Tristate Center VEIN
3006 Glenmore Ave. Suite B
Cincinnati, OH 45238
513-662-VEIN (8346)
Fax: 513-662-0033

Patient Venous History

Patient Name: _____Date:_____

What is the main reason for your visit today? _____

How long have you had this problem? _____ Years _____ Months Which Leg? ○Right ○Left ○Both

Please check which symptoms you have:

○Leg Pain	○Tired/Heavy Legs	○Discoloration	○Ankle Swelling
○Itching	○Aching/Throbbing	○Burning	○Stinging / Tingling
○Leg Cramps	○Open Sore/Ulcer	○Red Warm Areas	○Restless Legs
○None	○Other: _____		

On a scale from 0(none) to 10 (severe), how would you rate your symptoms? _____

Have your symptoms/veins gotten worse in recent months? ○No ○Yes

Are your symptoms worse with? ○Prolonged sitting/standing ○Hot Baths ○Menstrual Cycle ○Walking

Are your symptoms improved by? ○Rest and Elevation ○Walking

How do your symptoms alter your daily activities at work/housework?

○Have to stop activity to rest or elevate leg ○Unable to complete tasks

○Other_____

Do your symptoms restrict your leisure activities?

○Sports ○Hobbies ○Social Life ○Family ○Other_____

Do you stand much at work/home? ○No ○Yes

Do you need to stop and rest your legs during the day? ○No ○Yes

Do you need to rest/elevate your legs at the end of your day? ○No ○Yes

Do you exercise regularly? ○No ○Yes

○Walk ○Run/Jog ○Gym ○Other_____

Have you ever worn prescription compression stockings? ○No ○Yes If yes; For how long? _____

○ < 3months ○ > 3months ○ > 6months

Date first worn? _____

Pressure: ○20-30 mmHg ○ 30-40 mmHg

Type: ○Knee-hi ○Thigh-hi ○ Pantyhose

Any improvement of symptoms with stockings? ○No ○Yes

Have you taken any medications for your symptoms? ○No ○Yes ○ OTC ○ Prescription For how long?_____

Any improvement of symptoms with medications? ○No ○ Yes

Have you ever had treatment for veins? ○No ○Yes ○ Right ○ Left ○ Both

○ Stripping ○ Ultrasound Guided Sclerotherapy ○ Sclerotherapy ○ Phlebectomy ○ Thermal Ablation

_____

Patient Signature _____ Date _____

Recommendation: _____

Patient Medical History

Patient Name: _____Date: _____

Please check if you have ever been diagnosed with or treated for the following: ○ None

○ **High Blood Pressure** ○ **Diabetes** ○ Heart Disease ○ Asthma ○ Arthritis

○ Superficial Phlebitis ○ **Pulmonary Embolus** ○ HIV/AIDS ○ Hepatitis ○ Migraines

○ Lung Disease/COPD ○ **Blood Clots (DVT)** ○ Other: _____

Have you ever had surgery? ○ Yes ○ No

If yes, what type of surgery and when? _____

_____

Are you currently taking any medications? ○ Yes ○ No

If yes, please list_____

_____

Are your allergic to any medications / Latex? ○ Yes ○ No

(If yes, please list) _____

Do you take any blood-thinning medication? ○ Yes ○ No

(If yes, please list)_____

Have you ever had a prior leg injury or fracture? ○ Yes ○ No

(If yes, please explain)_____

Is there a family history of:

Blood Clots ○ Yes ○ No

(If yes, please explain)_____

Varicose or Spider Veins: ○ Yes ○ No

(if yes, please explain)_____

Do you smoke? ○ Yes ○ No

If yes, how many packs per day?_____

R.O.S. (Check if Positive): ○ Chest Pain ○ Shortness of Breath ○ Asthma ○ Migraines ○ Abdominal Pain

Females Only:

Are you pregnant or trying to become pregnant? ○ Yes ○ No

Are you currently taking hormones or birth control? ○ Yes ○ No

Are you currently breast-feeding? ○ Yes ○ No

Were your veins made worse with pregnancy? ○ Yes ○ No

Total number of pregnancies you had:_____ How many children?_____ # of miscarriages_____

Patient Signature_____ Date _____

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DATE:_____/_____/_____

Patient's First Name	Patient's Last Name	Date of Birth	Social Security #
Street Address		Email Address	
City	State	Zip Code	Home Telephone Number
Employee Name	Marital Status	Cell Phone Number	Work Phone Number

PRIMARY INSURANCE INFORMATION

Insurance Company Name	CoPay Amount	Group Name or #	ID #
Insurance Company Claims Address			
City	State	Zip Code	Telephone
Policy Holder's Name (if other than Patient)		Social Security #	Date of Birth
Address			
City	State	Zip Code	Telephone
Policy Holder's Employee		Employer's Group Plan: Yes ___ No___	

SECONDARY INSURANCE INFORMATION

Insurance Company Name	CoPay Amount	Group Name or #	ID #
Insurance Company Claims Address			
City	State	Zip Code	Telephone
Policy Holder's Name (if other than Patient)		Social Security #	Date of Birth
Address			
City	State	Zip Code	Telephone
Policy Holder's Employer		Employer's Group Plan: Yes ___ No___	

ADDITIONAL INFORMATION

Emergency Contact Name/Relationship	Home Phone	Work Phone Number	Cell Number
Referring Physician		Family or Primary Care Physician	
Pharmacy Name and Phone	How did you hear about us?		

ASSIGNMENT OF BENEFITS & INFORMATION RELEASE:

I hereby assign all medical and/or surgical benefits, to which I am entitled to Tristate Vein Center. This assignment remains in effect until revoked by me in writing. A facsmilie or photocopy of this assignment is to be considered valid as an original. I hereby authorize said assignee to release all information necessary to secure payment. I consent to the release of information by Tristate Vein Center and my health insurance and/or payor to Tristate Vein Center, and its employees/representatives to facilitate peer review and of my treatment including utilization and quality managaement. I understand that Tristate Vein Center will maintain the confidentiality of this information at all times.

I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that my medical insurance is a contract between myself and the insurance company and/or my employer. Tristate Vein Center is not a party to said contract. I understand that I am responsible for legal and/or collection fees necessary to settle my account, should it become delinquent.

I also attest that I have been provided with Tristate Vein Center's HIPPA Guideline policies.

SIGNED: _____ **DATE:**_____

Photo-Video Consent

AUTHORIZATION FOR RELEASE OF PATIENT PHOTOGRAPHS and VIDEO

NAME _____

This consent permits photography of me or parts of my body related to the procedure(s) that have been or will be performed. These Photographs will be used solely for the purpose of my medical care and treatment effectiveness; unless one of the additional consents is initialed below.

_____I agree to having my photographs posted as before and after pictures on their Website and/or Social Media, and/or to distribute them in print and/or electronic media to inform prospective patients. I will not be identified by name in any publication.

_____I agree to a brief video of my procedure which may be posted to their Website and/or Social Media without my name or other identifying information, unless I myself state my name.

The authorization hereby granted is voluntary, and continues until I submit a written request to Dr.'s Anjari & Foruhari withdrawing this authorization. Upon withdrawal, my photographs and/or video, in part or in total as requested by me, will be removed from any and all electronic media within 60 days. Photographs released in printed form by publisher before the date of my withdrawal will not be affected by my withdrawal.

Photographs and Videos of me may be considered private health information. It is my right to refuse to authorize the release of my private health information. Refusal to grant consent for release of my private health information will prevent the disclosure of such information, however will never affect the quality of care I receive.

I release and discharge Dr.'s Anjari & Foruhari, and all parties acting under their license and authority from all rights that I may have in the photographs and/or Video and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I certify that I have read the above Authorization and Release and fully understand its terms.

_____

Signature Date

HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care, and any related services. This includes the coordination or management of your health care with a third party, For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom youhave been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when yours physician is ready to see you.

We may use or disclose your protected health information, as necessary, to contact
you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers’ Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

2. Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation or, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

HIPAA Notice of Privacy Practices

HIPAA 3-07

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a aper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, of any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

3. **Complaints**
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a compliant.**

This notice was published and becomes effective on/or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.