ALBERT VEIN INSTITUTE
Colorado's Vein Specialist

Patient Registration

Please fill out completely

Today's Date _____

Patient Information

Last Name_____ First Name _____ MI_____

Gender _____ DOB ____/____/____ Age _____ SS# _____

Married Single Divorced Widowed (Circle One) Driver's License #_____

Address _____
City State Zip

Home Phone _____ Mobile_____ E-mail _____

Employer_____ Employer Phone_____

Primary Physician _____ Address _____ Phone_____

Referring Physician_____ Address _____ Phone_____

How did you hear about The Albert Vein Institute?
Referred to by my Doctor ☐ From a family member/friend ☐ Web ☐ Other _____

Is this a work related injury or illness? Y / N Is this an injury or illness related to an auto accident? Y / N

Insurance

FINANCIAL GUARANTOR (POLICY HOLDER OR PERSON OTHER THAN PATIENT GUARANTEEING PAYMENT)

Last Name_____ First Name _____ MI_____

Gender _____ DOB ____/____/____ Age _____ SS# _____

Relationship to Patient _____ Driver's License #_____

Address _____
City State Zip

Home Phone _____ Mobile_____ E-mail _____

Employer_____ Employer Phone_____

PRIMARY INSURANCE

Insurance _____ Member/Policy #_____ Group # _____

Policy Holder's Name _____ Employer _____ Phone_____

SECONDARY INSURANCE

Insurance _____ Member/Policy #_____ Group # _____

Policy Holder's Name _____ Employer _____ Phone_____

EMERGENCY CONTACT (CLOSE FRIEND OR RELATIVE THAT WE CAN CONTACT IN AN EMERGENCY)

Name_____ Phone_____ Relationship _____

Self pay and previous balance amounts are due and payable at the time of service. Insurance co-payments are mandated by your insurance company and MUST be paid at each visit. Patients with insurance claims pending will be sent statements for full amount due until the account is satisfied. I agree that if the insurance company denies benefits for any reason, I am responsible for the full amount owed for services provided.

I request that payment of authorized insurance and Medicare benefits be made payable to Albert Vein Institute on my behalf for services furnished to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. In the event that my account is turned over to a collection agency, I agree to pay all reasonable costs of collection and understand that I may no longer be a patient at this office. I understand and agree to pay a returned check charge of $25.00 for each check that is returned for any reason. In case of default, I agree to pay any and all costs of collecting this account including, but not limited to, attorney fees and court costs.

I authorize the holder of medical information about me to release any and all information to Centers for Medicare or Tricare Services, its agents, my insurance carrier(s), or other entities as needed to determine these benefits or the benefits for my dependents or myself. If I have health insurance coverage under an HMO, I authorize Albert Vein Institute to release information concerning any diagnosis and treatment to my primary care or referring physician after each visit.

I have been made aware of the privacy policies of Albert Vein Institute and have received (or reviewed or been given the option to receive and review) a copy of the Notice of Privacy Practices.

SIGNATURE OF PATIENTS, INSURED OR GUARANTOR_____

PATIENT RESPONSIBLITIES

The Patient has the Responsibility:

- To attend all scheduled appointments as a courtesy to other patients who are on a waiting list and to our staff.
- To notify our staff in advance (see cancellation policy) if you would need to reschedule.
- To provide, to the best of the patient's knowledge, accurate and complete information about present complaints, past illness, hospitalizations, existence of advance directive, medications and information relating to health status.
- To follow the treatment plan recommended by the practitioner primarily responsible for the patient's care and other personnel authorized by AVI to so instruct the patient.
- To accept the consequences of his/her own actions when refusing treatment, not following the practitioners' instructions.
- To assure that the financial obligations for the health care provided are fulfilled as promptly as possible.
- To follow rules and regulations affecting care and conduct pertaining to the procedures performed.
- To be considerate of the rights of other patients and facility personnel.

My signature below indicates that I have read this document **completely** and understand my responsibilities.

Patient Signature:_____ **Date:** _____

Thank you from all of us at the Albert Vein Institute!!

PH 719 550 VEIN (8346) FX 719 550 0304
PH 303 797 VEIN (8346) FX 303 797 8350
10807 New Allegiance Drive, Suite 450, Colorado Springs, CO 80921
9400 Station St., Suite 200, Lone Tree, CO 80124

www.albertvein.com

ALBERT VEIN INSTITUTE

HIPAA PATIENT CONSENT FORM

I understand that I have certain Rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent, I authorize **Albert Vein Institute** to use and disclose my protected health information (PHI) to carry out the following:

- Treatment (including direct and indirect treatment by others healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of Albert Vein Institute

I have also been informed of, and given the right to review and secure a copy of the **Albert Vein Institute** Privacy Statement, which contain a more complete description of the uses and disclosures of my PHI and my rights under HIPPA. I understand that **Albert Vein Institute** reserves the right to change the terms of this notice at any time and that I may contact Albert Vein Institute at any time to obtain the most current copy of this notice.

I understand that I may revoke this consent at any time. However, any use or disclosure that occurred prior to the revocation date us not affected.

_____ _____

Patient's Signature Date

APPOINTMENT CANCELLATION POLICY

I have read and agree to the cancellation Policy of the Albert Vein Institute that states I may be assessed a fee if I do not give proper notice of cancellation of an appointment or procedure.

_____ _____

Patient's Signature Date

CONTACT CONSENT

I wish to be contacted in the following manner, including *automated appointment reminders* (check all that apply), be sure to fill in phone numbers.

- □ Home Telephone#: _____
  - □ Can leave a message with detailed information.
  - □ Leave a message with a call back number only
- □ Work Telephone #: _____
  - □ Can leave a message with detailed information.
  - □ Leave a message with a call back number only
- □ Written Communication
  - □ Okay to mail to my home address.
  - □ Okay to EMAIL: _____
  - □ Okay to fax to this number(s): _____

Other Requests:

_____

_____

_____

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Patient Confidential Health History

Patient Information
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MEDICAL HISTORY

Name _____ Today's Date_____

DOB ____/____/____ Age_____

Primary Physician _____ Referring Physician _____

Occupation: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Children (ages): _____

☐ Smoke_____ packs per day for _____ years ☐ Alcohol _____ use for_____ years

What is the reason for this visit? (Check all that apply)

☐ Varicose Veins ☐ Spider Veins ☐ Aching and Pain ☐ Itching and Burning ☐ Tiredness and Fatigue

☐ Restless Legs ☐ Swelling ☐ Leg Cramps ☐ Heaviness ☐ Skin Changes/Skin Ulcers

Other: _____

How long have you had these symptoms?: _____

VENOUS HISTORY

Do you have a FAMILY history of spider veins or varicose veins? ☐ Yes ☐ No

If so, please check and describe:

☐ Mother_____ ☐ Father_____ ☐ Grandparents _____

Do you have a FAMILY history of deep venous thrombosis, stroke or clotting disorders? Describe which:

☐ Mother_____ ☐ Father_____ ☐ Grandparents _____

SYMPTOMS

Please check if you have:

☐ Red spider veins ☐ Bulging veins ☐ Purple veins ☐ Flat bluish-green veins ☐ Abdominal veins

☐ Skin discoloration below your knee ☐ Leg ulcer ☐ Purple vein network ☐ Diagnosis of vein disease

Other: _____

Please describe. Do your legs or ankles:

Ache/hurt? _____ Swell? _____

Cramp? _____ Itch? _____

Become tired/Heavy? _____ Other? _____

Have you ever been treated for your veins before? ☐ Yes ☐ No

By whom? _____ When? _____

What method? _____

☐ Cosmetic Injections ☐ Laser for Spider Veins ☐ Ambulatory Phlebectomy ☐ Ultrasound-Guided Injections

☐ Radiofrequency closure ☐ Laser Catheter Ablation ☐ Stripping ☐ Ligation

Other: _____

What have your results been?_____

Are you being treated for any current medical conditions? ☐ Yes ☐ No If so, what are these conditions?

_____

Reviewed By_____

Date_____

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Patient Confidential Health History

Patient Information

Do YOU have a history of:

- ☐ Kidney/Bladder Disease
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Diabetes: Insulin Dependent
- ☐ Thyroid Disease
- ☐ Stroke
- ☐ TIA
- ☐ Peripheral Vascular Disease
- ☐ Coronary Heart Disease
- ☐ Heart Valve Problems
- ☐ Anemia
- ☐ Bleeding or Blood Disorder
- ☐ DVT/Blood Clot
- ☐ Pulmonary Embolism
- ☐ Easy Bruising
- ☐ High Blood Pressure
- ☐ Carotid Disease
- ☐ Atherosclerosis
- ☐ Trauma to your legs
- ☐ Hemorrhoids
- ☐ Rupture of a vein
- ☐ Blood Transfusion (Date) _____
- ☐ Cancer of _____
- ☐ Other _____

Past Surgical History. Please list any procedures you have had and the year.

_____ _____

_____ _____

_____ _____

_____ _____

Bleeding History. Please check all that apply.

- ☐ Excessive bleeding
- ☐ Easy Bruising
- ☐ Coumadin Use
- ☐ Aspirin Use
- ☐ Other _____

Please list all medicines that you take (Prescription, Non-Prescription, Vitamins and Herbal):

Medication	Dose	# Per Day/Frequency	Reason for Taking

Are you allergic to any medications?

Medication	Reaction

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Patient Confidential Health History
Patient Information

Review of Systems. Please check all that apply

Constitution:
- ☐ Weight loss
- ☐ Weight gain
- ☐ Night sweats
- ☐ Fever

Skin:
- ☐ Change in size / color of moles
- ☐ Rash
- ☐ Bruising

Eyes:
- ☐ Decreased vision
- ☐ Double vision
- ☐ Blurred vision
- ☐ Glasses

Ear, Nose, Mouth, and Throat:
- ☐ Pain
- ☐ Deafness
- ☐ Discharge
- ☐ Ringing in ears
- ☐ Sinus drainage
- ☐ Nose bleed
- ☐ Hoarseness

Cardiac:
- ☐ Palpitations
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Fatigue
- ☐ Swelling in feet/legs

Respiratory:
- ☐ Cough
- ☐ Production of sputum
- ☐ Coughing of blood
- ☐ Pain

Gastro:
- ☐ Painful swallowing
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomit blood
- ☐ Indigestion
- ☐ Diarrhea
- ☐ Constipation
- ☐ Tarry stools
- ☐ Yellow jaundice
- ☐ Bloody stools
- ☐ Change in BMs

Genito:
- ☐ Kidney/Bladder disease
- ☐ Decreased urine stream
- ☐ Unable to urinate
- ☐ Painful urination
- ☐ Blood in urine

Musc/Skel:
- ☐ Weakness trauma
- ☐ Limited motion
- ☐ Bone/joint deformity

Neuro:
- ☐ Paralysis
- ☐ Weakness
- ☐ Seizure
- ☐ Fainting
- ☐ Headache
- ☐ Migraine
- ☐ Migraine with aura
- ☐ Numbness/ tingling in extremities
- ☐ Incoordination
- ☐ Head trauma

Psych:
- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations

Endocrine:
- ☐ Change of appetite
- ☐ Excessive thirst/urination
- ☐ Goiter

Hemato:
- ☐ Swollen lymph nodes
- ☐ Bleeding disorders

Immuno:
- ☐ Immune disorders
- ☐ Immunosuppressant

FEMALES ONLY

Breast:
- ☐ Lump
- ☐ Pain
- ☐ Nipple discharge
- ☐ Infection
- ☐ Trauma

Date of Last Mammogram_____

Date of Last pelvic exam_____

Gyn:
- ☐ Irregular periods
- ☐ Birth control
- ☐ Hormone therapy
- ☐ Menopause

Date of Last period _____

History of miscarriages; if so, how many_____

Signature _____ Date_____