Vein Specialists of Alaska

PATIENT INFORMATION

PROFILE

NAME:	DOB:

MAILING ADDRESS:	SOCIAL SECURITY #:	
HOW WOULD YOU PREFER APPOINTMENT REMINDERS? (Circle all) TEXT PHONE CALL EMAIL	CELL PHONE:	HOME PHONE:
EMAIL:		

ADDITIONAL INFO

PREFERRED PHARMACY:	
REFERRING PROVIDER:	PRIMARY CARE PROVIDER(PCP):

CONTACTS

EMERGENCY CONTACT: ZIP CODE:		WHERE HAVE YOU SEEN OR HEARD ABOUT US? (Circle all) TV: _____ RADIO: _____ GOOGLE: _____
PHONE:	RELATIONSHIP:	VSA Patient: _____ PCP: _____ OTHER: _____

INSURANCE

PRIMARY INSURANCE: _____	SECONDARY INSURANCE: _____
POLICY HOLDER: _____	POLICY HOLDER: _____
POLICY HOLDER DOB: _____	POLICY HOLDER DOB: _____
POLICY HOLDER PHONE: _____	POLICY HOLDER PHONE: _____
POLICY HOLDER MAILING ADDRESS IF NOT SELF: _____	POLICY HOLDER MAILING ADDRESS IF NOT SELF: _____

ANYONE OTHER THAN YOUSELF WE MAY DISCUSS APPOINTMENTS AND BILLING WITH?

FIRST: LAST:	FIRST: LAST:
DOB:	DOB:
PHONE:	PHONE:

REASSIGNMENT OF BENEFITS AND CONSENT FOR RELEASE OF INFORMATION:

I hereby authorize insurance to pay my benefits directly to Vein Specialists of Alaska, LLC for any surgical and/or medical treatment. 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.

Patient Signature:_____ **Today's Date:**_____

Vein Specialists of Alaska

PATIENT SYMPTOM QUESTIONNAIRE — VVSYM QUICK SURVEY

PATIENT:_____ DOB:_____ DATE:_____

Instructions: These series of questions pertain to your right leg and your left leg. Please answer for BOTH legs.
The 6 answer choices are the same for each question, and are as follows:

- **NONE** of the time
- **A LITTLE BIT** of the time
- **SOME** of the time
- **A GOOD BIT** of the time
- **MOST** of the time
- **ALL** of the time

RIGHT LEG QUESTIONS

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 LEG: _____

LEFT LEG QUESTIONS

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 LEG: _____

Vein Specialists of Alaska

CONSERVATIVE THERAPY AND SYMPTOM STATEMENT

Today's Date:_____

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.

Patient Name:_____ DOB:_____

Patient Signature:_____

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 in a timely manner. If you fail to inform us within 60 days of the changes, Vein Specialist of Alaska will not be responsible for filing your insurance. Please be aware that some, and perhaps all of 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. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

- **PAYMENT IS DUE AT THE TIME OF SERVICE**
- **WE ACCEPT CASH, CHECKS, AND ALL MAJOR CREDIT CARDS**
- **WE OFFER A PAYMENT PLAN WITH PRIOR BUSINESS OFFICE APPROVAL**
- **IF AN APPOINTMENT OTHER THAN A PROCEDURE IS NOT CANCELLED AT LEAST 48 HOURS IN ADVANCE YOU WILL BE CHARGED A $30.00 FEE; THIS WILL NOT BE COVERED BY YOUR INSURANCE COMPANY**
- **IF AN PROCEDURE IS NOT CANCELLED AT LEAST 5 BUSINESS DAYS IN ADVANCE YOU WILL BE CHARGED A $150.00 FEE; THIS WILL NOT BE COVERED BY YOUR INSURANCE COMPANY.**
- **THERE WILL BE A $30.00 SERVICE CHARGE ON ALL NSF CHECKS**

Note: If you have a balance after your insurance pas its portion, this balance represents your deductible amount and/or co-insurance amounts due. You will receive a statement for this balance. Once you have received three statements without paying on your account, we reserve the right to turn your account over to a collection agency.

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:

Responsible Party's Signature: _____ Date:_____

Responsible Parties Name: _____ DOB: _____

Patient Name if different than above: _____ DOB: _____

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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:

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.

DATE: _____

PATIENT NAME: _____ DOB: _____

PATIENT SIGNATURE: _____

Vein Specialists of Alaska

FOR LOWER EXTREMITY VARICOSE VEINS, UNEXPLAINED PAIN/SWELLING, SKIN PROBLEMS, AND/OR RESTLESS LEG SYMPTOMS

Affected legs: R L Both (worse in which leg? R L equal)

If you have bulgy leg veins, how long have they been visible to you? _____ years

How long have you had worrisome discomfort or other symptoms/swelling in your legs? _____ years

Your height: ____ ft ____ inches Your weight _____ lbs

Female: Have you been pregnant? Y N (Number of pregnancies: _____)

Do other blood relatives have varicose veins? Mom Dad Siblings Children

Other relatives with varicose veins on Mom's or Dad's side? _____

Have you ever seen a vein specialist for varicose vein problem? Y N

When/where/what was done? _____

What type of work do you do (or did you do)? _____

How many years have you/did you work in the job(s) described above? _____ years Retired? Y N

Please check if your leg problems have caused any of the following:

[ ] discomfort *if yes, does the discomfort awaken you from sleep, or impair your ability to fall asleep?* Y N

Please circle the words to describe the discomfort in your leg(s):

aching dull throbbing cramping sharp burning stabbing stinging itching other: _____

[ ] swelling
[ ] restless leg symptoms (creepy/crawly, fidgety legs when you are still/in bed)
[ ] bleeding
[ ] skin ulcer(s)
[ ] skin rash
[ ] permanent skin discoloration lower legs (either brownish darkening or whiter lightening)
[ ] blood clot(s) in leg(s)
[ ] phlebitis (warm, red, tender, swollen veins) diagnosed by a medical provider

Does leg elevation of your affected leg(s) seem to temporarily help the discomfort, swelling, other symptoms? Y N

What OTC medications do you take for aches and pains? (circle any that you use)

Acetaminophen (Tylenol) Ibuprofen (Motrin/Advil) Naproxen (Aleve)

Do you find this medication generally helpful for your leg discomfort? Y N

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MEDICAL INFORMATION

(circle or check positive answers)

Major Medical History:

[ ] Deep vein clot ("DVT") When? _____ Which leg(s)? _____

Hospitalized? Y N Surgery for DVT? Y N Blood thinner? Y N

[ ] Lung clot ("pulmonary embolus") When? _____ Surgery? Y N Filter? Y N

[ ] Cancer Describe: _____ Any cancer active? Y N

[ ] Inherited Blood Clotting problem Describe: _____

[ ] Inherited Free Bleeding problem Describe: _____

[ ] Diabetes Year diagnosed _____ On Insulin: Y N Last Hemoglobin A1C test & value: _____

[ ] High blood pressure

[ ] Hypothyroidism

[ ] Heart problems Heart attack: Y N Heart blockages: Y N Irregular heart rhythm: Y N

[ ] Take major blood thinner daily (examples: Coumadin, Xarelto, Eliquis, Lovenox, Plavix, Trental)

Please write name of current blood thinner(s): _____

[ ] High blood fats (cholesterol and/or triglycerides)

[ ] Other active major medical problem. Please list: _____

Surgical History:

[ ] Gallbladder [ ] Hysterectomy (ovaries taken: Y N) [ ] Heart bypass

[ ] Tonsillectomy [ ] Thyroidectomy [ ] Appendectomy

[ ] Tubal ligation [ ] C-section(s)

[ ] Other: _____

Medication Allergies: Y N List: _____

Medications: **Give list of your daily OTC and prescription medications to staff to be recorded

Social History: Married Divorced Single Widowed

Cigarette use ever? Y N How many packs/day? _____ Year started? _____ Year quit? _____

Alcohol use: Never Occasional (1-3x/month) Frequently (2-3x/week) Daily (how much? _____)

Vein Specialists of Alaska

REVIEW OF SYSTEMS

PATIENT NAME: _____

Please check all positives

General:
[ ] Recent unexplained weight gain 10 pounds or more
[ ] Recent unexplained weight loss 10 pounds or more

Cardiovascular:
[ ] Difficulty breathing lying flat or with one pillow
[ ] Walking frequently at night short of breath or smothering
[ ] Unexplained chest pain

Gastrointestinal:
[ ] Frequent heartburn

Neurological:
[ ] Migraine headaches
[ ] Unexplained numbness in legs or feet
[ ] Unexplained weakness in legs
[ ] Frequent shooting pains in legs

Hematology:
[ ] Prior blood clot(s) in leg(s)
[ ] Easy bruising
[ ] Family history of blood clotting problems
[ ] Free bleeding problems

Endocrine:
[ ] Excessive thirst
[ ] Excessive urination
[ ] Frequent fatigue

Musculosketetal:
[ ] Chronic or frequent back pain
[ ] Frequent leg cramps

Genitourinary (female):
[ ] Varicose veins in vaginal area
[ ] Leg pain worse with menstruation or just prior
[ ] Pelvic pain worse with menstruation or just prior
[ ] Pelvic pain worse with intercourse/orgasm

Genitourinary (male):
[ ] Varicose veins in scrotal area

Vein Specialists of Alaska

Joseph Ty Bell, M.D.
WASILLA • JUNEAU • SOLDOTNA
Phone: (855) 907-8346 Fax: (866)550-6776

RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB:_____

Contact #:_____

I hereby authorize _____
to release my medical information to:

Recipient:_____

Address:_____

Phone:_____Fax:_____

I wish to have the following information released:

- ❑ Clinic notes pertaining to Varicose Vein Disease
- ❑ Venous Ultrasound report of the legs
- ❑ All Medical Records
- ❑ Other: _____

****This release/authorization expires in 90 days.****

_____ _____

Patient Signature Date

Vein Specialists of Alaska

After VSA New Patient paperwork is completed, **please fax to 866-550-6776 in advance of your scheduled appointment.**

If a fax machine is not convenient for you, you may bring the completed paperwork with you to your scheduled appointment.

Please do NOT email your completed form or any sensitive personal information since it is not a secure method of transmission.