Patient Information

Name:_____ Date of Birth: _____

Gender: _____ Social Security Number: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

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

Email Address: _____ I want access to Patient Portal: Yes / No

Pharmacy:_____Address:_____Phone:_____

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

In order for us to provide better communication to your providers 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:_____ Phone:_____

Mailing Address:_____City:_____ State:_____Zip:_____

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), 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). 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:**_____

Photographic Image Consent and Release

I hereby authorize Richmond Vein Center, P.C. to take photographic images of my legs and allow them to be used to help document the progress of my leg treatments, to be mailed to my primary care 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 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 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 the Richmond Vein Center, P.C.

Patient 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

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:** _____

HIPPA: 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: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

□ **Release information to no one**

VEIN QUESTIONNAIRE

Patient Name:_____Age:_____ Date of Birth:_____ Date: _____

Reason for Visit:_____ Insurance Carrier_____

Please circle any of the following that apply:

Location: Right Leg Left Leg Both Legs Face

Symptoms: Aching Heaviness Cramping Throbbing Swelling Burning

Restlessness Itching Fatigue Other:_____ No Symptoms

I categorize my symptoms as: Mild Moderate Severe

Symptoms aggravated by: Prolonged Standing Prolonged Sitting Menstrual Cycle Walking Nothing

Symptoms alleviated by: Elevation Stockings Pain Medication Walking Rest Exercise Nothing

My symptoms affect the following activities of my daily living: Work Chores Exercise Childcare Shopping

Have you ever worn compression stockings? Yes / No If yes, how long? Weeks:____ Months:____ Years: _____

Do they help? Yes / No Are they prescription or over the counter?_____

Have you had prior vein treatment? Yes / No If Yes, please list:_____

Does anyone in your family have a vein condition? Yes / No If Yes, list relationship to you:_____

Do you have a history of blood clots or Deep Vein Thrombosis (DVT)? Yes / No If Yes, list date(s):_____

Have you ever had an ulcer or non-healing wound on your leg(s)? Yes / No

Are you currently, or have you ever, taken birth control or hormone therapy medication(s)? Yes / No

Number of Pregnancies: _____

Are you currently pregnant? Yes (Weeks: _____) / No Are you currently breastfeeding? Yes / No

What is your occupation?_____

Staff Use Only

Initials:

HT: WT:

BP: HR:

Temp:

Past Medical History

Please list any medical conditions you have had or are being treated for.

Condition/Disease	Condition/Disease
□ Arthritis	□ Heart Murmur
□ Asthma	□ High Cholesterol
□ Atrial Fibrillation	□ HIV / AIDS
□ Cancer	□ Hypertension
□ Clotting Disorder Type:_____	□ Kidney Disease
□ Depression / Anxiety / Other Psychiatric:_____	□ Lung Disease
□ Diabetes (Type I / Type II)	□ Patent Foramen Ovale (PFO)
□ GERD/Reflux	□ Thyroid (Hypo / Hyper)
□ Heart Disease	□ Other: _____

Past Surgical Procedures/Hospitalizations

Operation/Hospitalization	Month/Year	Operation/Hospitalization	Month/Year

Social History

Do you currently use tobacco? Yes / No PPD: _____ Former Smoker? Yes / No	Do you drink alcohol? Yes / No Quantity: _____/week
Flu Shot: Yes / No Date:_____	Pneumonia Shot: Yes / No Date:_____
Mammogram: Yes / No Date:_____	Colonoscopy: Yes / No Date:_____

Medication List

List prescription and over-the-counter medications you currently take:

Please List Any Allergies (Drug, Food, Environmental)