Advanced Vascular and Vein Center
4242 Farnam Street, Suite 490
Omaha, NE 68131

Patient Demographics

Name: _____ _____ _____
(First) (M.I) (Last)

DOB: _____/_____/_____ Age: _____ SS#: _____-_____-_____

Address: _____

_____ , _____ _____
(City) (State) (Zip)

Home Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____

Email Address:_____

Preferred Language: _____ Preferred Name: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Race: ☐ White ☐ American Indian ☐ Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic ☐ Native Hawaiian/Pacific Islander ☐ Other

Employer Information

Employment Status: ☐ Full time ☐ Part time ☐ Retired ☐ Unemployed ☐ Other: _____

Patient Employer: _____ Occupation: _____

Work Address: _____

_____ _____ _____ Work Phone: ( ) _____-_____
(City) (State) (Zip)

Emergency Contact Information

Name: _____ Relationship: _____

Contact Number: ( ) _____-_____

Name: _____ Relationship: _____

Contact Number: ( ) _____-_____

Name: _____ Relationship: _____

Contact Number: ( ) _____-_____

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VARICOSE VEIN PATIENT HEALTH INFORMATION

Name:_____ Date:_____

Sex: ☐ Male ☐ Female Age:_____ DOB:_____ Height:_____ Weight: _____

Primary Care Provider:_____ Best Daytime Phone #_____

Vein History:

Do both legs bother you? ☐ Yes ☐ No

Which leg is the most bothersome? ☐ Right ☐ Left ☐ Equal

Do you experience any of the following symptoms?

Aching/pain in your legs	☐ Yes	☐ No	Heaviness	☐ Yes	☐ No
Tiredness/fatigue	☐ Yes	☐ No	Itching/burning	☐ Yes	☐ No
Swollen ankles/legs	☐ Yes	☐ No	Bleeding	☐ Yes	☐ No
Restless legs	☐ Yes	☐ No	Spider Veins	☐ Yes	☐ No
Red/warm areas	☐ Yes	☐ No	Skin Ulcers	☐ Yes	☐ No
Throbbing	☐ Yes	☐ No	Skin Discoloration	☐ Yes	☐ No

Any other symptoms:_____

How long have you had the symptoms? Month _____ Years _____

Were any of these symptoms related to?

Pregnancy ☐ Yes ☐ No

Accident/Trauma ☐ Yes ☐ No

Do your symptoms get worse with:			Do your symptoms improve with:		
Prolonged Standing	☐ Yes	☐ No	Walking	☐ Yes	☐ No
Prolonged Sitting	☐ Yes	☐ No	Rest/Elevation	☐ Yes	☐ No
Menstrual Cycle	☐ Yes	☐ No	Pain Medication	☐ Yes	☐ No

Are you developing new veins? ☐ Yes ☐ No

Are your present veins getting bigger? ☐ Yes ☐ No

Do you stand much at work? ☐ Yes ☐ No How long?_____

Do you stand much at home? ☐ Yes ☐ No How long?_____

Have you ever had your veins evaluated before? ☐ Yes ☐ No

If so, what doctor and when? _____

Did this doctor perform any tests on your veins (ex. Ultrasound)? _____

Do you wear support hose prescribed by a doctor? ☐ Yes ☐ No

If yes, what brand and do they provide relief? ☐ Yes ☐ No

_____

Do you wear light support hose (ex. sheer energy)? ☐ Yes ☐ No

If yes, do they provide relief? ☐ Yes ☐ No

Have you ever had any vein surgery? (stripping) ☐ Yes ☐ No

If yes, which leg and what year? ☐ Right ☐ Left Year: _____

Have you ever had vein injections? ☐ Yes ☐ No

If yes, which leg and what year? ☐ Right ☐ Left Year? _____

Have you ever had any blood clots? ☐ Yes ☐ No

If yes, which leg and what year? ☐ Right ☐ Left Year? _____

Have you ever had phlebitis? ☐ Yes ☐ No

If yes, which leg and what year? ☐ Right ☐ Left Year? _____

Past Medical History:

Allergies:

Do you have any medication allergies?

_____

_

_____

_

Describe how they affect you:

_____

_____

Latex	☐ Yes	☐ No	Lidocaine	☐ Yes	☐ No
Band-Aid tape / adhesive	☐ Yes	☐ No	Anesthesia	☐ Yes	☐ No

Medications:

Are you taking blood thinning medications? ☐ Yes ☐ No

Are you taking birth control pills or hormones? ☐ Yes ☐ No

Are you taking any prescription medications? ☐ Yes ☐ No

If yes, please list:

_____
_____
_____
_____

Surgeries:
List any surgeries you have had and the date performed:_____
_____
Any prior problems with anesthetics? ☐ Yes ☐ No
If yes, please describe:_____

Hospitalizations:
If you have been hospitalized for reasons other than those above, please list the dates and reasons:
_____
_____

Prior Imaging:
Have you had a prior MRI, Ultrasound, CT scan or other images? ☐ Yes ☐ No
Dates and where performed:_____
_____

Social History:

What is your profession? _____ Do you drink alcohol? ☐ Yes ☐ No

Do you smoke or chew tobacco? ☐ Yes ☐ No If yes, how much and how often?

If yes, how much? _____

Marital Status: S M D W

Family History:
Please circle all that apply:

Hypertension Heart Disease Diabetes Lung Disease Varicose Veins

Blood Clots Cancer If so, what type:_____

<u>Review of Symptoms:</u>
Have you had any of the following problems (include both past and present)

General			**Genitourinary**		
Fatigue	☐ Yes	☐ No	Blood in Urine	☐ Yes	☐ No
Fever, Chills, or Sweats	☐ Yes	☐ No	Kidney Failure	☐ Yes	☐ No
Weight Changes	☐ Yes	☐ No	Kidney Stones	☐ Yes	☐ No
Diabetes or High Blood Sugar	☐ Yes	☐ No	Other:_____	☐ Yes	☐ No
Other:_____	☐ Yes	☐ No			

Psychiatric **Musculoskeletal**

Anxiety	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Other:_____	☐ Yes	☐ No
Other:_____	☐ Yes	☐ No			

Eyes

Glaucoma	☐ Yes	☐ No	Diabetes Mellitus	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Thyroid Disorder	☐ Yes	☐ No
Corrective Lenses	☐ Yes	☐ No	Other:_____	☐ Yes	☐ No
Other:_____	☐ Yes	☐ No			

Ear-Nose-Throat

Hearing Loss	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Nosebleeds	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Sinus Pain	☐ Yes	☐ No	History of Recent Chemotherapy	☐ Yes	☐ No
Other:_____	☐ Yes	☐ No	History of Radiation	☐ Yes	☐ No
			Other:_____	☐ Yes	☐ No

Respiratory

Asthma	☐ Yes	☐ No	Viral Hepatitis (A, B, C)	☐ Yes	☐ No
COPD/Emphysema	☐ Yes	☐ No	Other:_____	☐ Yes	☐ No
Frequent Cough	☐ Yes	☐ No			
Coughing up Blood	☐ Yes	☐ No	**Neurologic**		
Shortness of Breath	☐ Yes	☐ No	Chronic Headaches	☐ Yes	☐ No
Other:_____	☐ Yes	☐ No	Frequent Dizziness	☐ Yes	☐ No
			Seizures or Epilepsy	☐ Yes	☐ No
Cardiovascular			Stroke	☐ Yes	☐ No
Chest Pain/Pressure	☐ Yes	☐ No	Arm or Leg Weakness	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Other:_____	☐ Yes	☐ No
Heart Disease/Murmur	☐ Yes	☐ No			
Heart Attack	☐ Yes	☐ No	**Skin**		
Pacemaker	☐ Yes	☐ No	Hives or Rashes	☐ Yes	☐ No
Irregular Heart Beat	☐ Yes	☐ No	Skin Disorders	☐ Yes	☐ No
Other:_____	☐ Yes	☐ No	Other:_____	☐ Yes	☐ No

Gastrointestinal			Women		
Acid Reflux or heartburn	☐ Yes	☐ No	Could you be pregnant now?		
Ulcer Disease	☐ Yes	☐ No	How many times have you been		
Frequent Abdominal Pain	☐ Yes	☐ No	Do you intend to have any more children?	☐ Yes	☐ No
Change in Bowel Habits	☐ Yes	☐ No			
Gallbladder Problems	☐ Yes	☐ No	Are you currently breast-feeding?	☐ Yes	☐ No
Other:_____	☐ Yes	☐ No	Who is your OB/GYN?		
			Other:_____		

Patient Signature:_____ Date:_____

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Insurance Information

PLEASE HAVE YOUR PHOTO ID & INSURANCE CARDS AVAILABLE FOR COPYING AT EACH VISIT. ALL COPAYS ARE DUE AT THE TIME OF THE SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

Primary Insurance

Insurance Carrier:	Effective Date:
Member ID:	
Group:	
Policy Holder Name:	Policy Holder DOB:
Policy Holder SSN:	Policy Holder Employer:

Secondary Insurance

Insurance Carrier:	Effective Date:
Member ID:	
Group:	
Policy Holder Name:	Policy Holder DOB:
Policy Holder SSN:	Policy Holder Employer:

Tertiary Insurance

Insurance Carrier:	Effective Date:
Member ID:	
Group:	
Policy Holder Name:	Policy Holder DOB:

Policy Holder SSN:	Policy Holder Employer:

Information Release and Consent to Treatment
Private Insurance Authorization for Assignment of Benefits

I, the undersigned, authorize payment of medical services to Advanced Vascular and Vein Center for any services furnished to me by the physician/s. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

I, knowing that I have a condition requiring diagnosis, treatment, or related medical care do hereby consent to such care, medical examinations, operations, procedures, therapy sessions, photographs, and/or treatment by my attending physician, their assistants, or designees as may be necessary in their professional judgment. I further acknowledge that no guarantees have been made to me as to the results of such care, medical examinations, operations, procedures, therapy sessions and/or treatments.

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Patient Financial Policy

We are committed to providing you with the best possible care, and will help you receive your maximum allowable insurance benefits. However, we need your assistance and your understanding of our payment policy. Your insurance contract is between YOU/YOUR INSURANCE COMPANY/YOUR EMPLOYER. (Please refer to enclosed document-"Understanding Your Insurance Coverage") Not all services are covered by all contracts.

We participate and accept assignment from most major payers, which means covered charges, will be paid directly to us. If we do not participate in your insurance plan, you may still choose to be seen by the practice. As a courtesy to you, we will file a claim with your insurance carrier on your behalf. Any remaining balance will be billed to you once we have received a remittance from your insurance carrier.

Due to current federal and insurance regulations, ALL co-payments, co-insurance and deductibles are collected at the time of service. We accept cash or checks, and for your convenience, Visa, MasterCard, and Discover. Additional fees, which typically are not covered by insurance plans, will be charged for services such as copying of medical records and completion of disability forms. A fee of $35.00 will be charged for checks returned for insufficient funds. An additional monthly fee may be charged on all past due accounts and co-pays not paid at time of visit. We encourage you to contact our **Billing Company** promptly for assistance in the management of your account. We are here to help you and will be happy to answer any questions you may have about your treatment or insurance coverage.

Billing Company:
USMD Billing
13036 SE Kent-Kangley Rd, Suite 360

Kent, WA 98030
Toll Free (844) 218-1178 (Option #5)

Patient Financial Agreement

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for ANY professional services rendered. I have read the above Patient Financial Policy and have provided the Practice with true and correct insurance information. I will notify you of any changes in my health insurance coverage.

A copy of this agreement may be used in place of the original.

_____ _____

(Signature of Patient, Policy Holder or Legal Guardian) (Date)

_____

(Printed Name)

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Understanding Your Insurance Coverage

Your insurance policy is an agreement between you and your insurance company. The policy lists a package of medical benefits such as tests, drugs, and treatment services. The insurance company agrees to cover the cost of certain benefits listed in your policy. These are called "covered services".

Your policy also lists the kinds of services that are not covered by your insurance company. You have to pay for any uncovered medical care that you receive. Keep in mind that a medical necessity is not the same as a medical benefit. A medical necessity is something that your doctor has decided is necessary. A medical benefit is something that your insurance plan has agreed to cover. In some cases, your doctor might decide that you need medical care that is not covered by your insurance policy.

Insurance companies determine what tests, drugs and services they will cover. These choices are based on their understanding of the kinds of medical care that most patients need. Your insurance company's choices may mean that the test, drug or service you need isn't covered by your policy.

Your doctor will try to be familiar with your insurance coverage so he/she can provide you with covered care. However, there are so many different insurance plans that it is not possible for your doctor to know the specific details of each plan. By understanding your insurance coverage, you can help your doctor recommend medical care that is covered in your plan.

- ✓ Take the time to read your insurance policy. It's better to know what your insurance company will pay for before your receive a service, get tested or fill a prescription. Some kinds of care may have to be approved by your insurance company before your doctor can provide them.
- ✓ If you still have questions about your coverage, call your insurance company and ask a representative to explain it.

- ✓ Remember that your insurance company, not your doctor, makes the decisions about what will be paid for and what will not.
- ✓ Remember that your doctor, not your insurance company, makes medical decisions and recommendations about what will benefit your health status.

Most of the things your doctor recommends will be covered by your plan, but some may not. When you have a test or treatment that isn't covered, or you get a prescription filled for a drug that isn't covered, our insurance company won't pay the bill. This is often called "denying the claim". You can still obtain the treatment your doctor recommended, but you will have to pay for it yourself.

If your insurance company denies your claim, you have the right to appeal (challenge) the decision. Before you decide to appeal, know your insurance company's appeal process. This should be discussed in your plan book.

_____
(Patient Initials)

_____
(Date)

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Notice of Health Information Practices
Notice of Privacy Policies

Acknowledgement of Understanding Statement

I,_____, have had access to the Advanced Vascular and Vein Center, LLC, Notice of Privacy Policies.

I understand:

Each time I visit Advanced Vascular and Vein Center, LLC, a record of my visit is made. Typically, this record contains my symptoms, examination, test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as my health or medical record, serves as:

- Basis for planning my care and treatment.
- Means of communication among the many health professionals who contribute to my care.
- Legal document describing the care I received.
- Means by which I or a third-party payer can verify that services billed were actually provided.
- A tool in educating health professionals.
- A source of data for medical research, a source of information for public health officials charged with improving the health of this state and the nation.
- A source of data for Advanced Vascular and Vein Center, LLC's planning and marketing.
- A tool which Advanced Vascular and Vein Center, LLC, can assess and continually work to improve the care rendered and the outcomes achieved.

Authorized Release:

I understand that Advanced Vascular and Vein Center, LLC, is only allowed to release medical information to the individual patient with the exceptions of minors, Worker Compensation cases, and any individual designated by patient, in writing, to access his/her medical records. This includes picking up medication, prescriptions, DME products and x-rays. I give permission to the following individual/s to have access to this information. Proof of ID must be shown any time information is received.

_____	_____
(Name)	(Relationship)
_____	_____
(Name)	(Relationship)
_____	_____
(Name)	(Relationship)

I can change this information at any time by notifying Advanced Vascular and Vein Center, LLC, in writing of the changes.

_____	_____
(Patient/Responsible Party Signature)	(Date)