Vein Specialists of Alaska

DEMOGRAPHICS

FIRST:	**MIDDLE:**	**LAST:**		
MAILING ADDRESS:		MARRIED	SINGLE	OTHER
SOCIAL SECURITY #:		SPOUSE NAME:		
DOB:	CELL:	HOME:	OTHER:	
EMAIL:				
EMERGENCY CONTACT:	PHONE:	RELATIONSHIP:		
OCCUPATION:				

PRIMARY CARE PROVIDER: (Please note: this provider/office with receive all visit notes)	**PROVIDER OFFICE:**

HOW DID YOU HEAR ABOUT OUR OFFICE?	**INSURANCE INFORMATION**	
☐ TV COMMERCIALS ☐ RADIO ADS ☐ GOOGLE ☐ VSA PATIENT ☐ PREVIOUSLY SEEN WITH US ☐ PRIMARY CARE PROVIDER ☐ OTHER? _____	**PRIMARY INSURANCE**	**SECONDARY INSURANCE**
	INS NAME:	INS NAME:
	POLICY HOLDER NAME & DOB:	POLICY HOLDER NAME & DOB:

REASSIGNMENTS OF BENEFITS AND CONSENT FOR RELEASE OF INFORMATION:

- I hereby authorize my insurance to pay my benefits directly to Vein Specialists of Alaska, LLC or all appointments. I give permission to release any/all medical information to my insurance company(ies) for justification of payment of claims and/or pre-authorization if required.

- Our office does its best to bill everyone's insurance according to what is provided. The undersigned understands payment in full is required within 30 days of services He/she may be asked to remit payment in full even if he/she has insurance which has not paid within this time frame. If this creates a financial hardship, he/she may make special payment arrangements by contacting our Billing Department.

ANYONE OTHER THAN YOURSELF WE MAY DISCUSS APPOINTMENTS/MEDICAL RECORDS AND BILLING WITH? PLEASE NOTE WE WILL NEED A PICTURE ID AND A RELEASE OF INFORMATION SIGNED BEFORE ANY RECORDS WILL BE RELEASED	
NAME:	NAME:
DOB:	DOB:
PHONE NUMBER:	PHONE NUMBER:

PATIENT SIGNATURE:	DATE:

Vein Specialists of Alaska

FINANCIAL POLICY

Thank you for choosing Vein Specialists of Alaska, LLC

It is our goal to provide fast and efficient billing as a courtesy to you. We need your help to accomplish this goal by providing complete and accurate insurance information. Knowledge of your deductible and co-pays are your responsibility. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If for any reason, your insurance coverage changes, it is your responsibility to inform Vein Specialist of Alaska. If you fail to inform us within 30 days of the changes, Vein Specialist of Alaska will not be responsible for filing your insurance. Please be aware that some, and perhaps all the service provided may be non-covered services. Some insurance companies reduce or deny benefits saying they are not considered UCR (usual, customary or responsible). Please be advised that our fees are based on a national geographic standard and are, in fact, UCR for Alaska.

All deductibles and co-pays are due and payable at the time of treatment. (Unless arrangements are made with the office ahead of time). The balance is your responsibility whether your insurance company pays or not. If your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

FEES

- $50.00 FEE – Less than 2 business days' notice
- $150.00 FEE - Less than 5 business days' notice of your first scheduled procedure, all procedures after are also subject to the fee as they will all need to be rescheduled.
- $30.00 FEE - SERVICE CHARGE ON ALL NSF CHECKS
- WE OFFER A PAYMENT PLAN WITH PRIOR BUSINESS OFFICE APPROVAL (after your initial consult, if you need procedures, you will be required to complete a payment plan form PRIOR to scheduling if we see or are unaware you met DD &/or coinsurance.

NOTICE: If you have a balance after your insurance posts its portion, this balance represents your deductible amount and/or co-insurance amounts due which cannot be written off. We reserve the right to turn your account over to a collection agency.

- **Account Balance Policy:** If a balance is older than 90 days with no payment plan on file, the account will be sent to collections.
- **Payment Plan Collection Policy:** If the balance remains unpaid at the end of the 24-month period, the account will be referred to collections, which may incur additional fees and affect your credit rating. If a payment is missed and we cannot contact you, the account will be sent to collections.
- **No Insurance Payment –** If your insurance has not paid or is non responsive after 30 days the balance will become your responsibility.

Usual and Customary Rates: Our office is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. Please be aware that you may be responsible for payment regardless of any insurance company's determination of usual and customary rates.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read, understand, and agree to this financial policy:

PATIENT NAME:	DOB:
PATIENT SIGNATURE:	TODAY'S DATE:

Vein Specialists of Alaska

Acknowledgement of Receipt of Privacy Notice
(Health Insurance Portability and Accountability Act)

I have been presented Vein Specialists of Alaska's Notice of Privacy Policies, detailing how any information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my medical information:

RESTRICTIONS:

Further, I permit a copy of this authorization to be used here in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to medical assignment benefits apply.

PATIENT NAME:	DOB:
SIGNATURE:	TODAY'S DATE:

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Conservative Therapy and Symptom Statement

Due to my varicose vein disease (or suspected vein disease), I am suffering from one or more of the following symptoms: pain, swelling, heavy/tired and/or restless leg feelings, or I have suffered with unhealthy leg skin with/without infection, rash, skin discoloration, spontaneous varicose vein bleeding, and/or skin ulceration.

I have tried conservative therapy without relief for at least three months. I define conservative therapy as including daily wearing of compression stockings.

NAME:	DOB:
SIGNATURE:	TODAY'S DATE:

Vein Specialists of Alaska

PATIENT:	DOB:	
REFERRING PROVIDER:	PRIME INS:	SEC INS:
PRIMARY CARE PROVIDER:	NOTES:	

SYMPTOMS ARE: Choose One	Recent	Progressive	Chronic Progressive
WHICH LEG	Right Leg	Left Leg	Bilateral

HOW LONG:	Past Day	Past Few Days	Past Few Months	3 Months	6 Months	1 Year	Many Years	Several Years

PRIMARY REASON FOR YOUR VISIT: ☐ aching ☐ bleeding from varicose veins ☐ burning ☐ cellulitis ☐ cramping ☐ discoloration ☐ dull pain ☐edema/swelling ☐ fatigue ☐ heaviness ☐ Itching ☐ Pain ☐ restlessness ☐ Skin Changes ☐ Throbbing ☐ thrombophlebitis ☐ tingling ☐ tiredness ☐ ulcerations

HOW DO THESE SYMPTOMS EFFECT YOUR DAILY ACTIVITY: Check all that apply

☐Cannot stand longer than a few hours without pain.
☐ Is uncomfortable to bend legs.
☐ Find that it is becoming increasingly more difficult to stand at work.
☐ Find that it is becoming increasingly more difficult to sit at work.
☐ Can no longer perform the routine functions at work.
☐ Can no longer perform the routine functions at school.
☐ Is find it difficult to focus due to pain.
☐ Cannot walk without pain. Is unable to gain access to work, community and/leisure activities.
☐ Has difficulty with balance with or without assistive devices?
☐ Is finding it more difficult to stand and walk.
☐ Cannot sit more than an hour without pain.
☐ Cannot fully participate in sports.
☐ Is unable to gain access to home environments.
☐ Feels unsafe at work and/or at home.
☐ Finds it difficult to stand without discomfort.
☐ Is finding it difficult to sleep at night.
☐ Legs are painful to touch.
☐ Is constantly itching.
☐ Has difficulty sitting for extended periods of times

HAVE YOU TRIED COMPRESSION THERAPY:	IF YES: ☐ 3 MONTH or more ☐ 6 WEEKS or more	Physician Directed? ☐ YES ☐ NO	☐ have not tried

HAVE YOU TRIED ANY OF THE FOLLOWING:	☐ over the counter meds	☐ Acetaminophen	☐ Ibuprofen	☐ No pain medications	☐ Other

PAST MEDICAL HISTORY	☐ Hypertension (high blood pressure) ☐ Diabetes ☐ Bleeding/Clotting Disorder ☐ Peripheral Arterial Disease ☐ Coronary Arterial Disease (heart attack/stent/bypass) ☐ Pacemaker/Defibrillator ☐ Cancer ☐ Other notable medical problems
PAST VENOUS HISTORY	☐ Phlebitis (clot in surface veins) ☐ DVT (Deep Vein Thrombosis) ☐ Pulmonary Embolism (clot in lung) ☐ Bleeding from veins ☐ Hemorrhoids ☐ Previous trauma to legs ☐ Clotting Disorder (free bleeder) ☐ IV Drug use/AIDS/HIV/Hepatitis

PREVIOUS VEIN TREATMENT	☐ Sclerotherapy	☐ Stripping	☐ Phlebectomy	☐ laser or radiofrequency ablation	☐ no prior treatments
SURGICAL HISTORY					
FAMILY HISTORY	☐ varicose veins ☐ clotting disorder ☐ heart disease ☐ cancer ☐ stroke				
SOCIAL HISTORY	**Alcohol Use:** ☐ Never ☐ Occasional ☐ Frequent/Daily **Tobacco Use:** ☐ Yes ☐ No ☐ Quit **Exercise?** ☐Seldom ☐ Regularly ☐ Daily				
MEDS (prescribed)	☐ Coumadin ☐ Plavix ☐ Lovenox ☐ Xarelto ☐ Pradaxa ☐ Eliquis ☐ Other:				
ALLERGIES	☐ tape ☐ latex ☐ Other Medication Allergies (list):				
MISC	HEIGHT: _____ WEIGHT:_____				

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Patient Symptom Questionnaire—VVSYMQuick Survey

PATIENT:	DOB:	DATE:

Instructions: These series of questions pertain to your right leg and your left leg. Please answer for BOTH legs.

RIGHT LEG

HEAVINESS feeling in your right leg**?**
□ NONE □ A LITTLE BIT □ SOME
□ A GOOD BIT □ MOST □ ALL

ACHING feeling in your right leg?
□ NONE □ A LITTLE BIT □ SOME
□ A GOOD BIT □ MOST □ ALL

SWELLING in your right leg?
□ NONE □ A LITTLE BIT □ SOME
□ A GOOD BIT □ MOST □ ALL

NIGHT CRAMPS in your right leg?
□ NONE □ A LITTLE BIT □ SOME
□ A GOOD BIT □ MOST □ ALL

HEAT OR BURNING feeling in your right leg?
□ NONE □ A LITTLE BIT □ SOME
□ A GOOD BIT □ MOST □ ALL

RESTLESS LEG feeling in your right leg?
□ NONE □ A LITTLE BIT □ SOME
□ A GOOD BIT □ MOST □ ALL

THROBBING feeling in your right leg?
□ NONE □ A LITTLE BIT □ SOME
□ A GOOD BIT □ MOST □ ALL

ITCHING feeling in your right leg?
□ NONE □ A LITTLE BIT □ SOME
□ A GOOD BIT □ MOST □ ALL

TINGLING feeling in your right leg?
□ NONE □ A LITTLE BIT □ SOME
□ A GOOD BIT □ MOST □ ALL

TOTAL SCORE RIGHT LE: _____

LEFT LEG

HEAVINESS feeling in your left leg**?**
□ NONE □ A LITTLE BIT □ SOME
□ A GOOD BIT □ MOST □ ALL

ACHING feeling in your left leg?
□ NONE □ A LITTLE BIT □ SOME
□ A GOOD BIT □ MOST □ ALL

SWELLING in your left leg?
□ NONE □ A LITTLE BIT □ SOME
□ A GOOD BIT □ MOST □ ALL

NIGHT CRAMPS in your left leg?
□ NONE □ A LITTLE BIT □ SOME
□ A GOOD BIT □ MOST □ ALL

HEAT OR BURNING feeling in your left leg?
□ NONE □ A LITTLE BIT □ SOME
□ A GOOD BIT □ MOST □ ALL

RESTLESS LEG feeling in your left leg?
□ NONE □ A LITTLE BIT □ SOME
□ A GOOD BIT □ MOST □ ALL

THROBBING feeling in your left leg?
□ NONE □ A LITTLE BIT □ SOME
□ A GOOD BIT □ MOST □ ALL

ITCHING feeling in your left leg?
□ NONE □ A LITTLE BIT □ SOME
□ A GOOD BIT □ MOST □ ALL

TINGLING feeling in your left leg?
□ NONE □ A LITTLE BIT □ SOME
□ A GOOD BIT □ MOST □ ALL

TOTAL SCORE LEFT LE: _____

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NAME:	DOB:	DATE:

REVIEW OF SYSTEMS:

CONSTITUTIONAL	ENT	CARDIOVASCULAR	RESPIRATORY
☐ Lack of energy ☐ Unexplained weight loss or gain ☐ Fever ☐ Night sweats	☐ Difficulty hearing ☐ Sinus problems ☐ Nose bleeds ☐ Sore throat	☐ Irregular heartbeat ☐ Palpitations ☐ Chest pains ☐ Lower extremity swelling ☐ Pain in legs when walking	☐ Shortness of breath ☐ Cough ☐ Wheezing

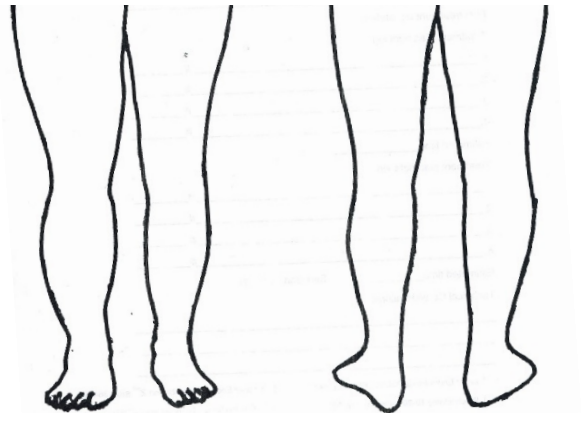
GI	MUSKULOSKELETAL	INTEGUMENT	NEURO
☐ GERD ☐ Difficulty Swallowing ☐ Nausea ☐ Vomiting ☐ Abdominal pain ☐ Constipation ☐ Diarrhea ☐ Bloody stools	☐ Leg pain ☐ Joint pain ☐ Myalgias (muscle ache) ☐ Swelling of joints ☐ Back pain	☐ Itching ☐ Rash ☐ Dry skin ☐ Stasis dermatitis (skin discoloration)	☐ Migraine headaches ☐ Frequent headaches ☐ Restless legs ☐ Dizziness ☐ Numbness ☐ Problems with walking or balance

PSYCHIATRIC	ENDOCRINOLOGY	HEMATOLOGIC	ALLERGIC
☐ Depression ☐ Insomnia ☐ Anxiety	☐ Intolerance to heat or cold ☐ Frequent hunger/urination/thirst	☐ Easy bleeding ☐ Easy bruising ☐ Anemia	☐ Seasonal allergies ☐ Hay fever symptoms ☐ Other

EXAM:

Right Left Left Right

Anterior Aspect **Posterior Aspect**



PLAN: