

Date of Service: _____

PATIENT INFO:

Last Name:	First Name:	MI:
Address:	Home Phone:	Marital Status:
City:	Work Phone:	S.S. Number:
State: Zip:	Birth Date:	Primary Care Physician:
*Emergency Contact/Relationship:		Phone#:

Referred By: _____ **Are you currently under another doctor's care?** _____
 (Doctor's name) (Doctor's name)

PRIMARY INSURANCE**

SECONDARY INSURANCE**

Insured's Name:	Insured's Name:
Birth Date:	Birth Date:
ID#	ID#
Group#	Group#
Employer Name:	Employer Name:

Which phone # may we use to contact you? Home Work Other (please specify) _____

Can we leave a message at this number?: Yes No

Email address: _____

May we contact you via Email? Yes No

How did you hear about us?:

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Television Ad | <input type="checkbox"/> Radio Ad | <input type="checkbox"/> Newspaper Ad |
| <input type="checkbox"/> Internet | <input type="checkbox"/> Family/Friend Referral | <input type="checkbox"/> Yellow Pages |
| <input type="checkbox"/> Physician Referral | <input type="checkbox"/> Other (Please List): _____ | |



List any medications you are currently taking (please include any prescription and over the counter drugs such as Aspirin, Excedrin, etc. as well as any vitamins & herbal supplements):

*Allergies?: _____

Do you have any problems with local anesthesia? † Yes † No

Vein/Leg Problems (please describe): [] Left [] Right [] Both

Symptoms: (please check all that apply)

- | | | | | |
|---|---|---------------------------------------|---|--|
| <input type="checkbox"/> throbs/aches | <input type="checkbox"/> easy bruising | <input type="checkbox"/> cramping | <input type="checkbox"/> standing | <input type="checkbox"/> heat |
| <input type="checkbox"/> itching | <input type="checkbox"/> pain | <input type="checkbox"/> bleeding | <input type="checkbox"/> sitting | <input type="checkbox"/> pre-menstrual |
| <input type="checkbox"/> heavy/full | <input type="checkbox"/> swelling | <input type="checkbox"/> restlessness | <input type="checkbox"/> night | <input type="checkbox"/> worse w/pregnancy |
| <input type="checkbox"/> burning/stinging | <input type="checkbox"/> muscle fatigue | <input type="checkbox"/> other _____ | <input type="checkbox"/> walking/exercise | <input type="checkbox"/> other _____ |

Worse:

Conservative Therapy: (please check all that apply)

- | | |
|------------------------------------|---|
| <input type="checkbox"/> elevation | <input type="checkbox"/> elastic compression: how long? _____ |
| <input type="checkbox"/> exercise | <input type="checkbox"/> medications _____ |
| <input type="checkbox"/> coolness | <input type="checkbox"/> other _____ |

Previous Treatment:

- | | | | |
|--|-------------|---|-------------|
| <input type="checkbox"/> stripping-left leg | Date: _____ | <input type="checkbox"/> stripping-right leg | Date: _____ |
| <input type="checkbox"/> ligation-left leg | Date: _____ | <input type="checkbox"/> ligation-right leg | Date: _____ |
| <input type="checkbox"/> injections-left leg | Date: _____ | <input type="checkbox"/> injections-right leg | Date: _____ |
| <input type="checkbox"/> laser-left leg | Date: _____ | <input type="checkbox"/> laser-right leg | Date: _____ |

**I confirm that the answers I provided to the previous questions are true and correct.*

Print Patient Name: _____

Signature: _____
(Parent or Guardian if patient is under 18)

Date: _____

Physician's Signature: _____

**Vein Center of Southern Connecticut
Patient Waiver/Consent and Agreement to Pay Form**

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

I hereby authorize the physician or staff to perform ultrasounds, photographs and any other diagnostic aids deemed appropriate by the physician to make a thorough diagnosis and to document treatment. Upon such diagnosis, I authorize physician and the assistant(s); which he/she may select to perform, or to assist in, or to observe the treatment/procedure(s) mutually agreed upon by me and to employ such assistance as required to provide proper care.

I acknowledge that the service(s) and/or items(s) listed below may not be covered by my insurance plan because of medical necessity determination. I acknowledge that every billing effort will be made to my insurer for the reimbursement of the service(s) and in the event of insurance denial to pay I agree to be responsible for the full amount of the billed charges or the remaining balance after my insurer has paid.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Service(s)/Items(s):	Fee (each Service/Item):
1. Bilateral Ultrasound _____	\$409.00 _____
2. Office Visit _____	\$128.00 _____
3. Stocking (If applicable) _____	\$69.00 _____

**The above charges apply to the initial patient Consultation Appointment only. Prices subject to change without notice/additional services/charges may apply.*

Patient's Signature _____ Date _____

Parent/Legal Guardian Signature _____

Photographic Release:

Your initials below indicate your consent for the Vein Center of Southern CT to use, reproduce, and publish photographic or computer illustrations of your legs for educational or marketing purposes and you waive claim against any party based on the usage of the images, or make any claim that the use of the images defames you or constitutes an infringement of your rights to privacy, or any other right you may enjoy. It is not mandatory that you initial this paragraph, and you agree that if you choose to initial this paragraph, it is done so freely and voluntarily.

Client Initial _____

**Vein Center of Southern Connecticut
Consent for Treatment and Release of Information**

1. Your insurance is filed as a courtesy to you. All services not paid within 30 days by your insurance company will become your responsibility.
2. All co-pays, deductibles, co-insurance, previous balances, and fees for non-covered services are due at the time of your visit.
You will be responsible for all collection fees associated with the collection of your account.
3. We will be happy to provide you with a statement of your account. We will file secondary insurances, when needed, if required by a specific contract.
4. If you are a Medicare recipient, we will file your Medicare as required for participation in the Medicare program. If your Medicare is primary, please notify Medicare of your supplemental insurance. Medicare normally forwards claims to a supplement for processing of co-insurance or deductibles. This does not guarantee your supplement will pay these balances.
5. As our patient, we will provide the best possible care for you. Services we provide to you may or may not be covered by your insurance due to routine, non-covered, or "deemed medically necessary" by your insurance company. In the event your insurance company does not cover your services, you will be responsible. We will make every effort to let you know if we feel your insurance company may not cover your services. You are responsible for knowing the benefits/coverage of your insurance.

I CONSENT to VCSC's use and disclosure of all individually identifiable personal, health, financial, and demographic information (know as Protected Health Information or PHI) for the purposes of:

- Providing medical treatment
- Obtaining payment and reimbursement
- Obtaining authorization from my insurance for tests/procedures (where required)
- Requesting healthcare services from other providers
- Cooperating with other providers in my medical treatment
- Fulfilling requests for information when specifically authorized by me
- In addition, doing all other things directly related to providing healthcare to me

The above purposes and other uses are known collectively as Treatment, Payment, and Other healthcare operations or TPO.

I AUTHORIZE any physician or healthcare facility to provide upon request any PHI to VCCC, when needed for the purposes of TPO.

I CONSENT to VCSC discussing any or all of my medical care including my evaluation, treatment, diagnosis, even if related to psychiatric or psychosocial impairments, substance abuse, acquired immunodeficiency virus (HIV), HIV-related opportunistic infections, or pregnancy with the following person(s).

- | | |
|----------|---------------------|
| 1. _____ | Relationship: _____ |
| 2. _____ | Relationship: _____ |
| 3. _____ | Relationship: _____ |

I understand my rights to restrict the use and disclosure of PHI and to revoke this contract at any time in writing.

Patient Name: _____
Patient's Signature: _____ Date: _____
Insured or Guardian Signature: _____ Date: _____

The Health Insurance Portability and Accountability Act of 1996 prohibits the use and disclosure of protective health information for treatment, payment, and other healthcare operations without a signed consent and prohibits the use and disclosure of protective health information for non healthcare related activities without specific and explicit authorization.

**Vein Center of Southern Connecticut (“VCSC”)
PRIVACY NOTICE**

Effective Date: January 5, 2004

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS CAREFULLY.

As a patient of VCSC, we want to provide you with the best possible care. We want you to feel free to make full disclosure of information to the physician(s) so that effective treatment can be provided. As required by the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), VCSC is providing you, the patient or the patient’s legal representative, with a copy of our Privacy Notice. HIPAA regulations require us to provide this information to you and to obtain your signature or the signature of your legal representative as proof that you have received our Privacy Notice.

The policy of VCSC is to protect the confidentiality, integrity, and security of the protected health and personal information of our patients and to prevent unauthorized access to or the use of such information. This policy applies to both current and former patients.

Protected Health Information (PHI) is individually identifiable health and personal information and includes any information obtained by VCSC in connection with providing healthcare treatment, obtaining payment and related healthcare operations. This relates to past, present or future information VCSC receives from you as our patient.

We will use this information to provide caring and quality medical care to you. Examples of PHI include diagnosis, treatment, and communications, both oral and written and including answering machines, voice mail and e-mail, used for follow-up, appointment scheduling and reminders, and test results reporting. As part of our standard healthcare operations we may share information with a facility such as a hospital, laboratory, diagnostic service or healthcare provider to coordinate your treatment plan in the most efficient manner. For insurance carriers, your information will be used for claim submission and to obtain payment for services provided. We will exchange data with your insurance carrier for activities such as confirming your eligibility with the plan, benefit and coverage determinations, and pre-certification/authorization and utilization review.

Your information is maintained in our office in our practice management information system. We also maintain information about you in your medical chart. VCSC limits access to your PHI to those employees and business associates who need to know this information and we restrict the types and amount of information provided to that which is “minimally necessary” in order to carry out their work.

We do not disclose PHI to third parties for purposes other than treatment, payment or healthcare operations unless the following exceptions occur:

- We receive a signed authorization from you to release your individually identifiable information. VCSC will provide you with an Authorization Form that will need to be signed by you, the patient, or in the case of a minor, his/her guardian. This authorization will be for a defined period of time and may be cancelled by you, the patient, or in the case of a minor, by his/her guardian, at any time.
- Federal, state or other applicable law requires us to share PHI.
- Workers’ Compensation purposes.

You have the right to request a review of your PHI, to amend your records, and request restrictions on how your PHI is used. You may request an accounting of how your PHI has been disclosed. Any requests for amendments or restrictions to the use of your PHI must be in writing. You have a right to request a copy of your medical records, VCSC will make every effort to provide you with your records within a reasonable amount of time and subject to normal copying charges. If you have any questions, comments, or complaints regarding the management of your PHI, please contact Lisa Riccio, VCSC Privacy Officer at (860) 827-0071.

I have been given the opportunity to review VCSC’s Privacy Notice. I understand that should I choose not to consent to the terms and conditions of VCSC’s Privacy Notice, the practice has the right and will withhold treatment except where required by law.

I acknowledge that I have received the above VCSC Privacy Notice.

Patient Name

Date