



## PATIENT HISTORY

**Patient Full Name:** \_\_\_\_\_ **Referred by:** \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ M \_\_\_ F \_\_\_ Occupation: \_\_\_\_\_ % of day standing: <25% \_\_\_ 25-50% \_\_\_ >50% \_\_\_

What is the reason you came to the Vein Center? \_\_\_\_\_

When did your problem begin? \_\_\_\_\_ Is your problem getting worse? \_\_\_\_\_

Previous Treatment? None \_\_\_ Injection \_\_\_ Surgery \_\_\_ Laser \_\_\_ Date: \_\_\_\_\_

Do your legs?: (check applicable) Ache \_\_\_ Feel Heavy/tired \_\_\_ Itch/burn \_\_\_ Swell \_\_\_ Cramp \_\_\_ Throb \_\_\_

Are your symptoms worse after prolonged standing, or at the end of the day? Y \_\_\_ N \_\_\_ N/A \_\_\_

Have you tried elevation?: Y \_\_\_ N \_\_\_ What medication (if any) have you used for leg pain? \_\_\_\_\_

Would you say your leg vein problem decreases your quality of life? \_\_\_\_\_

Do you have: Spider Veins \_\_\_ Varicose Veins \_\_\_ Both \_\_\_ Which leg(s)?: Left \_\_\_ Right \_\_\_

Have you ever worn compression/support stockings? Y \_\_\_ N \_\_\_ If Yes, when and for how long? \_\_\_\_\_

### **Past Medical History:**

Have you ever been diagnosed or treated for any of the following?

AIDS/HIV	Y N	Jaundice	Y N	Anemia	Y N	DVT ("clots")	Y N
Asthma	Y N	Kidney Disease	Y N	Heart Pacemaker	Y N		
Cancer	Y N	Liver Disease	Y N	Siezuers	Y N		
Diabetes	Y N	Lung Disease	Y N	Arthritis	Y N		
Heart Disease	Y N	Stroke/TIA	Y N	Eczema/Psoriasis	Y N		
Rheumatic Fever	Y N	Thyroid Disease	Y N	Acne	Y N		
Hepatitis	Y N	Leg Ulcer	Y N	Artificial Joint	Y N		
Hypertension	Y N	Peptic Ulcer/GERD	Y N	Thrombophlebitis	Y N		

**Past Surgical History:** List previous non-vein operations and dates: \_\_\_\_\_

**Current Medications:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

### **Review of Systems:**

Have you ever had a REACTION to a LOCAL anesthetic? (example Novocain, etc) Y N

Do you have excessive bleeding? Y N Have you had a miscarriage? Y N

Do you form heavy scars? Y N FEMALES- Last Menses: \_\_\_\_\_

### **Social History:**

Do you Smoke? Y N if yes, for how long? \_\_\_\_\_ Do you drink alcohol? Y N

### **Family History:** (Father, Mother, Sister, Brother, Children)

Varicose/Spider Veins  Cancer  Heart Disease  Kidney Disease  Lung Disease  
 Diabetes  High Blood Pressure  Liver Disease  Stroke  DVT

Have you seen other physicians about the same problem which brings you here today? Y N

NOTES: \_\_\_\_\_

# Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient

I consent to the use or disclosure of my protected health information by Cosmetic Vein Centers of Virginia (CVCV) for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of CVCV. I understand that analysis, diagnosis or treatment of me by CVCV may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. CVCV is not required to agree to the restrictions that I may request. However, if CVCV agrees to a restriction that I request, the restriction is binding on CVCV. I have the right to revoke this consent, in writing, at any time, except to the extent that CVCV has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been offered a copy of the Notice of Privacy Practices of Cosmetic Vein Centers of Virginia and understand that I have a right to a copy of CVCV Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of CVCV. The Notice of Privacy Practices for CVCV is also posted in the waiting room at 1901 South Main Street Suite 2 Blacksburg, VA. 24060. This Notice of Privacy Practices also describes my rights and duties of CVCV with respect to my protected health information.

CVCV reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of CVCV and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Date of Signing

\_\_\_\_\_  
Witness

## **Insurance Notification**

Your insurance company will only pay for services that it determines to be reasonable and medically necessary. If your insurance determines that a particular service is not medically necessary (cosmetic), it may deny payment for the services rendered.

If my insurance company denies payment, I agree to be responsible for all the charges and I understand that if I fail to pay my account in full that it will be sent to a collection agency and I will be responsible for any additional fees that may incur due to collections. I request that payment of authorized insurance benefits be made on my behalf to Cosmetic Vein Centers of Virginia for any services furnished to me by that provider. I certify that the information given by me to Cosmetic Vein Centers of Virginia in applying for payment under my insurance program is correct and complete. I authorize release of all records required to act on this release and assignment.

**YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS YOUR INSURANCE CLAIMS AND  
TO ENSURE PAYMENT OF SERVICES RENDERED.**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## **Consent to Photograph**

As a routine part of my medical evaluation I do hereby give my informed consent to being photographed. I further understand that the purpose of photography is as follows:

Photography will be used to document vein anatomy.

Appearance changes and improvements.

Detection of worsening of the vein condition which might lead to a need for reevaluation and changes in treatment plan.

I further understand that these materials will have the same confidential status, as would any other information obtained during the course of the evaluation, and that appropriate steps will be taken to maintain confidentiality.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

# Medicare Patients

## ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare may not pay for –**

**Items or Services:**

- Initial evaluation
- Diagnostic ultrasound

**Because the service might be considered:**

Cosmetic, Not a covered service, Not Medically Necessary

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make any decision about your options, you should:

- **Read this entire notice carefully.**
- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: \$ \_\_\_\_\_**), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

**Option 1. YES. I want to receive these items or services.**

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

**Option 2. NO. I have decided not to receive these items or services.**

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Signature of patient or person acting on patient's behalf

Date

**NOTE: Your health information will be kept confidential.** Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.



*Cosmetic Vein Centers of Virginia*

Please circle any of the following which are particularly troublesome to you:

Weight loss, weight gain, night sweats, fevers

Decreased vision, double vision, blurred vision

Palpitations, shortness of breath, chest pain, fatigue

Painful swallowing, indigestion, vomiting blood, severe diarrhea, jaundice, bloody or tarry stools

Kidney or bladder disease, inability to urinate or painful urination, bloody urine

Swollen lymph nodes, bleeding disorder

Rash, bruising, change in size or color of moles

Course, nosebleeds, sinus drainage, ringing in ears, pain, deafness

Cough, increased sputum production, painful breathing

Paralysis, weakness, seizure, incoordination, numbness or tingling

Bone or joint deformity, trauma, or limited motion

Change in appetite, excessive thirst or urination, goiter

Immune disorders or immunosuppression (transplant)

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