Center for
ADVANCED
VEIN CARE
LLC
YourHealthyVeins.com

Welcome to the Center for Advanced Vein Care!

We have enclosed our registration forms and new patient paperwork. Please complete the forms and bring them with you to your appointment. This will save you a lot of time on the day of your consultation. Please remember to bring your insurance card and a driver's license (or other form of ID if you do not have a driver's license) and a list of current medications with you to your appointment.

If you are being evaluated for concerns related to your legs, we will provide a pair of paper shorts and booties for your convenience. However, if you would prefer, feel free to bring (or wear) your own shorts and flip-flop like shoes for the consultation.

If you have any questions or concerns prior to your consultation, feel free to call us at (440)710-1140.

We look forward to seeing you soon!

Have a great day!

Patient Registration

Name: _____ D.O.B: _____ S.S.N: _____ Sex: _____
(Last) (First)

Address: _____ City: _____ Zip: _____

Phone: (Home) _____ (Cell) _____ (WorK) _____

E-mail: _____ Marital Status: _____

Occupation: _____ Employer: _____

Primary Language: _____ Race: _____ Ethnicity: _____

Best # to reach you?: Home:__ Cell:__ Work: __ Can we leave a message: Y / N

Do you give anyone authorization to receive messages on your behalf? Y / N
If yes, Name: _____

Primary MD: _____ Address: _____

Phone: _____ Can we discuss your care with them? Y / N

OB/Gyn: _____ Address: _____

Phone: _____ Can we discuss your care with them? Y / N

How did you hear about us?
Radio: _____ Internet: _____Newspaper/magazine: _____ Friend: _____
Doctor referred: _____ Other: _____

Insured's Name: _____ D.O.B: ____/____/_____
(last) (first) mo day year

SSN: _____ Relationship to you: _____

Address: _____ City: _____ Zip: _____

Phone: (Home) _____ (Cell) _____ (Work) _____

Employer: _____ Phone number: _____

Primary Insurance: _____ Phone: _____

Address: _____ City: _____ Zip: _____

ID#: _____ Group #: _____ Claim#: _____

Secondary Insurance: _____ Phone: _____

Address: _____ City: _____ Zip: _____

ID#: _____ Group #: _____ Claim#: _____

I authorize Center for Advanced Vein Care, LLC, to provide treatment, render testing and submit a claim to my insurance company. I authorize the payment directly to Center for Advanced Vein Care, LLC. I understand that I am responsible for all charges, whether or not paid by insurance and all services rendered on behalf of myself or my dependents. I authorize Center for Advanced Vein Care, LLC, to release information required for my care and to secure the payment of benefits. I authorize the use of my signature on all insurance submissions.

Signature: _____ Date: _____

Center for Advanced Vein Care, LLC

Name: _____ D.O.B: _____ Date: _____

Review of Systems – Below I a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems may affect your overall course of care, as well as be signs of less than optimal function or health.

Please circle **N/A** for **NONE OF THE ABOVE** OR **T for TODAY** OR **P for past**

Constitutional
T P chills
T P daytime drowsiness
T P fatigue
T P fever
T P night sweats
T P weight gain
T P weight loss
N/A none of the above

EYES
T P wear glasses or contact lenses
T P blindness
T P cataracts
T P glaucoma
N/A none of the above

EARS/NOSE/THROAT
T P difficulty/loss of hearing
T P ringing in the ears (tinnitus)
T P frequent earaches
T P discharge from the ears
T P attacks of vertigo
T P sinus trouble
T P nasal blockage
T P frequent sneezing
T P frequent sore throat
T P snoring
T P recent change in voice quality
T P sleep apnea
T P difficulty swallowing
T P nose bleeds
N/A none of the above

RESPIRATORY
T P asthma or wheezing
T P recent bronchitis or chest cold
T P cough
T P coughing up blood
T P shortness of breath
N/A none of the above

HEART & CIRCULATION
T P heart attack
T P high blood pressure
T P heart murmur
T P chest discomfort
T P heart failure or fluid on the lungs
T P palpitations, racing or pounding
T P shortness of breath with activity
T P stroke/mini stroke or TIA
T P blood clot in artery or vein
T P "blackout spells"
T P aneurysm of any blood vessel
T P swelling of the legs
T P heart surgery
N/A none of the above

STOMACH/INTESTINE
T P ulcer
T P frequent heartburn or indigestion
T P hiatal hernia or acid reflux
T P poor appetite
T P gall bladder attacks
T P frequent diarrhea
T P chronic constipation
T P bright blood (bowel or rectum)
T P abnormal stool
T P liver disease or jaundice
N/A none of the above

ENDOCRINE/METABOLISM
T P thyroid disorder
T P unusual hair loss or growth
T P goiter
T P diabetes
N/A none of the above

KIDNEYS/URINARY TRACT
T P kidney disease or failure
T P history of kidney dialysis
T P kidney stones or infection
T P pain or burning during urination
T P trouble starting urinary stream

MUSCLES/BONES/JOINTS
T P arthritis or other joint disease
T P chronic back trouble
T P one or joint surgery in the last year
N/A none of the above

ALLERGY
T P anaphylaxis
T P food intolerance
T P itching
T P nasal congestion
T P rash
T P sneezing
N/A none of the above

SKIN
T P rashes, psoriasis or dermatitis
T P new skin growth or mole
T P history of skin cancer
N/A none of the above

NERVOUS SYSTEM
T P headaches
T P epilepsy or seizures
T P date of last seizure
T P depression
T P other nervous disorder
specify: _____
N/A none of the above

PSYCHOLOGIC
T P anxiety
T P loss or change in appetite
T P behavior change
T P bi-polar disorder
T P confusion
T P convulsions
T P depression
T P insomnia
T P memory loss
T P mood changes
N/A none of the above

BLOOD
T P bleeding or bruising tendency
T P previous blood transfusions
T P history of hepatitis
N/A none of the above

WOMEN ONLY
T P painful periods
T P excessive flow
T P irregular cycles
T P vaginal burning
T P hot flash

Are you pregnant? Yes No
# of previous pregnancies: ____
# of miscarraiges: _____

MEN ONLY
T P prostate problems
T P frequent urination
T P testicular swelling

Past Medical History

Surgical History: _____
Medications you are taking: _____(attach list if needed)
Allergy History: _____

Estimated Height: _____ **Estimated weight:** _____

Please sign below after you have completed this form to the best of your ability and knowledge.

Signature: _____ Date: _____

Activities of Daily Living Questionnaire

Name: _____ DOB: _____ Date: _____

Current leg symptoms: (check all that apply)

Leg Symptoms: Leg Pain/aching Restless Legs Superficial Thrombophlebitis
Swelling Leg Cramps Previous DVT
Bulging/spider Veins Itching Tiredness/heaviness in legs
Leg ulcers Burning Other: _____

Previous Vein Treatment: Vein Surgery: _____ Date: _____
Sclerotherapy: _____ Date: _____
Other: _____ Date: _____

Have you ever worn Compression Stockings or hose? Y / N
Were they: ____ over the counter ___ prescription ___ given to you at the doctors or hospital
How long did you wear the stockings/hose? _____
How often did you wear the stockings/hose? _____

Do you have (or have you had) eczema or a rash anywhere on your legs? _____
Have you ever had a skin ulcer on your legs? _____
Have you noticed a change in color of the skin on your legs? _____
Have you ever had bleeding or a hemorrhage from veins on your legs? _____
Did you have to go to the hospital because of the bleeding? _____
Have you ever had a blood clot in your leg(s)? _____ Right leg or Left leg? _____
Have you ever had superficial thrombophlebitis? _____

Do you stop and sit, or take breaks during the day because your legs feel uncomfortable (or any symptom as above)?
Yes No
How many times during the day do you need to take a break from your activities (work/house work/yard work/etc) because of any of the symptoms listed above? _____

How many hours a day do you sit: at work: _____ at home: _____
How many hours a day do you stand: at work: _____ at home: _____

How many days in the last 2 weeks did you have to take pain medication (ibuprofen/aleve/motrin/Tylenol or other) because of your legs? _____

If you have use pain medication for your legs, what do you usually use? _____
Have you had to change work because of symptoms/discomfort in your legs? _____
Have you changed your leisure activities due to discomfort in your legs? _____

While completing the questions below, DO NOT try to determine if your symptoms are related to your veins. IF you have EVER experienced the symptoms during the activities listed, regardless of assumed cause, CHECK YES and mark the severity.

If you have never experienced the symptom during the activity, check NO.

Activity		Ranking (1=mild 3=moderate 5=severe)					Leg(s) (circle)	
Standing at work								
Pain	___ no ___ yes	1	2	3	4	5	Right	Left
Tiredness	___ no ___ yes	1	2	3	4	5	Right	Left
Fatigue	___ no ___ yes	1	2	3	4	5	Right	Left
Itching	___ no ___ yes	1	2	3	4	5	Right	Left
Swelling	___ no ___ yes	1	2	3	4	5	Right	Left
Sitting at work								
Pain	___ no ___ yes	1	2	3	4	5	Right	Left
Tiredness	___ no ___ yes	1	2	3	4	5	Right	Left
Fatigue	___ no ___ yes	1	2	3	4	5	Right	Left
Itching	___ no ___ yes	1	2	3	4	5	Right	Left
Swelling	___ no ___ yes	1	2	3	4	5	Right	Left
Walking at work								
Pain	___ no ___ yes	1	2	3	4	5	Right	Left
Tiredness	___ no ___ yes	1	2	3	4	5	Right	Left
Fatigue	___ no ___ yes	1	2	3	4	5	Right	Left
Itching	___ no ___ yes	1	2	3	4	5	Right	Left
Swelling	___ no ___ yes	1	2	3	4	5	Right	Left
While sitting in a car								
Pain	___ no ___ yes	1	2	3	4	5	Right	Left
Tiredness	___ no ___ yes	1	2	3	4	5	Right	Left
Fatigue	___ no ___ yes	1	2	3	4	5	Right	Left
Itching	___ no ___ yes	1	2	3	4	5	Right	Left
Swelling	___ no ___ yes	1	2	3	4	5	Right	Left
While on a plane								
Pain	___ no ___ yes	1	2	3	4	5	Right	Left
Tiredness	___ no ___ yes	1	2	3	4	5	Right	Left
Fatigue	___ no ___ yes	1	2	3	4	5	Right	Left
Itching	___ no ___ yes	1	2	3	4	5	Right	Left
Swelling	___ no ___ yes	1	2	3	4	5	Right	Left
While exercising								
Pain	___ no ___ yes	1	2	3	4	5	Right	Left
Tiredness	___ no ___ yes	1	2	3	4	5	Right	Left
Fatigue	___ no ___ yes	1	2	3	4	5	Right	Left
Itching	___ no ___ yes	1	2	3	4	5	Right	Left
Swelling	___ no ___ yes	1	2	3	4	5	Right	Left

After exercising

Pain	___ no ___ yes	1	2	3	4	5	Right Left
Tiredness	___ no ___ yes	1	2	3	4	5	Right Left
Fatigue	___ no ___ yes	1	2	3	4	5	Right Left
Itching	___ no ___ yes	1	2	3	4	5	Right Left
Swelling	___ no ___ yes	1	2	3	4	5	Right Left

During Meal Preparation

Pain	___ no ___ yes	1	2	3	4	5	Right Left
Tiredness	___ no ___ yes	1	2	3	4	5	Right Left
Fatigue	___ no ___ yes	1	2	3	4	5	Right Left
Itching	___ no ___ yes	1	2	3	4	5	Right Left
Swelling	___ no ___ yes	1	2	3	4	5	Right Left

During household chores (cleaning, laundry, etc)

Pain	___ no ___ yes	1	2	3	4	5	Right Left
Tiredness	___ no ___ yes	1	2	3	4	5	Right Left
Fatigue	___ no ___ yes	1	2	3	4	5	Right Left
Itching	___ no ___ yes	1	2	3	4	5	Right Left
Swelling	___ no ___ yes	1	2	3	4	5	Right Left

While doing yard work

Pain	___ no ___ yes	1	2	3	4	5	Right Left
Tiredness	___ no ___ yes	1	2	3	4	5	Right Left
Fatigue	___ no ___ yes	1	2	3	4	5	Right Left
Itching	___ no ___ yes	1	2	3	4	5	Right Left
Swelling	___ no ___ yes	1	2	3	4	5	Right Left

While doing leisure activities (sports, hobbies, social life, etc)

Pain	___ no ___ yes	1	2	3	4	5	Right Left
Tiredness	___ no ___ yes	1	2	3	4	5	Right Left
Fatigue	___ no ___ yes	1	2	3	4	5	Right Left
Itching	___ no ___ yes	1	2	3	4	5	Right Left
Swelling	___ no ___ yes	1	2	3	4	5	Right Left

While at school or doing school work

Pain	___ no ___ yes	1	2	3	4	5	Right Left
Tiredness	___ no ___ yes	1	2	3	4	5	Right Left
Fatigue	___ no ___ yes	1	2	3	4	5	Right Left
Itching	___ no ___ yes	1	2	3	4	5	Right Left
Swelling	___ no ___ yes	1	2	3	4	5	Right Left

While shopping

Pain	___ no ___ yes	1	2	3	4	5	Right Left
Tiredness	___ no ___ yes	1	2	3	4	5	Right Left
Fatigue	___ no ___ yes	1	2	3	4	5	Right Left
Itching	___ no ___ yes	1	2	3	4	5	Right Left
Swelling	___ no ___ yes	1	2	3	4	5	Right Left

Office Policies

Cancellation Policy

We make every effort to schedule your appointments according to your needs. Your appointment is time that we have set aside for you alone as we do not double book our appointments. We understand that sometimes things can come up or emergencies arise. Should you need to cancel or reschedule your appointment, we would greatly appreciate at least 48 hours notice. This will allow us adequate time to refill the appointment as well as reschedule your appointment for a time that will better fit your needs. A missed appointment that is cancelled without 48-hours notice will result in a $50.00 charge.

Late Arrival policy

We understand that at times your day is running behind schedule. If you are running behind, please contact the office at (440)710-1140 as soon as you are aware that you will be arriving late. If you are running more than 15 minutes late, it may not be possible to keep your appointment on the same day. We will make every effort to accommodate the change in your schedule and will work hard to keep your appointment on the scheduled day. However, since we schedule appointments according to all of our patients' needs, there will be times when we cannot adjust our schedule to maintain your appointment on the same day as it will impact all of our patients' schedules. In such cases, you will be asked to reschedule your appointment. We make every effort to keep our schedule on time so that we do not interfere with your scheduled plans for the day. Your help in this matter is greatly appreciated.

Insurance/Payment Policy

As a service to our patients, we will submit medical claims to your insurance company if applicable. In many cases your insurance company may cover all or a portion of the evaluation, diagnostics and procedures; however, we cannot guarantee this and you are responsible for payment of services rendered.

Please note: Payment for your expected out of pocket costs is to be paid prior to the start of any procedures we may perform. There may be additional funds due to our office or a refund to you once the claims process has been completed with your insurance company.

We will do our best to provide you with an accurate quote of the out of pocket expenses you can expect to incur.

A late charge of 1% will be added monthly to any patient-owed outstanding balance, not paid in full by the due date. We accept cash, check, Visa, and Mastercard as payment.

Please understand that although you insurance company may 'cover' the procedure, most patients will still have some out-of-pocket cost for each appointment as insurance does not cover 100% of costs most of the time. By accepting insurance coverage, you have entered into a contract with that company to accept responsibility for a certain percentage of the financial obligations of treatment as outlined in the details of your specific insurance plan. We are legally obligated to collect deductibles, co-pays and co-insurance amounts as outlined in the EOB's (explanation of benefits) that we receive from your insurance company after a claim has been processed. We are in-network with many insurance plans, including United Healthcare, Aetna, Humana, Anthem, Medical Mutual and Medicare. If you questions about our in network status, please speak with our office staff at (440)710-1140.

For those patients who are contracted with insurance carriers with whom we are an out-of-network provider, we will accept these insurances for payment but please realize that your choice to use an out-of-network provider for your treatment may affect your out-of-pocket costs.

We encourage you to contact your insurance company prior to your first procedure to ask for an estimate of your out-of-pocket costs. We will happily provide you with a list of procedure codes (CPT codes) for the procedures you need so that you can obtain as accurate an estimate as possible.

Our office strives to work with our patients to make treatment affordable. If cost is the only thing standing in the way of your treatment, please ask to speak with the practice administrator or financial assistant. We are committed to working with our patients as much as possible in eliminating cost as a barrier to treatment.

I have read and acknowledge the policies above and agree to abide by the terms set forth in these policies.

_____ _____

Signature Date

Center for Advanced Vein Care, LLC
Dr. Sonja Stiller
7200 Mentor Ave
Mentor, Ohio 44060
(440)710-1140

NOTICE OF PRIVACY PRACTICES

In accordance with the Health Insurance Portability and Accountability Act of 1996, as of April 14, 2003, all health care providers are required to provide their patients with a "Notice of Privacy Practice" statement.

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.

The health provider named above is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

DISCLOSURE OF YOUR HEALTH CARE INFORMATION

Treatment

1. We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.
2. On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with the healthcare provider named above.
3. It is our policy to provide a substitute health care provider, authorized by the healthcare provider named above to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation.

Payment

We may disclose your health information to your insurance provider for the purposes of payment or health care operations. As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to us for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purposes of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received

Worker' Compensation

We may disclose your health information as necessary to comply with state Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceedings.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved with procuring, banking, or transplanting organs or tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefit purposes.

Change of Ownership

In the event that the health care provider named above is sold or merged with another organization, your health information/record will become the property of the new owner.

Marketing

We may contact you for marketing purpose or fund raising purposes, as described below:

1. As courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment, along with a request to call our office if you need to cancel or reschedule your appointment.
2. It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of health care provider sponsored fund-raising events. If we conduct fundraising and we use communications like the U.S. Postal Service or electronic email for our newsletters, you have the right to opt-out of receiving such communications from us.
3. We may also provide educational and informative newsletters. We use communications like the U.S. Postal Service or electronic mail for our newsletters. You have the right to opt out of receiving such communications from us.

Your Health Information Rights

1. You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that the healthcare provider named above is not required to agree to the restrictions that you requested.
2. You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
3. You have the right to inspect or copy your health information.
4. You have a right to request that the healthcare provider named above is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reasons(s) and information about how you can disagree with the denial.
5. You have a right to a paper copy of this Notice of Privacy Practices.

Changes to this Notice of Privacy Practices

1. The health care provider named above reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make any new provisions effective for all information that it maintains. Until such amendment is made, the health care provider named above is required by law to comply with this notice.
2. The healthcare provider named above is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please call the office number listed at the top of this page.

Complaints

Complaints about your Privacy Rights, or how the healthcare provider named above has handled your health information should be directed to the Practice Privacy Officer by calling this office at the number noted at the top of this form. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to: DHHS, Office of Civil Rights, 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, DC 20201.

Right to a Copy of this Notice

You have a right to have a paper copy of our Notice of Privacy Practices at any time. If you would like to have a copy of our Notice, ask the receptionist for a copy or contact our Privacy Officer at 9440)710-1140.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide the healthcare provider named above with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient's Name (print): _____

Patient's Signature: _____ Date: _____

Authorized Facility Signature: _____ Date: _____