



Tristate Vein Center

3006 Glenmore Ave
 Cincinnati, OH 45238
 Tele: (513) 662-VEIN (8346)
 Fax: (513) 662-0033

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 facsimile 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 management. 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: _____



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 you 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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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?

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: _____



Tristate Veins Center Consent to Photograph

I consent to photographs being taken to evaluate treatment effectiveness, for medical education, training, professional publications or sales purposes. No photographs revealing my identity will be used without my written consent. If my identity is not revealed, these photographs may be used and displayed publicly without my permission.

Patient's Signature: _____ Date _____

Print Name: _____

Witness Signature: _____ Date _____

Print Name: _____

Recommendations For Better Legs

Regular Exercise

Walking, running, stairmaster, aerobics, swimming, elliptical machine, or biking for 30 minutes, 5-7 days per week will help reduce aching, pain and tiredness in your legs

Elevate Your Legs

Elevating your legs above heart level for at least 10 minutes once or twice daily may diminish aching and swelling

Move Your Legs Frequently

Flexing your ankles 10 times will pump the blood out of your legs like walking does. Repeat this every 10 minutes while standing or sitting and try to walk for at least 2 minutes every half hour.

Avoid Wearing High Heels

Wearing high heels interferes with the normal pumping action that occurs when you walk and may lead to aching and cramping to the legs

Maintain A Proper Weight

Even moderate weight loss may reduce aching in the legs due to varicose veins and diminish the rate at which spider veins develop

Wear Support Hose

Available at pharmacies and medical supply stores. There are many brands to choose from. Lighter support stockings are available at department stores.

However, it is best to wear a stocking that is labeled "graduated" as this will really help to improve your vein function.



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 you have 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 your 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 paper 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 complaint.**

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.