Richmond Vein Center

RVC-A1.4

Patient Information

Name:______________________________ Social Security Number:__________________

Gender: ☐Male ☐Female ☐Other: Date of birth:____________________

Mailing Address:____

City:__________________ State:________ Zip:________________

Is this the same address as on your driver's license/ID card? ☐Same ☐Different

Primary phone: (______) _________________ Work phone: (______) _________________

Email (please print):____

☐ I want online access to my medical information through Richmond Vein Center's Patient Portal.

☐ I agree to allow Richmond Vein Center to send me **infrequent** (never more than once per month) promotional emails containing offers, discounts and other information related to the treatment of veins. This is entirely optional and I can revoke my consent at any time.

____________________________ ____________________

Patient/Guardian Signature Date

Race:	☐American Indian or Alaska Native ☐Asian ☐African American / Black ☐White ☐**Not** Provided ☐Native Hawaiian or other Pacific Islander
Ethnicity:	☐Hispanic or Latino ☐**Not** Hispanic or Latino ☐**Not** Provided
Language:	☐English ☐French ☐German ☐Japanese ☐Mandarin ☐Russian ☐Spanish ☐Not Provided ☐Other:

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? _____________________

Insurance Information

Name of policyholder: _____________________ Date of birth:_____________________

Patient relationship to policyholder: ☐self ☐spouse ☐parent/guardian ☐other

Tricare East insurance only: Sponsor's Social Security Number: ____________________

Emergency Contact

Name:________________________ Relationship:_____________________

Mailing Address:____

City:__________________ State:________ Zip:________________

Primary phone: (______) _________________ Work phone: (______) _________________

Financial Responsibility Agreement

I/We hereby authorize Richmond Vein Center, PC 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, PC to file claims on my behalf and to receive medical benefit payments from my insurance carrier(s).

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

Upon approval from your insurance carrier(s), arrangements will be made for you to undergo the appropriate treatments. Richmond Vein Center, PC 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, PC 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, PC 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 Richmond Vein Center, PC permission to disclose health care information to:

Name	Relationship
______________________________	______________________
______________________________	______________________
______________________________	______________________

☐ **Release information to no one**

Richmond Vein Center

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Personal Vein History

Please check the following symptoms you experience in your ☐Left, ☐Right, ☐Both legs:

☐ Aching/pain ☐ Restless legs ☐ Itching ☐ Burning

☐ Heaviness ☐ Tiredness/fatigue ☐ Swelling ☐ Cramping

☐ Throbbing ☐ Other: ☐ No symptoms

My symptoms are aggravated by:

☐ Prolonged standing ☐ Menstrual cycle
☐ Prolonged sitting ☐ Walking
☐ Other:

My symptoms are alleviated by:

☐ Elevation ☐ Pain Medication ☐ Rest
☐ Stockings ☐ Walking ☐ Exercise
☐ Other: ☐ Nothing

My symptoms affect the following activities of daily living:

☐ Work ☐Shopping ☐ Home ☐ Chores ☐ Childcare ☐ Exercise ☐ Other:

Medication & Allergy History

☐ **I do not take any medications**

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 (don't worry if you have trouble with the spelling) or attach them on a separate sheet. Include any vitamins, supplements and over the counter medications too (asprin). The receptionist can make a copy if you brought a list with you.

Medication Name	Dose	Instructions	For Treatment of...

Are you allergic to shrimp, shellfish, or any form of iodine, IVP dye? ☐Yes ☐No

Please list your allergies and describe your reaction (medicines, food, environmental, etc.):

Past Medical History:

Previous surgeries (please list surgery and approximate date): ______________________________

____

____

____

Previous major illnesses & hospitializations: ______________________________

____

____

____

Have you ever had vein treatment (stripping, sclerotherapy, thermal/laser ablation)?
☐ No
☐ Yes please list procedure date and which leg(s):______________________________

Please check present and past medical conditions:

☐ Heart disease	☐ Diabetes	☐ Thyroid (Hypo/Hyper)
☐ Lung disease	☐ Clotting disorder	☐ Kidney disease
☐ High blood pressure	☐ High cholesterol	☐ Phlebitis (date:________________)
☐ Hepatitis (A/B/C)	☐ Atrial fibrillation	☐ DVT (date:________________)
☐ Arthritis	☐ Cancer	☐ Heart murmur
☐ Leg ulcer(s)	☐ Asthma	☐ HIV/AIDS
☐ Patent Foramen Ovale (PFO)	☐ Other:	

Do you smoke?
☐ No, ☐ Yes (packs per day:________)

Do you drink alcohol?
☐ No, ☐ Yes (drinks per week:________)

Have you had a colonoscopy?
☐ No, ☐ Yes (date:________)

Have you had your flu shot?
☐ No, ☐ Yes (date:________)

Have you had your pneumonia shot?
☐ No, ☐ Yes (date:________)

Have you had a mammogram?
☐ No, ☐ Yes (date:________)

Does anyone in your family have a vein condition? ☐ Father, ☐ Mother, ☐ Uncle, ☐ Aunt, ☐ Brother, ☐ Sister, ☐ Grandfather, ☐ Grandmother, ☐ Other:_________________

Child Rearing History (Females Only):

Number of pregnancies: ________________

Number of miscarriages: ________________

Are you currently pregnant? ☐No, ☐Yes (how many weeks:________)

Are you currently breastfeeding? ☐No, ☐Yes

Richmond Vein Center

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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). Please note that some insurance plans will not preauthorize procedures without us submitting photos.

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 Scott Gould at the Richmond Vein Center, P.C. or to whomever the current Practice Administrator of the Richmond Vein Center, PC is.

______________________	______________________
Printed Name	Witness
______________________	______________________
Signature	Date

In addition to the above stated purposes authorized, I also hereby authorize Richmond Vein Center, PC 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, PC 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, PC will make every effort to insure that all identifying information be removed when using these images.

______________________	______________________
Printed Name	Witness
______________________	______________________
Signature	Date

Stocking Policy

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. **All stocking sales are final.**

The Richmond Vein Center is not a Registered Durable Medical Goods Vendor/Provider; because of this, we cannot bill your insurance for the cost of your stockings or other durable medical goods. Prescription compression stockings are available for purchase elsewhere. If you are interested, we would be happy to provide you with a prescription and direct you to other pharmacies in the area.

Cancellation & Rescheduling Policy

Please note that **multiple cancellations of procedures may cause your insurance to revoke approval for procedures**.

Please understand that cancellations and rescheduling creates a great hardship on our practice, our staff, our providers' schedules and negatively impacts other patients as well. At times, our staff may spend hours on the phone with your insurance company getting approval for your procedures. As a courtesy to our practice and staff, we ask that you do your best to arrive on time for your appointments and let us know as early as possible when it becomes necessary to reschedule.

We have a cancellation fee of $50 for appointments scheduled for a duration of 30 minutes or less and a cancellation fee of $100 for appointments scheduled for a duration greater than 30 minutes. If you have any questions about the duration of your appointment(s), our staff is happy to let you know.

If you let us know at least 2 full business days prior to your appointment time for an **office visit** you will **NOT be charged a cancellation fee**. If you let us know at least 4 full business days prior to your appointment time for a **procedure** you will **NOT be charged a cancellation fee**.

While we regret to have to make such policies, it is necessary to offset some of our costs. Thank you in advance for your understanding.

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

______________________________	______________________________
Printed Name	Witness
______________________________	______________________________
Signature	Date