

Patient Information

Date: _____

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

DOB: _____ Gender: _____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip: _____

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

Cell #: _____ ok to leave message? Y N Home #: _____ ok to leave message? Y N

Email: _____ Is this in relation to a Work Comp Injury: Y N

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Referring Physician: _____ Primary Care Physician: _____

Preferred Pharmacy: _____ Location: _____

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*

Patient Appointment Responsibilities

Your appointments are determined by your care providers 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 care providers 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 48 hour notification in the event that your appointment must be rescheduled. Any no show appointment may result in a **\$50.00** fee which is not billable to insurance.

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X _____
Patient/Guardian signature *Date*



CONFIDENTIAL: This document may contain confidential information and/or patient protected health information (PHI). As such, this information should not be disclosed to any unauthorized persons or parties.

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 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



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New Patient History

Symptoms: (Please check if yes)

- | | | |
|-----------------------------|--------------------------|--------------------------|
| | R | L |
| Aching / Pain in legs | <input type="checkbox"/> | <input type="checkbox"/> |
| Heaviness | <input type="checkbox"/> | <input type="checkbox"/> |
| Tiredness / Fatigue | <input type="checkbox"/> | <input type="checkbox"/> |
| Itching / Burning / Warmth | <input type="checkbox"/> | <input type="checkbox"/> |
| Leg cramping | <input type="checkbox"/> | <input type="checkbox"/> |
| Leg restlessness | <input type="checkbox"/> | <input type="checkbox"/> |
| Throbbing | <input type="checkbox"/> | <input type="checkbox"/> |
| Swelling | <input type="checkbox"/> | <input type="checkbox"/> |
| Leg Pain on a scale of 1-10 | _____ | |

Height: _____' _____" Weight: _____ lbs

Regarding your health:

- Do you have diabetes? Yes No
- Do you drink alcohol? Yes No
- Smoker? Current Former Never

Check if you've had any of the following:

- | | | | |
|---------------|--------------------------|---------------------|--------------------------|
| Weakness | <input type="checkbox"/> | Weight Loss | <input type="checkbox"/> |
| Fever/ Chills | <input type="checkbox"/> | Loss of Appetite | <input type="checkbox"/> |
| Chest Pain | <input type="checkbox"/> | Night Sweats | <input type="checkbox"/> |
| Bleeding | <input type="checkbox"/> | Shortness of Breath | <input type="checkbox"/> |

Regarding your symptoms:

- Do your symptoms interfere with 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
- Have you ever worn compression stockings? Yes No

Major Surgery / Hospitalization

Year

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

Medication Allergies

Reaction

_____	_____
_____	_____
_____	_____
_____	_____

Past Medical History

Females Only

- Deep Pelvic Pain Pelvic Pressure Vulva Varicosities

Current Medications: *Include prescription drugs, Over-the-Counter drugs, vitamins, minerals, herbs, dietary supplements*

- None See list of medications attached/provided

#	Medication Name	Dose	Frequency	Reason
1				
2				
3				

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

- | | | |
|--|----------------------------|---|
| <input type="checkbox"/> A prior evaluation for your veins: _____ (yr) | <input type="checkbox"/> R | <input type="checkbox"/> L _____ (year) |
| <input type="checkbox"/> Previous vein surgery or laser treatments: _____ (yr) | <input type="checkbox"/> R | <input type="checkbox"/> L _____ (year) |
| <input type="checkbox"/> Previous vein injections: _____ (yr) | | |
| <input type="checkbox"/> Bleeding from a vein: _____ (yr) | | |
| <input type="checkbox"/> A leg ulceration: _____ (yr) | | |
| <input type="checkbox"/> Superficial thrombophlebitis or an inflammation of a vein: | | |
| <input type="checkbox"/> Any type of blood clot: | | |
| <input type="checkbox"/> Any type of clotting disorder: _____ (diagnosis) _____ (year) | | |
| <input type="checkbox"/> Migraines with aura | | |
| <input type="checkbox"/> Peripheral Arterial Disease (PAD) | | <input type="checkbox"/> Leg trauma / surgery |

FAMILY HISTORY:

- 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



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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 | • Radiofrequency Ablation | 36475 |
| • Follow up Visit | 99214 | • Venaseal Ablation | 36482 |
| • Ultrasound Scan (One leg) | 93971 | • Varithena Ablation | 36465 |
| • Ultrasound Scan (Both legs) | 93970 | • Sclerotherapy | 36471 |
| • Arterial Brachial Index Screen | 93922 | • Stab Phlebectomy (AP) | 37765 |

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, along with any available contact information, 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.

X _____

Patient/Guardian signature

Date



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