CAROLINA VEIN
SPECIALISTS

Name____ Date____________________ Preferred

Address____ Cell Phone ______________ ☐

City____________________________State_________Zip__________Work Phone ________________ ☐

Email______________________@___________________ Home Phone ______________ ☐

May we contact you by: **Text:** ___ No ___ **Yes (name of carrier:** __________**)** **E-Mail:** ____ Yes _____ No

SSN (last 4 digits) _________ Date of Birth _______________ Age ________________________

Sex: Male Female Genderqueer/Non-Binary __________(fill in the blank) Prefer not to disclose

Status: Single Married Divorced Widow

Employer____Occupation________________________

Employer Address ____

Primary Care Physician__________________________________Phone __________________________

1st Emergency Contact ____________________________ Phone __________________

Relationship ____________________

2nd Emergency Contact ______________________________ Phone __________________

Relationship _________________________

How did you hear about Carolina Vein Specialists? ____

◊◊

Primary Insurance Co.__________________Policy Holder's Name:__________________Date of Birth:_____________

Relationship to Patient:________________________________

Secondary Insurance Co.________________Policy Holder's Name:__________________Date of Birth:_____________

Relationship to Patient:________________________________

◊◊

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS. I ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIANS OF CAROLINA VEIN SPECIALISTS, PA.

Insured's Signature____Date ______________________

MEDICAL HISTORY

Name:_____ DOB: _____ Date:_____

Please circle Y or N for the following conditions you currently have or had , or not at all, in the past:

Deep Vein Thrombosis (DVT).....	Y	N	Heart Disease.....	Y	N	Leg Injury.....	Y	N
Recurrent Miscarriages.....	Y	N	Stroke / TIA	Y	N	Leg cast/splint.....	Y	N
Pulmonary Embolus.....	Y	N	Heart Murmur.....	Y	N	Hip/Knee/ankle surgery	Y	N
Phlebitis.....	Y	N	High Blood Pressure.....	Y	N	Leg Infection	Y	N
Clotting Disorder.....	Y	N	Diabetes.....	Y	N	Leg Ulcer.....	Y	N
Cancer	Y	N	Irregular Heart Beat.....	Y	N	Migraine.....	Y	N

Additional Medical Problems current or past: _____

_____

List all surgeries: _____

List all current prescription and over the counter medications, and herbal supplements: _____

_____

Have you ever taken any blood thinners (Coumadin, Warfarin, Xarelto, Pradaxa, etc.) other than aspirin? **No**___

Yes ___: List what you have taken and when you stopped: _____ _____ _

Drug Allergies/Reactions: No ____ **Yes**: (Please list): _____ _____ _

If you smoked in the **past**: **No** __ **Yes**___, when did you quit:_____ How much did you smoke per week: _____

Do you **currently** smoke: **No** ___ **Yes** ____: How much do you smoke per week:_____

Do you drink alcohol: **No** ___ **Yes**____: How much do you drink and how much per week: _____ _____ _

Do you regularly exercise: No_ Yes ___ : Type of excericse and how often: _____

Female Patients: Are you currently pregnant? No _ Yes_ Due date: ___ Are you currently breast feeding?: No___Yes __

Number of deliveries: _____ Are you taking birth control/hormone replacement? N ___ Y___: what type: _____Last menses date:__

Have you worn support stockings in the **past**? No ___ Yes ____: When did you last wear them: _____

Do you **currently** wear support stockings? No ____ Yes ____: When did you last purchase them: _____

Physician Notes:

Patient Signature: _____ **Date:** _____

Doctor Signature: _____ **Date:** _____

VENOUS SYMPTOMS HISTORY

CAROLINA VEIN SPECIALISTS

Name:_____DOB:_____Date: _____

LEG SYMPTOMS: Please check Y or N for the following symptoms:

Heaviness/Tiredness ..... Y____ N____	Leg Pain .....Y____N_____	Night Cramps ……..Y____N____
Achiness ..... Y____ N____	Burning pain ..... Y____N_____	Bleeding Veins ……Y____N____
Throbbing… .....Y____ N____	Red/Warm areas ……..Y____N_____	Varicose Veins ……Y____N____
Itching… .....Y____ N____	Skin Changes ……..Y____N_____	Spider Veins …….Y____N____
Tender to touch.....Y ____ N____	Restless legs at night ……Y____N_____	Ulcers ……..Y____N____

Swelling in the ankles…….N___If Yes_____, do they swell by: Morning_____Midday_____Late day _____

Other symptoms:

How long have you had problems with your legs and / or veins?: _____

Are your symptoms related to:

Current/previous pregnancy: Y____N_____

Previous Injury: Y_____N_____

Menstrual Cycles: Y_____N_____

Do your symptoms get worse with:

Prolonged Sitting: Y_____N____ Travel: Y____N ____

Prolonged Standing: Y_____N _____ Walking: Y____N ____

Work related activities: Y_____N ____ Exercise: Y____N____

Do your symptoms improve with: **Walking/ Exercise**: Y____N____**Leg elevation**: Y_____N_____**Pain meds:** Y_____N ____

How have symptoms affected your work and activities of daily living (e.g. cooking, yard work, social activities, driving, etc):

_____

_____

FAMILY HISTORY: (Please circle)

Varicose Veins: Mother Father Sister Brother Grandmother Grandfather Child / Children

Blood clots: Mother Father Sister Brother Grandmother Grandfather Child / Children

PREVIOUS VEIN TREATMENT HISTORY:

Ligation / Stripping: N____Y_____: Which leg: R____L_____Both____When: _____

Injections treatments: N____Y_____: Which leg: R____L_____Both____When: _____

Internal Laser: N____Y_____: Which leg: R____L_____Both____When: _____

Surface Laser: N____Y_____: Which leg: R____L_____Both____When: _____

_____ _____ _____ _____

Patient Signature Date Physician Signature Date

CAROLINA VEIN
SPECIALISTS

ABOUT FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance. We accept cash, checks, MasterCard, Visa, and Discover. We will be happy to help you process your insurance claim.

YOU MUST REALIZE, HOWEVER, THAT:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Not all services are a covered benefit in all contacts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility on the date the services are rendered.

We expect payment of the insurance co-pay each time that you are provided with services. We also expect you to pay your deductible and any service that your insurance carrier will not cover. We do expect to be paid any balance exceeding 60 days of said professional services.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I HEREBY ASSIGN AND AUTHORIZE PAYMENT OF THE COVERED INSURANCE BENEFITS INCLUDING MAJOR MEDICAL BENEFITS, OTHERWISE PAYABLE TO ME, TO BE MADE DERECTLY TO CAROLINA VEIN SPECIALISTS, PA. I ALSO AUTHORIZE THE RELEASE OF MEDICAL SERVICES RENDERED AND IT IS EXPRESSLY UNDERSTOOD THAT THE RIGHT OF SUCH INFORMATION TO BE PRIVILEGED IS HEREBY WAIVED. I UNDERSTAND AND AGREE THAT ANY SERVICES DENIED OR NOT PAID BY MY INSURANCE COMPANY WILL BE SOLELY MY RESPONSIBILITY AND I WILL IMMEDIATELY FORWARD THE APPROPRIATE PAYMENT TO CAROLINA VEIN SPECIALISTS, PA.

SIGNATURE _____ DATE _____

Note: You will be charged if our office is not given 24-hour notice of appointment cancellation. THANK YOU for your cooperation.

CAROLINA VEIN
SPECIALISTS

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of Carolina Vein Specialists Notice of Privacy Practice, detailing how my health information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice.

I understand that I have the right to request restrictions concerning the use of my information. I request the following restrictions:

_____

_____

_____

With whom may we discuss your treatment?

_____

With whom may we discuss your payment?

_____

_____ _____
PATIENT SIGNATURE DATE

_____
INTERNAL USE ONLY

If patient or patient's representative refused to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below:

Presented on: _____ _____
DATE TIME

By: _____
NAME AND TITLE

CAROLINA VEIN
SPECIALISTS

This notice describes how information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

Carolina Vein Specialists, PA
NOTICE OF PRIVACY PRACTICES

1. Carolina Vein Specialists, PA may use and disclose protected health information for treatment, payment, and healthcare operations. Examples of these include, but are not limited to, requested preschool or sports physicals, foster care homes, home health agencies, and/or referral to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers, and/or collection agencies. Healthcare operations include, but are not limited to, internal quality control and assurance, including auditing of records.
2. Carolina Vein Specialists, PA is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. Two examples of such are for public health requirements or court orders.
3. Carolina Vein Specialists, PA will not user or disclose PHI for marketing purposes and/or disclosures constituting a sale of PHI without the individual's authorization.
4. Carolina Vein Specialists, PA will not sell or make any other use or disclosure of a patient's protected health information without the patient's written authorization. Such authorization may be revoked at any time. Revocation must be requested in writing.
5. Carolina Vein Specialists, PA will abide by the terms of this notice currently in effect at the time of the disclosure.
6. Carolina Vein Specialists, PA reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains. Carolina Vein Specialists, PA will provide each patient with a copy of any revisions of its Notice of Information Practices at the time of the patient's next visit, or at the patient's last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at the Office of Carolina Vein Specialists, PA.
7. Any patient, guardian or personal representative has the right to object to the use of their health information for directory purposes.
8. Any patient, guardian or personal representative has the right to inspect and obtain copies of the patient's medical record. The records will be provided within 30 days of the request, and a reasonable charge may be assessed for any copies after the first request in a 12-month period. If Carolina Vein Specialists, PA is unable to act within the required period, Carolina Vein Specialists, PA may provide the patient with written notice of the reason for delay and expected date of completion of the request. This extension of time will not exceed 30 days.

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9. Any patient, guardian or personal representative has the right to request amendments be made to the patient's medical record.
10. Any patient, guardian or personal representative has the right to request a 6-year accounting of all disclosures of the patient's medical record. The history will be provided within 30 days of the request, and a reasonable charge may be assessed for any copies after the first request in a 12-month period. If Carolina Vein Specialists, PA is unable to act within the required period, Carolina Vein Specialists, PA may provide the patient with written notice of the reason for delay and expected date of completion of the request. This extension of time will not exceed 30 days.
11. Any patient, guardian or personal representative has the right to request restrictions as to how the patient's health information may be used or disclosed to carry out treatment, payment, or healthcare operations. Carolina Vein Specialists, PA is not required to agree to the restrictions requested, but if Carolina Vein Specialists, PA does agree, Carolina Vein Specialists, PA must abide by those restrictions.
12. Any patient, guardian or personal representative has the right to restrict disclosure of certain Personal Health Information to a health plan for payment for health care operation purposes, but not for treatment purposes, for items or services that have been paid in full and out-of-pocket.
13. Any affected patient will be notified by the Carolina Vein Specialists, PA Security Officer following a breach of unsecured Personal Health Information of the affected patient. The Practice has permission to contact me via e-mail.
14. Any person/patient may file a complaint to Carolina Vein Specialists, PA and to the U.S. Secretary of Health and Human Services if the patient believes his or her privacy rights have been violated. To file a complaint with the Practice, please contact the Privacy Officer at Carolina Vein Specialists, PA. Attention: Privacy Officer, Carolina Vein Specialists, PA, 1130 New Garden Road, Greensboro, NC 27410; telephone 336-218-8346. All complaints will be addressed, and the results will be reported to the Privacy Officer.
15. It is the policy of Carolina Vein Specialists, PA that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

Effective Date: _____

Name of Patient: _____

Signature of Patient or Legal Guardian: _____

Date: _____