Richmond Vein Center

RVC-A0

Free Screening Evaluation

Please be informed that your initial “free screening” is a complimentary evaluation of your lower extremities intended to establish the degree and extent of venous disease that may exist in them. This visit includes a physical examination, a history of present and past illness, a discussion of venous reflux and a discussion of the possible treatment options that may be appropriate for you. There is **no charge** to you or your insurance for this service.

This visit does NOT include additional service or tests such as ultrasound examinations, surgical procedures including sclerotherapy or return visits. Those services will be appropriately billed to your insurance company. Any additional co-payments, co-insurance and/or deductible will be your responsibility as specified by your insurance contract.

By signing below, I acknowledge that I have read and understand the terms of this policy.

Printed Name	Witness
Signature	Date

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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: _____

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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Free Screening Note

Patient's Name:

Date of Birth:

1. What is the main reason for attending this screening today?

2. Have you had any previous treatments for vein problems?

3. What are your major symptoms?

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

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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 _____