DALLAS VEIN SPECIALISTS

PATIENT INFORMATION

Patient Name:			Age:	Sex: M F	Date of Birth: _____/_____/_____
Address:			City:		State:
Zip:	E-Mail:				
Home No:	Work No:		Cell No:		Other:
Employer Name:		Occupation/Title:			Phone No:
Employer Address:			City:	State:	Zip:

SPOUSE INFORMATION (FOR INSURANCE PURPOSES)

Name:	Date of Birth: _____/_____/_____	Cell No:
Employer Name:		Phone No:

REFERRING PHYSICIAN (OR SOURCE) INFORMATION

Name:	Specialty:		
Address:	City:	State:	Zip:
Other Referring Source:			

EMERGENCY CONTACT INFORMATION

Name:	Relationship:	Phone No:

INSURANCE INFORMATION

Primary Insurance Company:
Secondary Insurance Company:

Does the office staff at Dallas Vein Specialists have permission to leave detailed voice mail messages? Please check all that apply: __ Home __ Work __ Cell

Does the office staff at Dallas Vein Specialists have permission to send email/or text messages? __ Yes __ No

Authorization to Release Information: I hereby authorize Dallas Vein Specialists to release any medical information to process a medical claim. I understand that I am financially responsible for any and all charges rendered at the time of the office visit and that fees are collected on the days of procedures. If for any reason it becomes necessary to initiate collections proceedings, I understand that I am responsible for the cost off all treatments received, as well as any and all legal or collection fees Dallas Vein Specialists incurs. **I agree to inform DVS of any changes in my insurance policy.**

Signature: _____ Date: _____

HEALTH INFORMATION

Patient Name:	Height:	Weight:
Primary Care Physician	Phone:	
Chief Complaint:		Date:

YOUR CURRENT LEG SYMPTOMS

Please circle all that apply			**Describe how long these symptoms / findings have been present**
Ache / Hurt:	Left	Right	
Swelling:	Left	Right	
Cramp:	Left	Right	
Restlessness:	Left	Right	
Fatigue:	Left	Right	
Itch:	Left	Right	
Other:	Left	Right	
Skin Discoloration:	Left	Right	
Purple / Red Veins:	Left	Right	
Vein Network:	Left	Right	
Flat Blue / Green Veins:	Left	Right	
Bulging Veins:	Left	Right	
Ruptured Vein / Bleeding:	Left	Right	
Abdominal Veins:	Left	Right	

CONSERVATIVE THERAPY

Please check any methods you may have used to relieve your symptoms			
Leg Elevation:		Cold Packs:	
Exercise:		Pain Medication:	
Flexion / Extension:		Asprin:	
Walking:		Tylenol:	
Support Hose (note amount of time worn): ____ Days / Months / Years		Ibuprofen:	
Wraps:		Other:	
Warm Soaks:			

Are you here for Prominent Eye Veins? ____ Yes ____ No

Patient Name:	Date:

DO YOU HAVE A HISTORY OF THE FOLLOWING

Please check those that apply		When were you diagnosed?
Migraine Headaches:		
Diabetes (list type):		
Anemia:		
Bleeding Disorder:		
Clotting Disorder:		
DVT (Deep Vein Thrombosis):		
Heart Disease:		
Hypertension:		
Superficial Thrombophlebitis:		
Leg Ulcers:		
Trauma to the Leg:		
Hepatitis (list type):		
HIV:		
Other:		

Do you smoke?	Yes	No	How often:
Do you drink?	Yes	No	How often:

FAMILY HISTORY

Do you have a family history of:

Please check those that apply		Relationship and Treatment (if known)
Varicose Veins:		
Spider Veins:		
Venuos Ulcers:		
Clotting Disorders:		
Bleeding Disorders:		
Stroke:		

Patient Name:	Date:

PAST MEDICAL HISTORY

Have you had any previous vein treatment? Please list the treatment and the doctor.

Are you currently being treated for an illness? If so, please explain.

Please list any operations or procedures you have previously had and when these occurred.

Are you pregnant or could you possibly be pregnant? _____ Yes _____ No

MEDICATIONS

Please list any medications (with doses) you have been prescribed or over-the-counter medications you take regularly.

Do you have any allergies to medicines or tape. List all:

DALLAS VEIN
SPECIALISTS

HIPAA AUTHORIZATION

I understand that I am giving authorization to Dallas Vein Specialists (and/or its designated record/database custodian) to release and disclose my protected health information. This information may relate to my past, present, or future payment for the provision of health care to me.

I may revoke this authorization at any time by notifying in writing of my intent to revoke this authorization. However, I also understand that such a revocation will not have any effect on any information already used or disclosed by Dallas Vein Specialists before receipt my written notice of revocation. I also understand that my revocation may not be honored if Dallas Vein Specialists has taken action in reliance upon my signed Authorization Form.

I understand that I may inspect and receive a copy of the protected health information to be released and disclosed pursuant to this Authorization Form. By signing this form below, I acknowledge that my signature is voluntary and I understand that I am not required to sign this form in exchange for receiving health care treatment.

A photocopy or facsimile copy of this authorization shall be considered as effective and valid as the original. If the patient is a minor, is incapacitated, or is deceased, then the signature of the guardian or representative shall be considered as effective and valid.

Signature of Patient (or Guardian/Representative) Date

Printed Name of Patient (or Guardian/Representative) Date

DALLAS VEIN SPECIALISTS

PAYMENT OPTIONS FORM

TO OUR PATIENTS:

Our primary goal is to provide excellent medical care. We also want to give you complete information regarding insurance coverage and any financial responsibilities you may have. Please read the summary below conceming insurance and reimbursement. Please do not hesitate to ask questions if anything is unclear.

MANAGED CARE CONTRACTS

We contract with a number of insurance companies or networks to provide medical care to their insured members at a negotiated discount. If a patient is insured by one of these companies or through one of the networks, we are considered IN-NETWORK providers for that patient. We abide by the terms of our contract with them, which includes the collection of copayments, coinsurance, and deductable amounts. By contract, we cannot waive these charges, and we collect them at the time of service for office visits and in advance for surgeries.

We aim to gather reliable information from the insurance/networks and determine your insurance benefits. Based on that information we collect the patient portion of the fee. If the information should prove to be incorrect when the claim is filed, the patient may owe additional money, or the patient may receive a refund depending on the insurance reimbursement. The patient receives an Explanation of Benefits (EOB) at the same time as we receive payment. The EOB states the contracted amount, the amount of Patient Responsibility, and the discounts for which the practice cannot bill a patient. If the EOB is incorrect, we will file an appeal. Otherwise, the amount due from the patient stands as per the contract. If, in spite of our best efforts, we have collected an incorrect amount from the patient, we will either refund an overpayment to the patient promptly or collect from the patient any funds of underpayment.

PROMPT PAY

We welcome patients who are not covered by insurance plans/payors with whom we are contracted. Some patients are covered by Medicare; we are NOT Medicare providers and cannot file claims with Medicare or receive payment from them. Some patients are covered by insurance plans/payors with whom we are NOT contracted. These patients are Out-of-Network. Some patients are not insured at all. We believe our fee schedule reflects a usual and customary fee for the medical services provided. Payment for surgery is due on or before the day of surgery.

WRITTEN ESTIMATE

A patient may request a written estimate of out-of-pocket expenses. We will gladly comply with such a request.

CARE CREDIT

Payment plans are available to qualifying patients. We offer Care Credit, which is a healthcare credit card specifically designed to pay for treatments and procedures. Care Credit has two unique features. Every transaction is eligible for a No Interest or Low Interest payment plan, and the patient may use the card at all healthcare practices that offer this option. Inquiries are welcome.

APPOINTMENT POLICY

We accommodate our patients with convenient appointments whenever possible. If unable to make an appointment, a patient should give at least 24 hour notice. If there is no notice given, a reasonable charge will be made.

Signature of Patient or Legally Responsible Party

Date

Printed Name of Patient