Vitality Vein Care

221 N. Preston Rd.
Suite A
469-750-2277
469-750-2886 Fax

www.VitalityVeinCare.com

Demographics

First Name: ______________ MI: ______ Last Name: ______________ Former Name: ______________

Address: ______________ City: ______________ State: __________ Zip: __________

Home Phone: ______________ Cell Phone: ______________ Cell Carrier: ______________ Work Phone: ______________

DOB & Age: ______________ Race: ______________ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Sex: __________ SSN: ______________ Email Address: ______________

Who is your primary care physician? ______________
First Name Last Name

Preferred Pharmacy (name & location): ______________

How did you hear about our practice?

☐ Patient: ______________ ☐ Dr. Referral: ______________

☐ Friend: ______________ First Name Last Name

☐ Other: ______________

Emergency Contact

Name: ______________ Relationship: ______________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Consent to Communicate: Please mark the ways that you consent to us communicating with you:

Method	OK to Leave Voicemail?	OK to Leave Message with Another Person?	Pick a Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐ Yes	☐ Yes	☐	______________
☐ Call Cell Phone	☐ Yes	☐ Yes	☐	______________
☐ Call Home Phone	☐ Yes	☐ Yes	☐	______________

☐ Send Email to Email Address ______________

☐ Email Appointment Reminders

☐ Email Medical Info – ***Please keep in mind that communications via email over the internet are not secure and are not HIPAA compliant. Although it is unlikely, there is a possibility that information in an email can be intercepted and read by other parties besides the person to whom it is addressed.***

☐ Email office specials including newsletter. No spam. We do not sell our lists. Send

☐ US Mail

Mail to: ☐ Home ☐ Other (please list): ______________

☐ Send Text Message. Cell Phone Carrier: ______________

☐ Text Appointment Reminders

Aaron Roberts, DO | Bradley Hart, MD, PhD, FACS |
Stephanie Sealy, APRN, FNP-C | Joshua Rocka, APRN, AGACNP-BC

MEDICAL HISTORY

NAME: ____ DATE OF BIRTH: _______________________
MALE: ☐ FEMALE: ☐ HEIGHT: __________________ WEIGHT: ________________

WHAT PROBLEMS ARE YOU SEEKING CARE FOR? ____

CIRCLE ALL ILLNESSES OR SYMPTOMS YOU ARE CURRENTLY TREATED FOR OR HAVE BEEN TREATED FOR:

CHEST PAIN/SHORTNESS OF BREATH	HEART PALPITATIONS	RECENT WEIGHT LOSS	NONE
ARTHRITIS	LIVER DISEASE	HEART ISSUES	SEIZURES
ASTHMA	COPD	EMPHYSEMA	DEGENERATIVE DISC
BLADDER/KIDNEY DISEASE	ANXIETY/DEPRESSION	HEPATITIS	NEUROPATHY
BLEEDING/CLOTTING DISORDER	DIABETES	HIGH BLOOD PRESSURE	STROKE/TIA
BLURRED VISION	GASTROINTESTINAL	HIGH CHOLESTEROL	THYROID DISEASE
CANCER	HEADACHES/MIGRAINES	HIV/AIDS	TUBERCULOSIS
RECENT WEIGHT GAIN	HEMORRHOIDS	COVID 19	OTHER

PLEASE LIST ANY SURGERIES YOU HAVE HAD:
____

SMOKING: YES☐ NO ☐ HOW MUCH? ___________ HAVE YOU EVER SMOKED? ________

ALCOHOL: YES ☐ NO ☐ HOW MANY GLASSES PER DAY/WEEK? ____

[FEMALE ONLY] NUMBER OF PREGNANCIES: ______ NUMBER OF LIVE BIRTHS: _______ ARE YOU CURRENTLY PREGNANT OR BREASTFEEDING? ___________

MEDICATION INFORMATION

PHARMACY PREFERENCE____

ARE YOU CURRENTLY ON ANY BLOOD THINNERS? {SUCH AS XARELTO, ELIQUIS, PLAVIX} YES ☐ NO ☐

DO YOU REGULARLY TAKE: ASPIRIN☐ IBUPROFEN ☐ TYLENOL ☐ ALEVE ☐

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING, OVER THE COUNTER AND PRESCRIBED. (YOU MAY USE A SEPARATE PIECE OF PAPER IF NEEDED) MEDICATION NAME: DOSAGE
____
____

ALLERGIES

ARE YOU ALLERGIC TO LOCAL ANESTETICS SUCH AS LIDOCAINE? YES ☐ NO ☐ LATEX ALLERGY? YES ☐ NO ☐
PLEASE LIST ANY MEDICATION, OR MEDICAL ADHESIVE ALLERGIES AND THEIR REACTIONS:
____
____

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VEIN SCREENING FORM

VASCULAR HISTORY: DO YOU HAVE OR HAVE YOU EVER BEEN DIAGNOSED WITH?

VARICOSE VEIN PROBLEMS YES ☐ NO ☐ LEG: RIGHT ☐ LEFT ☐
PHLEBITIS (VEIN REDNESS/TENDERNESS) YES ☐ NO ☐ LEG: RIGHT ☐ LEFT ☐
BLOOD CLOTS YES ☐ NO ☐ LEG: RIGHT ☐ LEFT ☐
DEEP VEIN THROMBOSIS (DVT) YES ☐ NO ☐ LEG: RIGHT ☐ LEFT ☐

DO YOU EXPERIENCE ANY OF THE FOLLOWING IN YOUR LEGS? HOW LONG HAVE YOU HAD THESE SYMPTOMS? ___________________

ACHING/PAIN YES ☐ NO ☐ LEG: RIGHT ☐ LEFT ☐
HEAVINESS YES ☐ NO ☐ LEG: RIGHT ☐ LEFT ☐
TIREDNESS/FATIGUE YES ☐ NO ☐ LEG: RIGHT ☐ LEFT ☐
HEMORRHAGING VEIN YES ☐ NO ☐ LEG: RIGHT ☐ LEFT ☐
SKIN OR ULCER PROBLEMS YES ☐ NO ☐ LEG: RIGHT ☐ LEFT ☐
CRAMPS YES ☐ NO ☐ LEG: RIGHT ☐ LEFT ☐
RESTLESS LEGS YES ☐ NO ☐ LEG: RIGHT ☐ LEFT ☐
THROBBING YES ☐ NO ☐ LEG: RIGHT ☐ LEFT ☐
SWELLING YES ☐ NO ☐ LEG: RIGHT ☐ LEFT ☐
ITCHING/BURNING YES ☐ NO ☐ LEG: RIGHT ☐ LEFT ☐

WHICH OF THE FOLLOWING DO YOU CURRENTLY DO TO IMPROVE YOU LEG VEIN SYMPTOMS?

MEDICATION FOR PAIN/SYMPTOMS YES ☐ NO ☐ WHAT? ___________
ELEVATION OF LEGS YES ☐ NO ☐
WEAR COMPRESSION STOCKINGS YES ☐ NO ☐

PLEASE LIST ANY SITUATIONS WHICH MAKE YOUR LEG SYMPTOMS WORSE (I.E. SITTING, STANDING, EXERCISE, ETC)?

____

FAMILY HISTORY: HAVE ANY OF YOUR FAMILY MEMBERS HAD?

VARICOSE VEINS YES ☐ NO ☐
VEIN STRIPPING YES ☐ NO ☐
BLOOD COAGULATION DISORDER YES ☐ NO ☐
BLOOD CLOTS YES ☐ NO ☐
STROKE, HEART ATTACKS YES ☐ NO ☐
PULMONARY EMBOLI YES ☐ NO ☐

TREATMENT HISTORY: HAVE YOU EVER BEEN TREATED FOR VARICOSE VEINS WITH?

SCLEROTHERAPY YES ☐ NO ☐
LASER THERAPY (SPIDER VEINS) YES ☐ NO ☐
PHLEBECTOMY YES ☐ NO ☐
VEIN STRIPPING SURGERY YES ☐ NO ☐
RF ABLATION YES ☐ NO ☐

PERSONAL ACTIVITIES LIST: DOES YOUR WORK/LIFESTYLE INVOLVE ANY OF THE FOLLOWING:

PROLONGED STANDING YES ☐ NO ☐
PROLONG SITTING YES ☐ NO ☐
EXERCISE REGULARLY YES ☐ NO ☐
FLY FREQUENTLY YES ☐ NO ☐
WEIGHT LOSS YES ☐ NO ☐

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HIPAA Information and Consent

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. We can use and share your health information to bill and get payment from health plans or other entities such as credit card companies. Patient files may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: ____ Date: ________________________________

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FINANCIAL POLICY

ALLOWABLE FORMS OF PAYMENT
With the exception of insurance covered procedures, full payment is due at least one week before the scheduled surgery, or on the day of service for non-surgical procedures. Our office accepts payment by cash, check, money order and credit cards from Visa, Mastercard, Discover and American Express. We also offer patient financing through Care Credit. Not all patients will qualify for financing, and not all procedures are eligible to be financed.

INSURANCE, CO-PAYS, DEDUCTIBLES
The patient or his/her legal representative is ultimately responsible for all charges incurred. Our office accepts assignment of benefits for many insurance companies. However, we are not preferred providers with all of them. It is your responsibility to **contact your insurance as to whether we are in your plan**, obtain your individual benefits and to be prepared to pay for any out of pocket expenses such as co-pays, deductibles and co-insurance before any surgery or office procedure is done. **Co-pays and past due balances are due at time of check-in**.

Your health care policy is a contract between you and your insurance company. If your insurance company does not cover your surgery, you will be liable for the payment. For example, Medicare does not have a pre-authorization process. If it is determined that your surgery was not medically necessary, you will then be billed for the surgery. It is ultimately **your responsibility to pay for all services** provided by Vitality Vein Care.

BILLING
Statements are mailed monthly and expected to be paid in full within 60 days after your insurance has settled your claim. If you have financial difficulties, please contact our office manager as soon as you are aware of the situation. The worst thing that you can do is to ignore the bill. Doing so will make you ineligible for any further service. If payment is not received within 90 days, your account may be referred to a collection agency.

DISPUTES
Services that are performed that are paid with a credit card, debit card or with financing, are not eligible for post-care payment challenges. The practice encourages a complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy. I agree that this credit, debit card or financing challenge agreement is irrevocable.

I have read the above Financial Policy. I understand and agree to this.

Patient or Responsible Party's Signature	Date

PLEASE SIGN BELOW FOR INSURANCE CASES ONLY.

I, ____ have insurance coverage and directly assign to VVC all medical benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for any out of pocket expenses such as, but not limited to co-pays, deductibles and co-insurance.

Patient or Responsible Party's Signature	Date

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General Administrative & Financial Agreement

- I will keep my account current, therefore, all self-pay, deductibles, insurance co-payments, and co-insurances will be collected at the time of service payable by cash, check, or credit card.
- I will inform **Vitality Vein Care** of any address or telephone number changes.
- I will be charged **$35.00** for a returned check.
- Credit on the account will be issued within four weeks from the date we are notified by you.
- I will be charged **$50.00** in advance for the completion of requested forms such as Disability, FMLA, etc., and forms will be completed within 10 business days.
- I will inform **Vitality Vein Care** of any changes to my insurance policy so that my coverage can be re-verified prior to any future appointment.
- If my insurance policy requires a referral from my primary care physician, I will provide **Vitality Vein Care** with my primary care physicians' contact information.
- It is my responsibility to be aware of whether **Vitality Vein Care** services are covered by my insurance company. I understand that if **Vitality Vein Care** services provided are not covered by my insurance policy that I am responsible for any non-covered charges.
- **Vitality Vein Care** will file my insurance claims as a courtesy; however, my charges are always my responsibility.

Cancellation Policy and Fees

If you must cancel or reschedule your appointment, CALL us at (469) 750- 2277 at least **24 hours** before your scheduled appointment. The following fees will be incurred:

- Cancelling or rescheduling less than 1 business days' notice or not showing up for your appointment will result in a **$50 fee**.
- Any cancellation or rescheduling fees above that have been placed on your account must be paid in full prior to scheduling future visits or procedures.
- Although we do understand that sometimes situations arise beyond your control, if you find it necessary to reschedule an appointment more than once, we reserve the right to double book your next appointment.

Late Policy

If you are 15 minutes late for your scheduled appointment, your appointment will be cancelled so as not to inconvenience our on-time patients. If you would like to wait, we MAY be able to accommodate you, however, that cannot be guaranteed. Otherwise, your appointment will be rescheduled.

Signature: ____ Date: __________________________

I understand the information stated above regarding my estimated cost and treatment. This estimated cost is based on the details provided by my insurance company and that I am ultimately responsible for any services and charges not covered by my insurance company. I also understand the cancellation policy and fee if I should fail to comply.

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HIPAA NOTICE OF PRIVACY PRACTICES (signature page of 8 page document)

Your Rights Regarding Your Protected Health Information

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by Vitality Vein Care to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would no apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. Vitality Vein Care may deny an access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that Vitality Vein Care send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that Vitality Vein Care not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests by you.

You have the right to request that Vitality Vein Care amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of the disclosures of your protected health information made by Vitality Vein Care for the six years prior to the date of the request. We are not required, however, to record disclosures we make pursuant to signed consent or authorization.

You may request and receive a paper copy of this Notice, if you had previously received or agreed to receive the Notice electronically.

Any person or patient may file a complaint with Vitality Vein Care and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with Vitality Vein Care, please contact the office manager at Vitality Vein Care.

It is the policy of Vitality Vein Care that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

I have been given the opportunity to read, review, obtain a hard copy and ask questions about Vitality Vein Care's **HIPAA Notice of Privacy Practices**, and how Vitality Vein Care uses and discloses my information and my rights concerning my information.

Patient or **Personal Representative**

Signature: ____ Date: ________________

If Personal Rep, describe relationship ____

☐ The patient's condition prohibits the individual from signing an acknowledgement at the time. It will be obtained as reasonably practicable after the patient's condition improves.

☐ Acknowledgment was unable to be obtained. Reason:

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Prosper, TX 75078
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vvc@vitalityveincare.com

Consent to Release Protected Health Information (PHI)

I understand that in order to disclose my PHI, Vitality Vein Care, PLLC must have my consent. Therefore, I authorize Vitality Vein CARE, PLLC to disclose my PHI (checked below) to the following recipients:

Description of the information able to be disclosed (check all that apply)

☐ All procedures ☐ Test results ☐ Appointments ☐ Surgeries ☐ Billing/Account information

Name(s) of the person(s) authorized to obtain the above mentioned information. (e.g. physician other than referring doctor, family members, and other specified person(s)

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

Patient (print): ______________________________ Signature: ______________________________

Date: ______________________________

Patient Representative (Print, Sign, Relationship): ______________________________

Date: ______________________________

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OPTIONAL: VIDEO AND PHOTOGRAPH RELEASE AND AUTHORIZATION

I hereby consent to and authorize the use and reproduction by Vitality Vein Care (VVC), or anyone authorized by them, of any and all photographs, electronic images or video footage of me taken by VVC has in its possession, provided either by me or by a third party (collectively, Images) for the purpose of informing the medical profession and the general public about plastic surgery and plastic surgery procedures and techniques without compensation to me. Such use shall include, but not be limited to, distributing the Images via print, visual and electronic media, specifically including the VVC website and social media sites such as YouTube, Facebook and Twitter. The Images (including any photographic negatives) shall be the sole property of VVC.

I understand that the Images will not be identified by my name, but that such Images may reveal my identity. I understand and accept these terms.

I hereby waive any right to inspect or approve the finished product, photograph, video, DVD, CD-ROM or matter that may be used in conjunction therewith or to the eventual use that it might be applied.

I hereby release, discharge and agree to hold harmless VVC and its affiliates and their respective representatives, assigns, and employees, and any person acting under their permission or authority, from and against any claims whatsoever in connection with the use of my Images and the reproduction thereof as stated above, including any claim for payment in connection with distribution or publication of the video and/or photographs.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Vitality Vein Care.

I understand that once content is posted on the web, it may remain on the web even after the content is deleted from the source.

I hereby warrant that I am at least eighteen years old, and competent to contract in my own name insofar as the above is concerned.

The purpose of this form is to obtain my prior written consent so that Vitality Vein Care may photograph or film me for one or more of the following purposes listed below for which I do hereby consent.

Initial all that apply:

_________ **Medical Use:** Use or disclosure of image for medical specialty board in formulating its examination of applicant physicians, or in a professional presentation or journal publication

_________ **Office Use:** Use or disclosure of image for marketing or advertising purposes and patient education within the office

_________ **Website Use:** Use or disclosure of image for marketing or advertising purposes and patient education via print, visual and electronic media

Photo Limitations: ____

(For example: No face, no tattoo, etc.)

I have read and understand the foregoing release, authorization and agreement, before signing my name below, and enter into it knowingly and voluntarily.

Patient's Signature	Date