



ID:

DEMOGRAPHICS

FIRST:		M.	LAST:		
MAILING ADDRESS:			MARRIED	SINGLE	OTHER
SOCIAL SECURITY #:			SPOUSE NAME:		
DOB:	CELL:	HOME:	Occupation:		
EMAIL:					
EMERGENCY CONTACT:		PHONE:	RELATIONSHIP:		

PRIMARY CARE PROVIDER: (Please note: this provider/office with receive all visit notes)	PROVIDER OFFICE:
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HOW DID YOU HEAR ABOUT OUR OFFICE?	INSURANCE INFORMATION	
<input type="checkbox"/> TV COMMERCIALS <input type="checkbox"/> RADIO ADS <input type="checkbox"/> GOOGLE <input type="checkbox"/> VSA PATIENT <input type="checkbox"/> PREVIOUSLY SEEN WITH US <input type="checkbox"/> PRIMARY CARE PROVIDER <input type="checkbox"/> 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:
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ID:

FINANCIAL POLICY

Thank you for choosing Vein Specialists of Alaska. 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 Specialists of Alaska. If you fail to inform us within 30 days of the changes, VSA will not be responsible for filing your insurance. Please be aware that some, and perhaps all the service provided may be non-covered services. If something is not covered by your insurance, you may be held responsible. 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. If there is an exclusion and your insurance does not pay you will also be held responsible, and we are happy to give you a self-pay rate for that charge. 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/NOTICES

- **\$50.00 Fee** – Less than 2 business days’ notice
- **\$150.00 Fee**- UGS -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.
- **\$250.00 Fee** – RFA, PLEB & Varithena -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
- **Scheduling**-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.
- **Balance** – I understand that it is my responsibility to confirm that all required authorizations for medical procedures have been obtained. If my insurance denied a claim due to lack of prior authorization, I agree to be financially responsible for the cost of the services provided. This includes any balance remaining after secondary insurance processing. 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 nonresponsive after 30 days the balance will become your responsibility.
- **Assignment of Benefits** - I hereby assign all medical and surgical benefits, to include major medical benefits which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, VA, private insurance,

and any other health/medical plan, to issue payment directly to Vein Specialists of Alaska LLC for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

- **Authorization to Release Information** - I authorize Vein Specialists of Alaska to:
 1. Release any information necessary to insurance carriers regarding my illness and treatments
 2. Process insurance claims generated during examination and treatment.
 3. Allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime.

This order will remain in effect until revoked by me in writing.

- **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

Patient Signature

Today’s Date



HIPAA

COMPLIANCE POLICIES AND PROCEDURES

Privacy Standards: Protected Health Information

Vein Specialists of Alaska will not use or disclose protected health information without the consent or authorization of its patients for purposes other than treatment and billing. All personnel will understand and be able to identify the elements of protected health information.

Procedures:

1. Protected information is any individual identifiable information contained in the patient's medical record or files. This includes the patient's name, address diagnosis, chart notes, lab results, treatment plan, insurance or financial information.
2. Every chart should contain a signed consent form from the patient that authorizes or prohibits the practice from using or disclosing protected health information. The consent form must have been signed within one year of the current date.
3. Personnel may use and disclose protected health information for treatment, billing or operations related to treatment and billing without patient consent. Any other use of protected health information must be authorized by the patient and documented in the chart.
4. It is expected that personnel who release protected health information for any reason will release only the minimum amount of information necessary based on the purpose of the request. For example, if any insurance company requests chart notes for the purpose of reviewing a claim, only the notes specific to that date of service and procedure under review should be released.
5. If protected health information is used or disclosed for any other purpose than treatment, billing, or operations related to treatment and billing, or operations related to treatment and billing, the information must be "de-identified" by removing all information that would distinguish the individual's record from a group.



HIPAA Acknowledgement Form

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of 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:
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 the assignment. Regulations pertaining to medical assignment benefits apply.

Signed: _____ Date: _____

If the patient refuses to sign, indicate your attempt to obtain a signature below.

() Patient refused to sign this acknowledgement

Date: _____

Time: _____

Employee Name: _____

ID:



Vein Specialists of Alaska

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

ID: _____

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

<input type="checkbox"/> Cannot stand longer than a few hours without pain. <input type="checkbox"/> Is uncomfortable to bend legs. <input type="checkbox"/> Find that it is becoming increasingly more difficult to stand at work. <input type="checkbox"/> Find that it is becoming increasingly more difficult to sit at work. <input type="checkbox"/> Can no longer perform the routine functions at work. <input type="checkbox"/> Can no longer perform the routine functions at school. <input type="checkbox"/> Is find it difficult to focus due to pain. <input type="checkbox"/> Cannot walk without pain. Is unable to gain access to work, community and/leisure activities. <input type="checkbox"/> Has difficulty with balance with or without assistive devices?	<input type="checkbox"/> Is finding it more difficult to stand and walk. <input type="checkbox"/> Cannot sit more than an hour without pain. <input type="checkbox"/> Cannot fully participate in sports. <input type="checkbox"/> Is unable to gain access to home environments. <input type="checkbox"/> Feels unsafe at work and/or at home. <input type="checkbox"/> Finds it difficult to stand without discomfort. <input type="checkbox"/> Is finding it difficult to sleep at night. <input type="checkbox"/> Legs are painful to touch. <input type="checkbox"/> Is constantly itching. <input type="checkbox"/> Has difficulty sitting for extended periods of times
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HAVE YOU TRIED COMPRESSION THERAPY:	IF YES: <input type="checkbox"/> 3 MONTH or more <input type="checkbox"/> 6 WEEKS or more	Physician Directed? <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> have not tried
HAVE YOU TRIED ANY OF THE FOLLOWING:	<input type="checkbox"/> over the counter meds	<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> Ibuprofen <input type="checkbox"/> No pain medications <input type="checkbox"/> Other
PAST MEDICAL HISTORY	<input type="checkbox"/> Hypertension (high blood pressure) <input type="checkbox"/> Diabetes <input type="checkbox"/> Bleeding/Clotting Disorder <input type="checkbox"/> Peripheral Arterial Disease <input type="checkbox"/> Coronary Arterial Disease (heart attack/stent/bypass) <input type="checkbox"/> Pacemaker/Defibrillator <input type="checkbox"/> Cancer <input type="checkbox"/> Other notable medical problems		
PAST VENOUS HISTORY	<input type="checkbox"/> Phlebitis (clot in surface veins) <input type="checkbox"/> DVT (Deep Vein Thrombosis) <input type="checkbox"/> Pulmonary Embolism (clot in lung) <input type="checkbox"/> Bleeding from veins <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Previous trauma to legs <input type="checkbox"/> Clotting Disorder (free bleeder) <input type="checkbox"/> IV Drug use/AIDS/HIV/Hepatitis		
PREVIOUS VEIN TREATMENT	<input type="checkbox"/> Sclerotherapy	<input type="checkbox"/> Stripping	<input type="checkbox"/> Phlebectomy <input type="checkbox"/> laser or radiofrequency ablation <input type="checkbox"/> no prior treatments
SURGICAL HISTORY			
FAMILY HISTORY	<input type="checkbox"/> varicose veins <input type="checkbox"/> clotting disorder <input type="checkbox"/> heart disease <input type="checkbox"/> cancer <input type="checkbox"/> stroke		
SOCIAL HISTORY	Alcohol Use: <input type="checkbox"/> Never <input type="checkbox"/> Occasional <input type="checkbox"/> Frequent/Daily Tobacco Use: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Quit Exercise? <input type="checkbox"/> Seldom <input type="checkbox"/> Regularly <input type="checkbox"/> Daily		
MEDS (prescribed)	<input type="checkbox"/> Coumadin <input type="checkbox"/> Plavix <input type="checkbox"/> Lovenox <input type="checkbox"/> Xarelto <input type="checkbox"/> Pradaxa <input type="checkbox"/> Eliquis <input type="checkbox"/> Other:		
ALLERGIES	<input type="checkbox"/> tape <input type="checkbox"/> latex <input type="checkbox"/> Other Medication Allergies (list):		
MISC	HEIGHT: _____ WEIGHT: _____		



Vein Specialists of Alaska

ID: _____

Patient Symptom Questionnaire

PATIENT: _____	DOB: _____	DATE: _____
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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: _____



Vein Specialists of Alaska

ID:

NAME:	DOB:	DATE:
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REVIEW OF SYSTEMS:

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

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

PSYCHIATRIC	ENDOCRINOLOGY	HEMATOLOGIC	ALLERGIC
<input type="checkbox"/> Depression <input type="checkbox"/> Insomnia <input type="checkbox"/> Anxiety	<input type="checkbox"/> Intolerance to heat or cold <input type="checkbox"/> Frequent hunger/urination/thirst	<input type="checkbox"/> Easy bleeding <input type="checkbox"/> Easy bruising <input type="checkbox"/> Anemia	<input type="checkbox"/> Seasonal allergies <input type="checkbox"/> Hay fever symptoms <input type="checkbox"/> Other

EXAM:	<div style="display: flex; justify-content: space-around; align-items: flex-start;"> <div style="text-align: center;"> <p>Right</p> <p>Anterior Aspect</p> </div> <div style="text-align: center;"> <p>Left</p> <p>Posterior Aspect</p> </div> <div style="text-align: center;"> <p>Left</p> <p>Posterior Aspect</p> </div> <div style="text-align: center;"> <p>Right</p> <p>Posterior Aspect</p> </div> </div>	PLAN:
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