The Vein Doctor, LLC
4820 S Arrowhead Drive
Independence, MO 64055
(P) 816-350-8181
(F) 816-350-8184

Liberty Office
2529 Glenn Hendren Dr. Ste G60
Liberty, MO 64055
(P) 816-792-1188
(F) 816-792-1190

Name_____ Today's date_____
Last First Middle

Address_____

City_____ State_____ Zip_____

Home Phone ( )_____ Cell Phone ( )_____

Place of Employment_____ Position Title_____

Work Phone ( )_____ Ext_____ Email:_____

Which phone number do you prefer we call? ___**Home** ___**Cell** ___**Work** Can we leave a message? **Yes** **No**

Date of Birth_____ Age_____ Sex M or F

Social Security Number_____ Marital Status: **M** **S** **D** **W** (please circle one)

Spouse's Name_____ Emergency Contact Name_____

Emergency Contact Phone ( )_____ Is this a ___**Work** ___**Cell** ___**Home** number?

Emergency Contact Relationship to the patient_____

*Please present **all** insurance cards so we may make copies.*

How did you learn about our office?

☐ From your health care physician _____

☐ Friend ☐ Newspaper ☐ Internet search ☐ Phonebook ☐ Other_____

Medical Information

Family Doctor_____ Phone ( )_____

May we send your information to your Family Doctor/Primary Care Physician? **Yes** **No**

Pharmacy_____ Phone ( )_____

Medications-list all medications including prescriptions and over the counter:

_____ _____ _____ _____ _____

****Are you on any Anti-Clot/Blood Thinning Medication?** Yes No **If Yes, what medication?**_____

Allergies-list all medication allergies and the type of adverse reaction, including latex:

_____ _____ _____ _____ _____

The Vein DOCTOR, LLC

Name_____ Today's date_____

Tobacco Use/Smoking:

Do you currently smoke/use tobacco: **Yes No**

Have you used tobacco in the past: **Yes No**

If yes, when did you discontinue use:_____

Women Only:

Are you pregnant now? **Yes No** Breast feeding now? **Yes No**

Considering pregnancy in the future? **Yes No**

Number of pregnancies:_____ Deliveries:_____

Are your leg symptoms worse during your menstrual cycle? **Yes No**

Leg symptoms - Please check if yes:

	Right Leg	Left Leg
Aching/pain in legs	☐	☐
Heaviness	☐	☐
Fatigue/tiredness	☐	☐
Itching/burning	☐	☐
Leg cramping	☐	☐
Leg restlessness	☐	☐
Throbbing	☐	☐
Any skin non healing sore	☐	☐

	Right leg	Left Leg
Swelling	☐	☐
Bothered by Appearance	☐	☐
Do your symptoms interfere with your sleep?	☐	☐
Do your symptoms interfere with activity?	☐	☐
Do your symptoms worsen with activity?	☐	☐
Do your legs feel better with activity?	☐	☐
Do your symptoms wake you at night?	☐	☐
Abnormal blood clot treated with meds?	☐	☐

On a scale of 0-10, with 10 being severe symptoms, I rate my vein problem at:

No symptoms 1 2 3 4 5 6 7 8 9 10 Severe

How long have you had these symptoms? _____

Do daily activities require prolonged standing? **Yes No**

If yes what activities _____

Is sitting or taking breaks required due to symptoms? **Yes No**

If yes how many times a day? _____

Conservative Treatments for vein problems - Please check if using now or in past:

Pain medication (NSAID)

☐ Ibuprofen ☐ Aspirin ☐ Advil ☐ Aleve

☐ Other _____

If yes how often _____

Herbal supplements ☐

Leg elevation ☐

Have you worn Compression stockings: **Yes No**

☐ Daily for the last 3 months

☐ Daily for the last 6 months

Exercise ☐

Job or activity restriction ☐

Weight loss ☐

Prior Vein Treatment:

Any prior treatment to veins ☐

What Type_____

Any prior vein surgery or laser ☐

What Type_____

Bleeding from a vein requiring treatment ☐

Family History:

Family History of Abnormal Blood Clots ☐

Family History of Cancer ☐

Family History of Heart Disease ☐

Family History of High Blood Pressure ☐

Family history of Substance Abuse ☐

Family history of Varicose Vein Problems ☐

PATIENT Medical History - Please check if YOU have any of the following:

Heart disease or surgery ☐

Pacemaker or defibrillator ☐

Stroke ☐

Cancer ☐

Hepatitis ☐

Stomach ulcer ☐

High Blood pressure ☐

Diabetes ☐

Thyroid disease ☐

Chronic skin condition ☐

DVT (deep vein thrombosis) ☐

Leg or ankle fracture or trauma ☐

Prescribed anti-clotting medication ☐

Reason:_____

Major surgery or other illness (list surgeries) ☐

_____

THE Vein Doctor

CANCELLATION POLICY

Due to the level of service we provide our patients, your appointment time is reserved especially for you. Please call our office to cancel your appointment at least **24 hours prior** to your scheduled appointment if you will be unable to keep that appointment. This allows us ample time to offer that spot to another patient.

If you, the patient, fail to show up/forget to cancel the appointment, there will be a $50.00 fee charged to your account for regular office visits and a $150 fee for a missed surgery appointment.

Thank you for your cooperation in adhering to this cancellation policy.

Please sign and date below which indicates you have read and understand our cancellation policy.

X_____ X_____
(Patient Signature) (Date)

X_____ X_____
(Witness Signature) (Date)

Effective September 1, 2011

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4820 S. Arrowhead Drive ~ Independence, MO 64055 ~ Phones: 816-350-8181 ~ Fax: 816-350-8184
Timothy Raveill, M.D. Joseph Caresio, M.D.

2529 Glenn Hendren Dr
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4820 S. Arrowhead Drive
Independence, MO 64055
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Fax (816) 350-8181

HIPAA PRIVACY POLICY NOTICE

This notice describes our Privacy Policy. It is to inform you of your rights and describes how your health information may be used and disclosed to others. Your health and your privacy are our concerns. Please review it carefully.

Our Company wishes to inform you of your rights regarding your private healthcare information. You have the right to review our Privacy Policy prior to signing this consent form. By signing this notice you acknowledge that you have had the opportunity to review our Privacy Policy. If you want to copy of this policy, or in the event that our policy changes and you would like a revised copy, please contact us at the address above.

You have the right to request that we restrict the method in which we use or disclose your health information for the purpose of treatment, payment, or health care operations. We have the right to refuse to comply with your request.

By signing this form, you acknowledge our use and disclosure of your health information for purpose of your treatment, payment, or other health care operations. This notice will not expire and will apply to services provided to you form this day forward.

We will keep and record information about your medical condition. We may use this information or disclose this information to others as follows:

> We may use or disclose your health information in order to receive payment for services that we provide to you. For example, we may disclose your condition in order for your insurance company to understand why you have received treatment so that they will pay your claim. We may also disclose your information to our billing department/billing company/attorney in order to seek payment for the services that we provide to you.
>
> We may disclose your health information for our own evaluations and operation. For example, we may review your information so that we can evaluate your treatment and our services in order to insure that our care for you is the best it can be.
>
> We may use your health information to contact you in the future. We may disclose your information to contact you in the future.
>
> We may also disclose your information as required by law.

Name:_____ Date:_____

Witness:_____ Date:_____

THE VEIN DOCTOR FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of bills we send to you. The following is a summary of our payment policy.

The Vein Doctor accepts PERSONAL CHECKS (in-state only), VISA, MASTERCARD, DISCOVER and MONEY ORDERS. There is a service charge of $25 for each returned check.

Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling further appointments.

INSURANCE:
If you have a diagnosis that is considered medically necessary, we will call your insurance company to verify your benefits for the treatment/procedures we perform. We can only rely on what we are told by your insurance. Insurance companies will never state they will cover treatment for sure. Their standard disclaimer is that determination will be made upon receipt of the actual claim. We strongly encourage each patient to call the insurance company themselves to verify their coverage. It is up to each patient to know the exact requirements of his/her own insurance plan.

We bill participating insurance companies as a courtesy to you. You are expected to pay your copayments, deductible and coinsurance. If we have not received payment from your insurance company within 60 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier.

We do not verify secondary insurance benefits for you but again, we urge you to check your benefits and we will file the claim on your behalf.

You may request a copy of treatment done for each date of service (in the form of a superbill).

If you need assistance or have questions, please contact our **Billing Office between 8:00 a.m. and 4:00 p.m., Monday through Friday at 913-234-1671.**

MANAGED CARE:
If you are enrolled in a managed care insurance plan (i.e., HMO), you may need to receive a referral from your primary care physician office before seeing us. It is your responsibility to obtain that referral. Retroactive referrals are not guaranteed.

MISSED APPOINTMENTS/LATE CANCELLATIONS:
Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. **Cancellations are requested 24 hours prior to the appointment.** We reserve the right to charge for missed or late-canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read and understand THE VEIN DOCTORS Financial Policy. I agree to assign insurance benefits to THE VEIN DOCTORS Practice whenever necessary. Also, I authorize the release of any medical information necessary to process the claims, billings or to obtain payment. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Patient Signature: _____Date: _____

Witness: _____ Date:_____