Vein Care Solutions
4401 Coit Rd Medical Pavilion I Suite 401
Frisco, TX 75035

PATIENT INFORMATION

	Employer:
Social Security #:	**Employer Address**:
Name:	**Employer City**:
Address One:	**Employer State**: Zip:
Address Two:	**Email**:
City:	**Usual Provider**:
State: **Zip**:	**Referring Provider**:
Home Phone#:	**PCP**:
Work Phone#:	**Marital Status**:
Mobile Phone#:	**Employment Status**: FT / PT / Self
Sex:	Not Employed / Retired / Military
Date of Birth:	**Student Status**: FT / PT / Not a Student
Referral Source: Allen Image, Internet, Insurance, Frisco Style Magazine, Living Magazine McKinney Magazine, Vein Directory, VNUS website, Centennial Medical Center, Word Of Mouth.	

EMERGENCY INFORMATION

Name:	**Home Phone#**:
Address One:	**Work Phone#**:
Address Two:	**Cell Phone#**:
City:	**Relationship to Patient**:
State: **Zip**:	

INSURANCE POLICY INFORMATION

Primary Insurance:	**Secondary Insurance**:
Copay:	**Copay**:
Subscriber:	**Subscriber**:
ID#:	**ID#**:
Subscriber SS#:	**Subscriber SS#**:
Subscriber DOB:	**Subscriber DOB**:
Group Number:	**Group Number**:
Group Name:	**Group Name**:
Ins. Phone#:	**Ins. Phone#**:

Patient Signature:_____Date:_____

Assignment of Benefits/Release of Information/Notice of Privacy Practices/Appointment of Authorized Representative

Please read and initial each paragraph

_____ Vein Care Solutions and associated physicians are committed to securing the privacy of your health information. We are supplying you with a copy of our Notice of Privacy Practices. You are not required to read this notice. By initialing, you are acknowledging receipt of this notice.

_____I request that payment of authorized Medicare and other insurance benefits be made on my behalf to Vein Care Solutions for any services furnished to my by any healthcare providers associated with that group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or insurance company any information needed to determine these benefits or the benefits payable for related services.

_____I appoint Vein Care Solutions to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

_____Unless I request to the contrary in writing, I will accept appointment reminders on my home telephone answering system and/or appointment reminder cards sent by mail, whichever is the policy of this practice

_____ Our office reserves the right to charge for a late cancellation or failure to not show. If we do not receive a 24 hour notice that an appointment will not be kept we may/will charge a late fee of $50.00.

Patient Financial Responsibility Statement

In order to maintain our fees at the lowest possible level, it is important that we have a good understanding with our patients regarding financial responsibility. We hope that this summary will be helpful toward that end. We encourage you to discuss it with us and to ask questions.

We understand that your health coverage is provided through

- If you have out-of-network benefits, we will happily file claims on your behalf.
- You must pay any co-payment and applicable deductible amounts at the time of service unless other arrangements have been made with our office
- The remainder of your bill will be sent to your health plan for direct payment to our office
- If your insurance carrier has not paid our claim within 45 days, we will expect payment from you.
- If, by mistake, your health plan remits payment to you, please send it to us along with all paperwork sent to you at the time.
- You will remain responsible for amounts and any services that are not covered by your insurance plan.
- Your health plan may refuse payment of a claim for some of the following reasons:
    1) This is a pre-existing illness that is not covered by your plan
    2) You have not met your full calendar year deductible
    3) The type of medical service required is not covered by your plan
    4) The health plan was not in effect at the time of service
    5) You have other insurance which must be filed first

Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies this claim for any of these or other reasons, our office cannot be responsible for this bill. It is your responsibility as the patient to pay the denied amounts in full.

Our primary mission is to provide you with quality, cost effective, medical care. Together we are trying to adapt to the changing way that health care is financed and delivered. Again, we value you as a patient and our first priority is to provide you with the best possible care. With this housekeeping chore complete, we are pleased to serve you.

Sincerely,
Vein Care Solutions.

I have completed this form with accurate information and have read and understand my obligations. I acknowledge that I am fully responsible for supplying correct insurance information, billing information, and payment of any services not covered or approved by my insurance carrier.

_____ _____

Signature of Patient Date

Vein Care Solutions

Venous Health History Form

Patient Name: _____ **Date of Birth:** _____
Age _____ **Sex** _____ **Height**_____ **Weight** _____
Referred by _____

1. Do you experience any of the following in your legs?

Aching?	☐ Yes	☐ No	☐ One leg R/L	☐ Both legs
Burning?	☐ Yes	☐ No	☐ One leg R/L	☐ Both legs
Cramping?	☐ Yes	☐ No	☐ One leg R/L	☐ Both legs
Heaviness?	☐ Yes	☐ No	☐ One leg R/L	☐ Both legs
Itching?	☐ Yes	☐ No	☐ One leg R/L	☐ Both legs
Throbbing?	☐ Yes	☐ No	☐ One leg R/L	☐ Both legs
Tiredness/fatigue?	☐ Yes	☐ No	☐ One leg R/L	☐ Both legs
Swollen ankles?	☐ Yes	☐ No	☐ One leg R/L	☐ Both legs
Rash/discoloration?	☐ Yes	☐ No	☐ One leg R/L	☐ Both legs

2. How many years have you had this problem? _____

3. Have you ever been treated for this problem? ☐ Yes ☐ No
   By whom?_____ When? _____
   By which method?
   Injection_____ Laser (surface)_____ Catheter_____Surgery_____

4. Have you ever been treated for one of the following?
   Phlebitis (inflammation of a vein) ☐ Yes ☐ No R/L leg
   Pulmonary embolism/blood clot ☐ Yes ☐ No R/L leg
   Leg ulcer? ☐ Yes ☐ No R/L leg

5. When did your veins appear?
   Age____ Before/During/After pregnancy_____ After trauma_____
   After birth control pills_____ After hormonal therapy_____

6. Have you ever been pregnant? ☐ Yes ☐ No
   If so, how many children have you delivered? _____

7. Are you developing new veins? ☐ Yes ☐ No

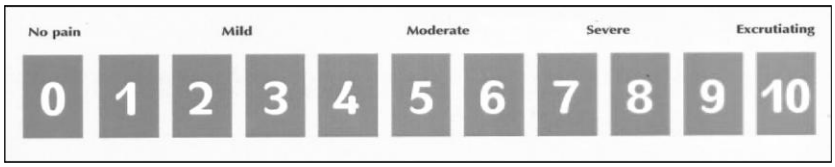
8. Are your existing veins getting bigger? ☐ Yes ☐ No

9. Does walking or exercise ☐ relieve ☐ aggravate the pain? (Check one)

10. Do you take any medication for pain (i.e., aspirin, ibuprofen, Advil, Motrin or similar medications) ☐ Yes (list med and dose) _____ ☐ No

    If yes, how many days in a two week period of time do you take the medication?
    ☐ 0-2 days ☐ 3-4 days ☐ 5-6 days ☐ 7 or more days

11. Rate the intensity of symptoms (check one)



12. Do you elevate your legs to relieve discomfort? ☐ Yes ☐ No
If yes, how long per day do you elevate and does it provide relief?
_____

13. Do you wear prescription compression stockings? ☐ Yes ☐ No
If yes, what strength/gradient? _____
How long have you worn them? _____
Did wearing stockings provide relief? _____

14. In the course of a normal day, how much time is spent in the following positions? Check one

Standing:		Sitting:	
10% of the day	_____	10% of the day	_____
20% of the day	_____	20% of the day	_____
30 to 50% of the day	_____	30 to 50% of the day	_____
More than 50%	_____	More than 50%	_____

15. Are your symptoms interfering with your daily activities? ☐ Yes ☐ No
If yes, how many times during the day do you have to sit or take a break due to leg aching, cramping, burning, itching or swelling?
☐ Never ☐ Once per day ☐ 2-3 times per day ☐ 4 or more times per day

Do you have a family history of
a. Varicose vein problems? ☐ Yes ☐ No b. Phlebitis/Blood Clots ☐ Yes ☐ No

Do you smoke? ☐ No ☐ Yes If yes, how long? _____ Packs per day_____

Do you have any allergies to medications? Please list _____

Do you have a history of?

Diabetes	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No
Thyroid problems	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Blood transfusions	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Autoimmune disease	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Heart disease	☐ Yes	☐ No
Migraine headaches	☐ Yes	☐ No	Other _____		

Please list current medications

_____

_____

Please list any previous surgeries and year

_____

_____

Signature:_____Date:_____

Vein Care Solutions
Ana Cecilia Lorenzo MD,FACS,RVT
Telephone: 214-387-4202
Fax: 214-387-4863

Date_____

Patient: _____

Date of Birth: _____

New federal privacy guidelines, HIPAA, prevent this office from disclosing protected health information ("PHI") to anyone other than the patient. By signing this form, you are allowing us to communicate with designated individuals regarding your medical and financial record with this facility.

I, the undersigned, hereby authorize **Vein Care Solutions** to disclose PHI from my medical or financial record to the following person/people:

- ☐ I do not want anyone in my family to have access to my PHI. I am the only one who should access my PHI.
- ☐ **Name:** _____Relationship:_____
  Type of Information: (Circle One) Medical Financial Both
- ☐ **Name:** _____Relationship:_____
  Type of Information: (Circle One) Medical Financial Both

ADDITIONAL PERSONS MAY BE LISTED ON THE OTHER SIDE IF NECESSARY

This authorization is given freely with the understanding that:

1. I may revoke this authorization in writing at any time, but not retroactively.
2. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the information I have authorized.

Patient's printed name _____

Patient Signature _____

Date _____

Signature of Vein Care Solutions Witness: _____ Date:_____

Vein Care
SOLUTIONS

To Prospective Patients,

My staff and I strive to keep my medical practice running efficiently as this is particularly important in the ever changing medical climate. Likewise, we realize that your time is important and we will therefore never double book appointments. To this end, we ask that you arrive on time and that you kindly give us at least 24 hour notice prior to cancelling or rescheduling regular appointments and 2 weeks' notice prior to cancelling or rescheduling surgical procedures**. Patients will be assessed a $50 no show fee for missed appointments and a $250 fee for late cancellations of surgical procedures.** Again, we are here to provide you the best of care in an office setting that you can look to for its efficiency and professional atmosphere.

Please note that any excessive no shows or same day cancellations will result in dismissal from our practice. Thank you in advance for your understanding and cooperation.

Respectfully,

Ana Cecilia Lorenzo, MD FACS RVT
Vein Care Solutions

SIgnature: _____ Date: _____

Witness: _____ Date: _____