_____ **Relationship:**_____

Mailing Address:_____

City:_____ **State:**_____ **Zip:**_____

Home phone: (____)_____ **Work phone:** (____)_____

In order for us to provide better communication to your physicians regarding your care, please complete the following:

1. My primary care physician is: _____
2. My OB/GYN is (if applicable): _____
3. How did you hear about the Richmond Vein Center: _____

Financial Responsibility Agreement

I/We hereby authorize Richmond Vein Center to furnish all information regarding my medical history, diagnosis and proposed treatment of myself or my child to my insurance carrier(s) regarding my claims for benefits. I authorize the Richmond Vein Center to file claims on my behalf and to receive medical benefit payments from my insurance carrier(s).

The Richmond Vein center will notify and request authorizations for the following office procedures: Dopplers, Endovenous Ablation Radiofrequency (Closure Procedure), Mechanical Chemical Transcatheter Ablation (ClariVein Procedure), and Microphlebectomy.

Upon approval from your insurance carrier(s), arrangements will be made for you to undergo the appropriate treatments. Richmond Vein Center will bill your insurance carrier(s) after your authorized procedure(s) have been performed and will accept their assignment.

If however, said insurer fails to meet this obligation in whole or in part, or if I am non-insured,I/we agree to be responsible for the fee and cost involved in the treatment of the above named patient. **Additionally, the patient is responsible for copays, co-insurance, and deductibles required by your insurance carrier(s).** Please contact your insurance carrier(s) with any questions you may have in reference to your responsibility.

I/We authorize payment of medical benefits to the Richmond Vein Center and further understand that should my account have to be referred to an attorney for collection that I am responsible for all fees and costs incurred therein. I/We hereby authorize Richmond Vein Center to act on my behalf in accessing hospital records when and if needed.

_____ _____

Patient/Guardian Signature **Date**

This notice describes how information about you may be used and disclosed and how you can gain access to this information. Please review it carefully:

Notice of Information Practices

1. Richmond Vein Center, PC. may use and disclose protected health information for treatment, payment and healthcare operations. Examples of these include, but are not limited to, requested preschool, life insurance or sports physicals, referral to nursing homes, foster care homes, home health agencies and/or referral to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers; collection agencies. Healthcare operations include, but are not limited to, internal quality control and assurance including auditing of records.
2. Richmond Vein Center, PC. is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. Two examples of such are for public health requirements or court orders.
3. Richmond Vein Center, PC. will not make any other use or disclosure of a patient's protected health information without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.
4. Richmond Vein Center, PC. may at times contact the patient to provide appointment reminders or information regarding treatment alternatives or other health-related benefits and services that may be of interest to the individual patient.
5. Richmond Vein Center, PC.will abide by the terms of this notice or the notice currently in effect at the time of the disclosure.
6. Richmond Vein Center, PC. reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains.
7. Richmond Vein Center, PC. will provide each patient with a copy of any revisions of it's Notice of Information Practice at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our offices.
8. Any person/patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their rights have been violated. To file a complaint with the practice, please contact the Privacy Officer at the following address: 7702 East Parham Road, MOB III, Suite 102, Henrico, VA 23294. All complaints will be addressed and the results will be reported to the Corporate Compliance Officer/Managing Physician/Board of Directors.
9. It is Richmond Vein Center, PC. policy that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.
10. For further Information you may contact our Privacy Officer at (804) 346-1612.
11. Effective Date: April 14, 2003

Notice of Privacy Practices Acknowledgement Form

Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy. You will find the Notice of Privacy Practices in the white notebooks throughout the waiting room.

I, _____(**please print patient name)** have been provided access to Richmond Vein Center's Notice of Information Practices. A copy of the Notice of Information Practices is available upon request. I have had an opportunity to read the Notice of Information Practices. I understand that I may ask questions to the Medical Practice if I do not understand any information contained in the Notice of Information Practices.

_____ _____

Patient/Guardian Signature **Date**

_____

Relationship to patient if applicable

Disclosure to Family Members and/or Friends

I, _____, give the following individuals permission to access my medical records and West End Surgical and/or Richmond Vein Center permission to disclose health care information to:

Name	**Relationship**
_____	_____
_____	_____
_____	_____

☐ **Release information to no one**

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Vein Treatment Question Sheet

Name:_____ **Date:**_____

Gender: ☐Male ☐Female **Date of Birth:**_____ **Age:**_____

Directions: Please answer the following questions, trying not to leave any blanks.

Past Medical History:

1. Have you ever been in the hospital as a patient? ☐Yes ☐No
   - if yes, for what reason? _____
2. Have you ever had surgery? ☐Yes ☐No
   - if yes, what type of surgery and when? _____

   _____
3. Have you ever had vein stripping surgery? ☐Yes ☐No
   - if yes, when and which leg(s)? _____
4. Have you ever had vein injections (sclerotherapy)? ☐Yes ☐No
   - if yes, when, which leg(s) and where on the leg?_____

   _____
5. Are you presently under the care of a physician? ☐Yes ☐No
   - if yes, for what illness or purpose? _____
6. Do you have any of the following?
   - heart disease ☐Yes ☐No
   - lung disease ☐Yes ☐No
   - high blood pressure ☐Yes ☐No
   - hepatitis ☐Yes ☐No
   - arthritis ☐Yes ☐No
   - leg ulcer(s) ☐Yes ☐No
7. Do you smoke? ☐Yes ☐No
   - if yes, how many packs per day? _____
8. Do you drink Alcohol? ☐Yes ☐No
   - if yes, how many drinks per week? _____

Child Rearing History:

1. Do you think that you are presently pregnant? ☐Yes ☐No
2. How many times have you been pregnant? _____
3. Do you intend to have any more children? ☐Yes ☐No
4. Are you presently breast feeding? ☐Yes ☐No
5. Have you ever miscarried? ☐Yes ☐No

Family History:

Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers or swollen legs?

☐Father
☐Mother
☐Brother(s)
☐Sister(s)
☐Other _____

Personal Vein History:

1. Do experience any of the following?
   - Aching/pain in your legs ☐Yes ☐No
   - Heaviness ☐Yes ☐No
   - Tiredness/fatigue ☐Yes ☐No
   - Itching/burning ☐Yes ☐No
   - Swollen ankles ☐Yes ☐No
   - Leg cramps ☐Yes ☐No
   - Restless legs ☐Yes ☐No
   - Throbbing ☐Yes ☐No
   - Other: _____ ☐Yes ☐No
2. Do you have any problems with walking? ☐Yes ☐No
   - if yes, how does it affect you? _____
3. Do you stand much at work? ☐Yes ☐No
   - at home? ☐Yes ☐No
4. How does this standing affect your legs? _____

   _____
5. Have you ever had your veins evaluated before? ☐Yes ☐No
   - if so, when and where? _____
6. Have you ever had any test(s) done on your veins? ☐Yes ☐No
7. Have you ever had phlebitis (inflammation of a vein)? ☐Yes ☐No

Clotting History:

1. Are you taking birth control pills? ☐ Yes ☐ No
2. Have you ever had a blood clot in your leg? ☐ Yes ☐ No
   - When? _____
   - Which leg? ☐ Right ☐ Left
   - Was it deep? ☐ Yes ☐ No
   - Superficial? ☐ Yes ☐ No
3. Do you have a history of multiple miscarriages? ☐ Yes ☐ No
4. Do you have a family history of blood clots in the leg? ☐ Yes ☐ No
5. Do you have a clotting disorder? ☐ Yes ☐ No
6. Has it ever been recommended that you take blood thinners? ☐ Yes ☐ No
7. Do you have a malignant disease (cancer)? ☐ Yes ☐ No
8. Have you had major surgery lasting over an hour in the last month? ☐ Yes ☐ No
9. Within the last month, have you had more than 3 days of continuous bed rest attributable to injury or illness? ☐ Yes ☐ No
10. Within the last month, have you had a pelvic fracture or a plaster leg cast? ☐ Yes ☐ No

Current Medical History:

1. Do you have any allergies (medicines, food, pollen, etc.)? ☐ Yes ☐ No
   - if yes, please list them and describe your reaction? _____

   _____

   _____
2. Are you allergic to shrimp, shellfish or any form of iodine, IVP dye? ☐ Yes ☐ No
3. Do you take blood thinning medications? ☐ Yes ☐ No
4. Are you taking hormones or birth control pills? ☐ Yes ☐ No
5. Are you presently taking any medication(s) including prescription and/or non-prescription (over-the-counter) medicines (aspirin, vitamins)? ☐ Yes ☐ No
6. I give consent for the Richmond Vein Center to download my prescriptions from Surescripts:

_____ _____

Signature Date

- If you do not consent, please list your medications below or attach them on a separate sheet. The receptionist can make a copy if you brought a list with you.

Medication Name	Dose	Instructions	For Treatment of...

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Photographic Image Consent and Release Form

I hereby authorize Richmond Vein Center, P.C. to take photographic images of my legs and allow them to be used to help document and track the progress of my leg treatments, to be mailed to my Primary Care Physician and/or referring physician as well as to my insurance carrier(s) if required for preauthorization for any procedures.

I understand that these images will be the property of Richmond Vein Center, P.C. and that I will not receive any compensation (either financial or otherwise) in exchange for the use of these images. I understand that Richmond Vein Center, P.C. will remove all identifying information to the best of it's ability when the images will be seen by those who are not related to my care and medical treatment (i.e. anyone other than Richmond Vein Center Staff, other physicians, insurers or other parties involved with the treatment of my legs).

I have had the opportunity to ask questions about the purpose for which, and about the manner in which the images will be used, and all of my questions have been answered satisfactorily. I hereby release and hold harmless Richmond Vein Center, P.C. and their respective physicians, officers, employees and agents from liability for any claim I have, or might ever have, in connection with the use of these photographic images.

I understand that I may refuse to sign this Authorization. If I choose not to sign, my treatment will not be affected in any way. I also understand that I may revoke this authorization at any time except to the extent that Richmond Vein Center, P.C. has already taken action in reliance on it. I may revoke the authorization by written notification to Debra Gould at the Richmond Vein Center, P.C. or to whomever the current practice manager of the Richmond Vein Center, P.C. is.

Printed Name	Witness
Signature	Date

In addition to the above stated purposes authorized, I also hereby authorize Richmond Vein Center, P.C. to use these images for marketing and educational purposes, and that they may be published in scientific journals and/or shown for scientific reasons. I understand that all of the same terms, conditions, and limitations will still apply as authorized above, and that by signing here I am allowing Richmond Vein Center, P.C. to use the images of my legs for additional purposes and not changing the agreement in any other way. I also understand that Richmond Vein Center, P.C. will make every effort to insure that all identifying information be removed when using these images.

Printed Name	Witness
Signature	Date

Richmond Vein Center

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Stocking Information

After your initial consultation, if it is determined that you are a candidate for procedures, it is required that you wear medically prescribed compression stockings. We sell these stockings at a surgical discounted price as a convenience to our patients.

In order to achieve optimal results and prevent any complications from your treatment, it is medically necessary to wear post-operative compression on the treated leg for a total of 7 days.

Cancellation & Rescheduling Policy

When scheduling procedures, not including sclerotherapy, it is important that you check your personal calendar to be sure that your scheduled dates and times are ideal for you. Rescheduling your procedures requires multiple phone calls to your insurance company and causes a hardship on our practice's schedule and staff time. Richmond Vein Center has instituted a $50 rescheduling fee for all surgical procedures (Closure/ClariVein/ Microphlebectomy).

Any appointments cancelled less than 24 hours prior to your scheduled time will be charged accordingly. While we regret to have to make such policies, it is necessary to cover our costs. **Appointments cancelled more than 24 hours prior to your scheduled time will not be charged**.

Thank you in advance for your understanding.

Our cancellation fees are:

Office Visit/Sclerotherapy	$50
Ultrasound-Guided Sclerotherapy	$50
Unilateral (1 leg) doppler exam	$50
Bilateral (2 legs) doppler exam	$75
Carotid Doppler Exam	$75
Closure/ClariVein/Microphlebectomy	$100

By signing below, I have read and agree to the terms of the "Cancellation and Rescheduling Policy" of the Richmond Vein Center.

Printed Name _____ Witness _____

Signature _____ Date _____