## PATIENT INFORMATION

*PLEASE VERIFY ALL INFORMATION BELOW IS CORRECT*

| | | | |
|---|---|---|---|
| Patient name: | | Phone (Home): | |
| Patient SSN: (Required) | **(required for insurance purposes)** Please put SSN here: _____-_____-_____ | Phone (Work): | |
| Address: | | Phone (Cell): | |
| City/State/Zip: | | Email: | |
| Marital Status: | | Occupation: | |
| Gender: ❑ F ❑ M | Date of Birth: | Preferred Contact: | ❑Cell Phone ❑Home Phone ❑ Work Phone ❑Email |
| Emergency Contact: | Relationship to Patient: | Emergency Contact Phone: (Work / Home) | |

Race: ❑ American Indian ❑ Asian ❑ Black/African American ❑ Native Hawaiian /Other Pacific Islander ❑ White ❑ Other

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino

| | | | | | |
|---|---|---|---|---|---|
| Referring Physician: Phone Number: | | Primary Care Physician: Phone Number: | | | |
| Preferred Pharmacy: Phone Number: | | Please circle where you heard about us? | Google Search – Magazine – Galleria - Radio – Newspaper – Commercial – Bing Search – Facebook – Instagram - Word of Mouth OTHER _____ | | |

Name of Primary Insurance Company:_____

Is the above Primary Insurance Policy in your name? Yes ☐ No ☐

**If the policy is not in your name please complete the following information:**

Name of the Policy Holder:_____

Social Security # of the Policy Holder:_____(**required for insurance purposes**)

Date of Birth of the Policy Holder:_____

Your Relationship to the Policy Holder:_____

Name of Secondary Insurance Company:_____

Is the above Secondary Insurance Policy in your name? Yes ☐ No ☐

**If the policy is not in your name please complete the following information:**

Name of the Policy Holder:_____

Social Security # of the Policy Holder:_____(**required for insurance purposes**)

Date of Birth of the Policy Holder:_____

Your Relationship to the Policy Holder:_____

**Please tell us why you are here**:_____

**May we send a report of our findings, recommendations findings to your family doctor?** Yes ☐ No ☐

**Please check in the box if any of the following conditions were present in you.**

| | You | | Family | | | You | | Family | |
|---|---|---|---|---|---|---|---|---|---|
| | Yes | No | Yes | No | | Yes | No | Yes | No |
| Abnormal Bleeding (Hemophilia, Von WIllebrand, DIC, etc.) | ☐ | ☐ | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | ☐ | ☐ |
| Abnormal Clotting Disorder (Factor V, MTHFR, etc.) | ☐ | ☐ | ☐ | ☐ | Kidney Disease – What stage? | ☐ | ☐ | ☐ | ☐ |
| Abnormal Heart Rhythm (A. Fib, SVT, Heart Block, Wolf Parkinson White, etc.) | ☐ | ☐ | ☐ | ☐ | Liver Disease | ☐ | ☐ | ☐ | ☐ |
| Acid Reflux | ☐ | ☐ | ☐ | ☐ | Lung Disease (Oxygen at Home, COPD, Asthma, Blood Clots, Pulmonary Hypertension, etc.) | ☐ | ☐ | ☐ | ☐ |
| Cancer- what type? Active or in remssion? | ☐ | ☐ | ☐ | ☐ | Malignant Hyperthermia | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | MRSA | ☐ | ☐ | ☐ | ☐ |
| Defibrillator, Pacemaker or IVC Filter | ☐ | ☐ | ☐ | ☐ | Neurological (Stroke, TIA, Neck/Spine injury, Myasthenia Gravis, Parkinsons, etc.) | ☐ | ☐ | ☐ | ☐ |
| Endocrine Disease (Thyroid, etc.) | ☐ | ☐ | ☐ | ☐ | Seizures – Date of most recent seizure? | ☐ | ☐ | ☐ | ☐ |
| Heart Disease (Heart attack, stents, Coronary Artery Disease, PFO, ASD, Mitral Valve Prolapse, etc.) | ☐ | ☐ | ☐ | ☐ | Sleep Apnea | ☐ | ☐ | ☐ | ☐ |
| If yes, Please provide Additional Information | | | | | | | | | |

| | You | | | | Family | | | |
|---|---|---|---|---|---|---|---|---|
| **LEG VEIN HISTORY** | Right | Left | Both | Neither | Right | Left | Both | Neither |
| Operation or Casting | ☐ | ☐ | ☐ | ☐ | | | | |
| Deep Vein Thrombosis (Blood Clot) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Phlebitis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Venous Stasis Ulcer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Bleeding From Varicose Vein | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sclerotherapy | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Vein Stripping | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Previous Vein Ablation | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| If yes, Please provide Additional Information | | | | | | | | |

**Pain Management Information, Please give reason: _____**

| **Physician:** | **Physician Number:** |
|---|---|

**Please list any Current Medications you are taking with dosage and frequency information:** **Reasons for Taking Medication**

| | | |
|---|---|---|
| **1** | | |
| **2** | | |
| **3** | | |
| **4** | | |
| **5** | | |
| **6** | | |
| **7** | | |
| **8** | | |

**Are you currently on any of these medications (Please check Yes or No and any Details and Frequency information):**

| | **Yes** | **No** | **Details and Frequency** |
|---|---|---|---|
| Coumadin | ☐ | ☐ | |
| Eliquis | ☐ | ☐ | |
| Plavix | ☐ | ☐ | |
| Daily Aspirin | ☐ | ☐ | |
| Xarelto | ☐ | ☐ | |
| Antibiotics | ☐ | ☐ | |
| Steroids | ☐ | ☐ | |
| Diet Pills or Injections (Wegovy, Mounjaro, etc.) | ☐ | ☐ | |

**Please list any and all allergies and reactions:**

| **Latex Allergy ? Yes** ☐ **No** ☐ | |
|---|---|
| **1** | |
| **2** | |
| **3** | |
| **4** | |
| **5** | |
| **6** | |
| **7** | |

## Past Surgical History / Hospitalizations

| | Surgery / Hospitalization | Date | Anesthesia Complications | Notes |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |

## Social History

Your Height

_____

Your Weight

_____

Estimate please if unsure

| | Yes | No | | Length of Time of Use | Length of Time of Quit |
|---|---|---|---|---|---|
| Alcohol | ☐ | ☐ | **Drinks Per Week _____** | | |
| Illegal Drugs | ☐ | ☐ | **Please Explain ?** | | |
| High Risk Factors | ☐ | ☐ | **Please Explain ?** | | |
| HIV / Hepatitis | ☐ | ☐ | | | |
| Tobacco Smokeless | ☐ | ☐ | | | |
| Tobacco Smoker | ☐ | ☐ | **Packs per Day _____** | | |

Have you received the flu vaccine within the past year? Yes ☐ No ☐

Have you received the pneumonia vaccine within the past 3 years? Yes ☐ No ☐

Have you had a colonoscopy? Yes ☐ No ☐

Have you been screened for osteoporosis? Yes ☐ No ☐

## For Women Only

| | Yes | No | Details |
|---|---|---|---|
| Are you pregnant or think you might be? | ☐ | ☐ | |
| Are you currently nursing (breast feeding)? | ☐ | ☐ | |
| Any recent changes in oral contraceptive use | ☐ | ☐ | |
| On Hormone Replacement Therapy? | ☐ | ☐ | |
| Have you ever had a miscarriage?<br>If (**Yes**) how many? _____ | ☐ | ☐ | |
| Have you ever had a mammogram? | ☐ | ☐ | |

## REVIEW OF SYSTEMS

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. **PLEASE CHECK THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask one of the nurses, or your doctor.

| | N | Y | DETAILS |
|---|---|---|---|
| **CONSTITUTIONAL** | | | |
| Lack of energy | | | |
| Unexplained weight loss or gain | | | |
| Fever | | | |
| Night sweats | | | |
| **ENT** | | | |
| Difficulty hearing | | | |
| Sinus problems | | | |
| Nosebleeds | | | |
| Sore throat | | | |
| **CARDIOVASCULAR** | | | |
| Irregular heartbeat | | | |
| Racing heart | | | |
| Chest pains | | | |
| Swelling of feet or legs | | | |
| Pain in legs when walking | | | |
| **RESPIRATORY** | | | |
| Shortness of breath | | | |
| Prolonged cough | | | |
| Oxygen at home | | | |
| Abnormal chest x-ray | | | |
| Coughing up blood | | | |
| **GI** | | | |
| Nausea | | | |
| Vomiting | | | |
| Abdominal pain | | | |
| Diarrhea | | | |
| | | | |
| | | | |
| | | | |

| | N | Y | DETAILS |
|---|---|---|---|
| **MS** | | | |
| Joint paint | | | |
| Aching Muscles | | | |
| Swelling of joints | | | |
| Back pain | | | |
| **SKIN** | | | |
| Itchy | | | |
| Rash | | | |
| Pigmentation of legs | | | |
| **NEURO** | | | |
| Frequent headaches | | | |
| Dizziness | | | |
| Problems with walking or balance | | | |
| **PHYCHIATRIC** | | | |
| Depression | | | |
| Insomnia | | | |
| Anxiety | | | |
| **ENDOCRINOLOGY** | | | |
| Intolerance to heat or cold | | | |
| Frequent hunger/urination/thirst | | | |
| **HEMATOLOGIC** | | | |
| Easy bleeding | | | |
| Easy bruising | | | |
| Anemia | | | |
| Unexplained swollen areas | | | |
| **ALLERGIC** | | | |
| Seasonal allergies | | | |
| Hay fever symptoms | | | |
| Exposure to HIV | | | |
| Hepatitis C positive | | | |

Please explain if you checked yes to any::_____

_____

I agree all the proceeding information is correct to the best of my knowledge. Please sign here: _____

**CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS**

By signing below, you hereby consent for this Practice to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations. You may refuse to sign this consent form.

You should read the Notice of Privacy Practices for PHI attached to this form before signing the Consent. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the Privacy Officer for this Practice.

You have the right to request that the Practice restrict how PHI is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to requested restrictions, however; if the Practice agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law. Upon request, we will make available to you within three business days a summary of your visit.

You may communicate with the following individuals regarding my condition or course of treatment:

_____

_____

_____

Personal representative:_____

You may communicate confidential information to me or my representative, including invoices for services and medical records to my addresses/ phone number/ email provided by me unless directed otherwise by me in writing.

_____ _____

Signature Date

**Photograph Release to Insurance companies for procedure approval**

The undersigned enters into this Agreement with Alabama Vein & Restoration Medspa. I authorize Alabama Vein & Restoration Medspa, and/or I representative (s) to take photographs of me to be used for my care. I understand insurance companies may request photographs of my vein pathology to approve my particular procedure. I authorize the use of photographs/ images for this specific purpose.

If I have questions about the use or disclosure of my photographs, I can contact Alabama Vein & Restoration Medspa at 205.823.0151.
I hereby give all clearances, copyright and otherwise, for the use of my photographs for the above intended purpose. I expressly release and indemnify Alabama Vein & Restoration Medspa's officers, employees, and agents from any and all claims known and unknown arising out of or in any way connected with the above granted use. The rights granted to Alabama Vein & Restoration Medspa are perpetual and worldwide.
I have read the foregoing and understand its terms and agree to all of them:

_____ _____

Signature Date

ALABAMA VEIN
& RESTORATION MEDSPA

# Cancellation policy

We understand that unplanned issues can come up and you may need to cancel an appointment due to emergencies or obligations for work or family. If that happens, we respectfully ask for scheduled appointments to be cancelled in advance. Our staff wants to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

Thank you for being a valued patient and for your understanding and cooperation. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

**Cancellation or No Show of Surgery Appointments**

If a Surgery appointment is not cancelled at least 3 days (72 hours) in advance you will be charged a $250 fee; this will not be covered by your insurance company.

**Cancellation or No Show of Sclerotherapy (spider vein treatment), Cosmetic, and/or Aesthetic Treatment Appointments**

If a Sclerotherapy, Cosmetic, or Aesthetic appointment is not cancelled at least 2 days (48 hours) in advance you will be charged a $50 fee.

**How to cancel your appointment:**

To cancel or reschedule an appointment please call
205-823-0151 or 877-268-VEIN

_____ _____

Signature Date

ALABAMA VEIN
& RESTORATION MEDSPA

## Consent to charges

By signing below, you hereby consent for this practice to bill your insurance provider for services rendered to aid in your symptoms diagnoses. Services may include various tests such as lab work and/or ultrasound if the Physician deems necessary to accurately diagnose your symptoms. Charges for tests along with your office visit charge will be submitted to your insurance provider for payment.

However, you may or may not have met your yearly insurance deductible or individual financial responsibility. In the event that you have not met your annual insurance deductible, Alabama Vein is required by law to collect the portion of your deductible that your insurance company deems necessary. Alabama Vein may or may not be privy of this information prior to your initial office visit. The information depends on the cooperation of your insurance provider and their process time of providing information.

You understand that payment is due at the time of service. You agree to pay collection fees of 33 1/3% of the unpaid balance at such time that my account is placed with a collection agency. You further agree that you are responsible for all costs associated with the collection of your account, including but not limited to postage costs, and all credit card processing costs. In the event that your account is referred to an attorney for collection, you agree to be liable for attorney's fees of 33 1/3% of the unpaid balance, and all costs of court. You also authorize your employment location and status to be verified for the purpose of processing your bill for payment.

You authorize the use of the phone numbers and other contact information provided, including cellular number and any future number assigned to you for calls, texts, emails, to include automated dialers to contact me regarding my care and my account by the medical provider and the medical provider's business associates.

Alabama Vein will know what your out of pocket expenses will be (if any) for any procedures that you may need regarding your office visit with us. Please contact our billing director with any billing or financial obligation questions or concerns. Billing phone number is 205.716.6060. Alabama Vein greatly appreciates your understanding.

_____ _____

Signature Date