PATIENT REGISTRATION

Today's Date: _____

PATIENT INFORMATION (Please Print)

Legal Name: _____ DOB _____
Last First MI

Mailing Address: _____
Street City State Zip

E-Mail: _____ Primary language: _____

Sex: ☐ Male ☐ Female

Primary phone#: _____ ☐ Cell ☐ Home MAY WE LEAVE A MESSAGE? ☐ YES ☐ NO

Secondary phone#: _____ ☐ Cell ☐ Home MAY WE LEAVE A MESSAGE? ☐ YES ☐ NO

EMPLOYMENT INFORMATION

Employment Status:

☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Self Employed ☐ Retired ☐ Unemployed

Employer: _____ Occupation: _____

Work Phone: _____ Ext: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Secondary Insurance Company: _____

Subscriber Name: _____ ☐ M ☐ F Subscriber Name: _____ ☐ M ☐ F

Subscriber DOB: _____ /_____ /_____ Subscriber DOB: _____ /_____ /_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE. I acknowledge that I have received a copy of Precision Vein Center. I understand that the Notice of Privacy provides an explanation of the ways in which my health information may be used or disclosed by Precision Vein Center and my rights with respect to my health information.

The undersigned has read and understands the above.

Date: _____ _____

(Signature of Patient or Patient's Legal Representative - if patient is unable to sign)

_____

(Relation to Patient)

FOR OFFICE USE ONLY

☐ Patient was unable or unwilling to complete this form or portions of this form. Explain: _____

PRECISION VEIN CENTER

10945 N Port Washington Road | Suite 201 | Mequon, WI 53092 | o: 262.292.3151 | f: 262.643.4707
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CONSENT FOR TREATMENT & FINANCIAL AGREEMENT

GENERAL CONSENT TO CARE

- I am coming for care and treatment. I agree to services including examinations, procedures, imaging, tests and treatments, medication, monitoring, nursing care, counseling and education.
- I understand that if tissue is removed when I am in the clinic, the radiologist may dispose of the tissue at their discretion unless I disagree.
- I understand that electronic communication such as telemedicine may be used to help healthcare providers at different locations to participate in my care.
- I understand that the provision of healthcare is not an exact science and I acknowledge that no guarantees have been made to me as a result of examinations or treatments provided to me.

IMPORTANT INFORMATION:

- I know that I need to follow up with recommended care after my appointment.
- I agree to notify the clinic or my doctor within 24 - 48 hours if I am canceling or rescheduling an appointment.
- I know that the facility may take pictures or video of me for my care and safety.
- I understand that if I allow anyone to accompany me throughout my visit while I receive treatment and my personal health Information is discussed, this will constitute an implied consent regarding the disclosure of my personal health information in the presence of the individual.
- I understand that I am responsible for the security and whereabouts of any money, documents, personal items, or other articles of unusual value. All personal property that I wish to keep with me while I am receiving treatment is at my own risk as to loss or damage. I release the physician, other health care professional, agents, and employees of Precision Vein Center from any liability whatsoever for the lost articles and money that I might have kept with me.

ACCIDENTAL EXPOSURE OF HEALTH CARE WORKER:

- I understand and acknowledge that If any person is exposed to my blood or other bodily fluid, the facility may perform tests, with or without my consent, on my blood or other bodily fluid to determine the presence of any communicable disease, including but not limited to, Hepatitis and Human Immunodeficiency Virus (the causative agent of AIDS).
- I understand that the results of tests taken under these circumstances are confidential and do not become part of my medical record.

ACCESS TO HEALTHCARE RECORDS

- I know that I may review my medical record during normal business hours upon reasonable notice.
- I know that I may get a copy of my medical record and I may be asked to pay for the copies.

RELEASE OF INFORMATION

- I agree that the facility and all healthcare providers participating in my treatment may release my health information to my insurers and other payers or other persons as necessary for billing, collection or payment of claims for services provided.
- I authorize the release of information to and from my primary or referring physician that may be deemed pertinent to my care.

ASSIGNMENT & FINANCIAL AGREEMENT

- I assign to the facility or healthcare provider any payment for such services otherwise payabie to me under a benefit plan through Medicare, Medicaid, an insurance carrier(s), an employer health plan(s) or any other third-party payer(s) (each referred to as a “Plan”).
- I allow my Plan (s) to send all payment directly to the billing facility or healthcare provider.
- Precision Vein Center will try to verify my Plan(s) coverage for services and obtain any approvals and authorization required by my Plan and shall notify me of any services it knows are not covered by the Plan.
- I understand that should my Plan deny payment for the services provided to me, I am ultimately responsible for paying the charges billed for the services, including co-pays, co-insurance, and deductibles charges consistent with any applicable, written contractual agreements between Precision Vein Center and my Plan. I agree to cooperate with Precision Vein Center on any appeals of my payer’s denials and authorize Precision Vein Center to be my representative on these appeals.

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- I agree not to revoke this assignment and authorization without the facility's or healthcare provider's consent. If I receive payment directly from my Plan, it is my responsibility to forward it to Precision Vein Center within 30 days of receipt.
- I know that I am responsible for knowing the limitations of my Plan's benefit coverage. If my Plan determines that a service is not a covered benefit under the Plan or is experimental or investigational, I will be responsible for paying the charges billed by the facility or healthcare provider for the service. Precision Vein Center reserves the right to balance the bill for any services in which a payment is made by a non-network plan (i.e., there is no written contract between Precision Vein Center and patient's employer). I further acknowledge that, should the amount covered by my Plan(s) benefits be insufficient to cover the charges for the services rendered to me, I will be responsible for the payment of the difference.
- I agree that credit balances resulting from payments made by the patient or other sources may be applied to any account owed to the facility or healthcare provider by the same guarantor (me or my family).

COLLECTION & ASSIGNMENT
Should my account or any unpaid portion thereof be referred to an attorney for collection, I agree that I shall also be responsible for all reasonable attorney fees, including Precision Vein Center attorney fees and personal attorney fees, and any other costs, fees or expenses incurred as a result of the collection process as allowed by Wisconsin law.

PRIVACY NOTICE AND PATIENT RIGHTS
I confirm that I received or was offered and declined a copy of the Notice of Privacy Practices. I know I can get more information about the uses of my medical record from that notice.

TELEPHONE CONSUMER PROTECTION ACT
I authorize Hospital and all clinical providers who have provided care or interpreted my tests, along with any billing service and their collection agency or attorney who may work on their behalf, to contact me at any number I am providing or have previously provided orally or in writing, including my cell phone which could result in text/data charges to me and/or home phone or VOIP (voice over internet provider) using pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication for any follow up purposes and to discuss any past, future or current services, including billing and collection of any past due amounts.

DOCUMENT CHANGES
I know that if I refuse to sign this form or make any changes to this form prior to non-emergent services performed it may keep me from getting the care and services.

DOCUMENT ACKNOWLEDGEMENT AND DURATION
- My signature indicates that 1 have read and understand the Consent to Treatment and Financial Agreement form.
- I understand that this agreement applies to all Precision Vein Center services and is valid for one year for treatment at the Precision Vein Center.

The undersigned certifies that she/he is the patient of or is duly authorized by the patient as the patient's general agent to execute the above and accepts it terms.

_____ _____ _____

Patient/Authorized Representative Signature **Date** **Time**

_____ _____

Printed Name **Relationship to Patient**

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VENOUS HISTORY FORM

Please complete patient section to the best of your knowledge

Name: _____ DOB: _____

Primary Physician: _____

Facility Location: _____

Referring Physician: _____

Facility Location: _____

Which leg/s are you seeking treatment for: ☐ right ☐ left ☐ both

Symptoms (mark all that apply):

☐ Pain ☐ Varicose veins ☐ Pelvic pain with ☐ standing ☐ sitting ☐ activity
☐ Heaviness ☐ Spider veins ☐ Painful intercourse
☐ Burning/itching ☐ Skin discoloration ☐ Other: _____
☐ Swelling ☐ Restless leg syndrome

How long have you had symptoms: _____

Have you ever been told or been diagnosed with:

Phlebitis: ☐ yes ☐ no When: _____

Blood clot in leg/s: ☐ yes ☐ no When: _____

Were you ever treated or are you currently being treated with blood thinners: ☐ yes ☐ no

When: _____ How long: _____

Name of blood thinner: _____

Skin sores/ulcers: ☐ yes ☐ no

When did sore/ulcer first appear: _____

How long did it take to heal: _____

Treatments used to aide the healing: _____

What makes symptoms worse? (check all those that apply)

☐ Prolonged standing ☐ Walking/exercise ☐ Menstrual periods ☐ Other: _____
☐ Prolonged sitting ☐ Sleeping ☐ Pregnancy (year/s)

How much of the day do you spend on your feet: _____

What activities require prolonged standing: _____

What makes symptoms better or what therapy have you tried? _____

Leg elevation: ☐ yes ☐ no How many times per day: _____

Medications (Tylenol, advil, motrin, aspirin, etc.): ☐ yes ☐ no How often per week: _____ Dosage: _____

Weight loss: ☐ yes ☐ no

Exercise: ☐ yes ☐ no What kind or exercise: _____

Have you worn stockings: ☐ yes ☐ no How long: _____

Prescription: ☐ yes ☐ no Stocking strength: ☐ 20-30mmHg ☐ 30-40mmHg ☐ other: _____

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VENOUS HISTORY FORM

Prior vein treatments: ☐ **YES** ☐ **NO**

☐ Stripping/Surgery (dates) ☐ Ablation (dates) ☐ Injections (dates)

Family History:

Varicose Veins: ☐ yes ☐ no If yes who: _____

Clotting problems: ☐ yes ☐ no If yes what is the problem: _____

Any other information that you feel may be important for us to know? _____

History (all categories require a response):

Stroke	☐ yes ☐ no	TIA/mini stroke	☐ yes ☐ no
Seizures	☐ yes ☐ no	Neurologic disorder	☐ yes ☐ no
Heart attack	☐ yes ☐ no	High blood pressure	☐ yes ☐ no
"Hole in heart'VASD	☐ yes ☐ no	Murmur/extra heart sounds	☐ yes ☐ no
Irregular heart beat	☐ yes ☐ no	Peripheral arterial disease	☐ yes ☐ no
IVC filter	☐ yes ☐ no	Blood clot in lungs	☐ yes ☐ no
Smoker	☐ yes ☐ no	Lung disease	☐ yes ☐ no
Stomach ulcer	☐ yes ☐ no	Gastritis	☐ yes ☐ no
Indigestion/GERD	☐ yes ☐ no	Kidney disease	☐ yes ☐ no
Liver disease/hepatitis	☐ yes ☐ no	Bleeding disorder	☐ yes ☐ no
Arthritis	☐ yes ☐ no	Diabetes	☐ yes ☐ no
HIV/AIDS	☐ yes ☐ no	Cancer	☐ yes ☐ no
Pregnancies	☐ yes ☐ no	Planning on future pregnancies	☐ yes ☐ no

Most recent mammo date: _____

Social History

Smoker	☐ yes ☐ no	pack/cigarettes per day: _____	
Alcohol	☐ yes ☐ no	how often: amount: _____	
Caffeine	☐ yes ☐ no	cups per day: _____	
Education:		Military service: _____	

Surgeries/Procedures/Hospitalizations: _____

_____

_____

OFFICE STAFF/PHYSICIAN TO FILL IN

CC: _____

Temp: _____ BP: _____ RR: _____ HR: _____ Oxim: _____ Wt: _____ Ht: _____

ROS: ☐ fever ☐ chills ☐ weight loss/gain ☐ fatigue ☐ headaches ☐ numbness/tingling ☐ weakness ☐ edema ☐ chest pains ☐ palpitations ☐ cough ☐ congestion ☐ shortness of breath ☐ snoring ☐ abd pain ☐ rash ☐ skin sores ☐ easy/unusual bruising

Notes: _____

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VENOUS HISTORY FORM

Drug/Food/Seasonal Allergies/Sensitivities:	Reaction(s):

List all Medications you are currently taking including over-the-counter, vitamins, supplements, etc.:

Medication name	Dose/Strength	Frequency (how many times per day)	Route (pill, liquid, powder, etc)

Reviewed: _____

_____

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