Patient Information

Date:_____

Last Name:_____ First Name:_____ Middle Initial:_____

DOB:_____ Gender: Male / Female Marital Status:_____

Address:_____

City:_____ State:_____ Zip:_____

Social Security Number:_____ and/or Driver's License: _____

Phone Number:_____home/cell/work __ okay to leave message

Additional Phone Number: _____home/cell/work __ okay to leave message

Email:_____ Are you here in relation to a Work Comp Injury: Yes / No

Referring Physician:_____ Primary Care Physician:_____

Preferred Pharmacy:_____ Pharmacy Location:_____

Emergency Contact_____ Relationship:_____ Phone Number:_____

Insurance Information

Primary Insurance Company:_____ Insurance ID #:_____

Secondary Insurance Company:_____ Insurance ID #:_____

Do you have any additional Health Care Coverage? Y__ N__ Company Name:_____

Are you under the care of a Home Health Agency or a Resident of a Skilled Nursing Facility? Y__ N__
Company Name:_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Inovia. I understand that I am financially responsible for any balance. I also authorize Inovia Vein Specialty Center or insurance company to release any information required to process my claims.

X_____ _____

Patient/Guardian signature Date

Referral Notice (SB 683) Compliance (Required by State of Oregon)

According to (SB 683) the Oregon Health Authority Public Health Division requires a health care practitioner to notify a patient of the patient's right of choice when referred for care. The patient has a choice and when referred to a facility for a diagnostic test or health care treatment or service the patient may receive the diagnostic test or health care treatment or service at a facility other than the one recommended by the health practitioner; If the patient chooses to have the diagnostic test, health care treatment or service at a facility different from the one recommended by a practitioner, the patient is responsible for determining the extent of coverage or the limitation on coverage for the diagnostic test, health care treatment or service at the facility chosen by the patient; A health practitioner may not deny, limit or withdraw a referral solely because the patient chooses to have the diagnostic test or health care treatment or service at a facility other than the one recommended by the health practitioner. I acknowledge I have been informed of my rights and my provider/ Inovia staff is available if I have further questions or need more information.

_____ Patient/Responsible Parties' Initials

Patient Appointment Responsibilities

Your appointments are determined by your physician to optimize the results from your treatment plan. In addition to the clinical benefit of the structured appointment schedule, the schedule makes it possible to assure that the appropriate medical personnel, including the physician, ultrasound technologist, or medical assistant as well as the required medical equipment and facilities are available to complete your treatment safely and effectively. To ensure your quality of care and the quality of care of all other scheduled patients, we require a minimum of a 24 hour notification in the event that your appointment must be rescheduled. Any No Show appointment may result in a $50.00 fee not billable to Insurance.

Patient Signature _____ *Date*_____

Disclosure of Relevant Industry Relationships

Inovia, LLC, care providers (Physicians and Physician Assistants) may collaborate with the pharmaceutical or medical device industries with products used in this practices industries to help develop medical breakthroughs, provide medical expertise or education. Inovia, LLC discloses the names of companies where when (i) its care providers receive $5,000 or more per year for speaking and consulting, (ii) its care providers serve as a fiduciary, (iii) its care providers receive or have the right to receive royalties or (iv) its care providers hold any equity interest for the care provider's role as inventor, discoverer, developer, founder or consultant. In disclosing this information, Inovia, LLC tries to provide information as accurately as possible about its care provider's connections with industry that has relevant products to this practice. As of October 1, 2018, these include:

- Dr. Jones discloses he receives fees of $5,000 or more as a paid consultant, speaker or member of an advisory committee for the following companies:
  - Medtronic (which makes the VenaSeal and ClosureFast products used in this practice.
- Dr. Boyle discloses he receives fees of $5,000 or more as a paid consultant, speaker or member of an advisory committee for the following companies:
  - Medtronic (which makes the VenaSeal and ClosureFast products used in this practice.
- Dr. Gilster reports he has no relevant disclosures related to companies that make products or services related to this practice.
- Dr. Nicoloff reports he has no relevant disclosures related to companies that make products or services related to this practice.
- Trebor Struble, PA-C, reports he has no relevant disclosures related to companies that make products or services related to this practice.
- Beth Orton, PA-C, reports he has no relevant disclosures related to companies that make products or services related to this practice.

Patient Signature _____ *Date*_____

HIPAA- Receipt of Notice of Privacy Practices & Authorization for Release of Information

I understand that Inovia Vein Specialty Centers will use and disclose health information about me. My health information may include information both created by and received by Inovia Vein Specialty Centers. This may be in the form of written or electronic records, words spoken and may include information about my health history, health status, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

I also understand that I have the right to receive and review a written description of how Inovia Vein Specialty Centers will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Inovia Vein Specialty Centers and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a current version of Inovia Vein Specialty Centers Notice of Privacy Practices. I understand that a copy or summary of the most current version of Inovia Vein Specialty Centers in effect will be posted in the reception area and available on the website, if applicable.

I understand that I have the right to ask that some or all of my health information not to be used or disclosed in the manner described in the Notice of Privacy Practices and I understand that Inovia Vein Specialty Centers is not required by law to agree to such requests.

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to anyone other than yourself, you must sign this form. Signing this form will only give information to those indicated below.

I authorize Inovia Vein Specialty Center to release my medical and/or billing information to the following individual(s):

1. _____ Relationship:_____ Phone Number:_____
2. _____ Relationship:_____ Phone Number:_____

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to disclosure by the above recipient.

You have the right to revoke this consent in writing.

By Signing below, I agree that I have reviewed and understand the information above and that I have been offered a copy of the Notice of Privacy Practices.

X_____ _____

Patient/Guardian signature Date

New Patient History

Symptoms: (*Please check if yes)*

	R	L
Aching / Pain in legs	☐	☐
Heaviness	☐	☐
Tiredness / Fatigue	☐	☐
Itching / Burning / Warmth	☐	☐
Leg cramping	☐	☐
Leg restlessness	☐	☐
Throbbing	☐	☐
Swelling	☐	☐

Check if you've had any of the following:

☐ Weight Loss ☐Weakness ☐ Night Sweats
☐ Loss of Appetite ☐ Bleeding Problems ☐ Fever
☐ Chest Pain ☐ Shortness of Breath ☐ Chills

Allergies: **Reaction:**

_____/_____
_____/_____
_____/_____

Regarding your symptoms:

Do your symptoms interfere with your sleep? ☐ Yes ☐ No
Do your symptoms keep you from doing anything? ☐ Yes ☐ No
Are your symptoms worse later in the day? ☐ Yes ☐ No
Are your symptoms worse with or after activity? ☐ Yes ☐ No
Do you / have you ever worn compression stockings? ☐ Yes ☐ No
Leg Pain on a scale of 1-10 _____ ☐ R ☐ L

Major surgery / hospitalizations: **Year**:

_____/_____
_____/_____
_____/_____
_____/_____

Regarding your health:

Are you Diabetic? ☐ Type I ☐ Type II
Do you drink alcohol? (Frequency)_____ ☐ Yes ☐ No
Are you a current smoker? ☐ Yes ☐ No
Height ____ ft ____ inches Weight _____ lbs

Past Medical History:

_____
_____
_____
_____
_____
_____

Current Medications: *Include prescription drugs, Over-the-Counter drugs, vitamins, minerals, herbals, dietary (nutritional) supplements*

☐ None ☐ See list of medications provided

#	Medication Name	Dose	Frequency	Reason
1				
2				
3				
4				
5				
6				

Please check if you have, or have had, any of the following:

☐ A prior evaluation for your veins: _____ (yr)
☐ Previous vein surgery or laser treatments: _____ (yr) ___ R ___ L
☐ Previous vein injections: _____ (yr) ___ R ___ L
☐ Bleeding from a vein: _____ (yr) ___ R ___ L
☐ A leg ulceration: _____ (yr) ___ R ___ L
☐ A family history of vein disease
☐ A family history of leg ulceration
☐ A family history of blood clots
☐ A family history of a clotting disorder
☐ Superficial thrombophlebitis or an inflammation of a vein: _____ (yr) _____ R _____ L _____ (Location)
☐ Any type of blood clot: _____ (yr) _____ R _____ L _____ (Location)
☐ Any type of clotting disorder: _____ (Diagnosis)
☐ Migraines with aura
☐ Diagnosed with a PFO (patent foramen ovale)
☐ Peripheral Arterial Disease (PAD)
☐ Leg trauma / surgery

Financial Policy/Acknowledgement

Inovia Vein is committed to providing you with the highest quality of medical care in an efficient and cost effective manner. We ask that you please read through and sign our financial acknowledgement prior to any treatment. This form will be given back to you for your records.

All charges, regardless of insurance coverage, are the responsibility of the patient. Inovia Vein will verify Insurance benefits as a courtesy to you. We do not guarantee benefits quoted by your insurance company are a guarantee of payment. Knowledge of any Covered/Non Covered services is the responsibility of the patient. At Inovia Vein, we encourage every patient to contact their insurance company to verify coverage. Any service not covered by your insurance company is ultimately the responsibility of the patient.

Inovia Vein must bill the visit according to services rendered. Please see the following list of common CPT codes used here at Inovia Vein:

- New Patient Visit 99204
- Established Patient Visit 99214
- Ultrasound Scan (one leg) 93971
- Ultrasound Scan (bilateral) 93970
- Arterial Brachial Index Screen 93922
- Radiofrequency Vein Ablation 36475
- Stab Phlebotomy (AP) 37765
- Venaseal 36482
- Varithena 36465
- Sclerotherapy 36471
- Ultrasound Guided Needle Placement 76942

Patients will be asked to provide their current insurance along with current demographics at time of their initial visit with Inovia Vein. We will also ask to verify demographics upon the patient's first visit of each new calendar year. It is ultimately the patient's responsibility to inform our office of any insurance, address or telephone number changes. Failure to do so could result in a balance being the patient's responsibility.

Under the terms of the contract we have with your insurance company, once your insurance has processed your claim, any remaining balance is your financial responsibility. We expect prompt payment of any co-insurance, deductibles or any other monies due. For any returned or denied payments a $25.00 Non-Sufficient Fund fee may apply. Please be aware that some of the treatments or tests performed at Inovia Vein may not be a covered service with your insurance policy or may not be considered medically necessary. Again we urge our patient's to call their insurance company to verify coverage.

Patients will receive monthly statements. If the patient account remains delinquent through 3 billing cycles the account will be referred to an outside collections agency and patient may be responsible for collection fees. At that time, patient care may be terminated if account continues to remain delinquent.

Co-payments will be verified upon your first visit at Inovia Vein and will be expected at each visit. We are required under agreement with your insurance company to collect this from you.

For patients without insurance, full payment is due at the time of service. We do not offer payment plans for these services.

I, _____ have read and understand the above Financial Policy for Inovia Vein Specialty Center.

Patient Signature: _____ Date: _____