# Welcome To PhysiciansVeinCare

Date:______________

607 Highway 466 Lady Lake, FL 32159 352-259-7994
John D. Burress, D.O.

Name: ________________________________________________
Last First Middle

Home Address: ________________________________________________

City: ____________________ State: ______________ Zip: __________

Telephone: ( ) ____________________ Cell: ( ) ____________________

Gender: M F Birth date: ____________________ SSN: _____/_____/_____

Marital Status: ________ Driver's License #: ____________________ State: ______

Email:______________________________

Permanent ☐ or mailing ☐ address if different from above:

Street: ________________________________________________

City: ____________________ State: ______________ Zip: __________

Phone: ______________________

Person Responsible for Account: ________________ Relationship to Patient: ______

Name of Spouse: ______________________ Birth Date: ________________

SSN: ______/_______/______ Cell: ( ) ____________________________

In case of emergency, contact: ______________________________________

Relationship to Patient: ____________________________________________

Phone 1: ( ) ____________________ Phone 2. ( ) ____________________

Primary Care Physician: ________________________ Phone #:______________

**How did you hear about our practice?**

☐ Dr. __________________________________________ recommended you.

☐ My friend/relative, _______________________________ recommended you.

☐ Advertisement in ____________________/ Other ______________________

Patient: ______________________________ DOB: ________________________

***PRIMARY INSURANCE INFORMATION:***

Insurance Company: ______________________________________________

Address: ______________________________ Phone# ____________________

Policy # ______________________________ Group # ____________________

Policy Holder ____________________________________________________

Relationship to Patient: ____________________ DOB: ____________________

***SECONDARY INSURANCE INFORMATION:***

Insurance Company: ______________________________________________

Address: ______________________________ Phone# ____________________

Policy # ______________________________ Group # ____________________

Policy Holder ____________________________________________________

Relationship to Patient: ____________________ DOB: ____________________

***ASSIGNMENT and RELEASE:***

I certify that I, and/or my dependent(s), have insurance coverage with________________
Name of Insurance Company(s)

______________________________, and assign directly to Physicians Vein Care and Dr. John Burress, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named physician may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

______________________________________ ____________________
Signature of Patient, Guardian or Representative Date

______________________________________ ____________________
Please print name of Patient, Guardian or Representative Date

# Medical History

Patient's Name: ______________________________ DOB: ______________________

Please list any medication that you are allergic to: _________________________________

________________________________________________________________________

Please list any medication you are currently taking and include dose and amount you are taking

________________________________ _____________________________________

________________________________ _____________________________________

________________________________ _____________________________________

NSAID Therapy (taking Aspirin, Advil, Motrin or Ibuprofen)? Yes __________ No ____________

Please List Past and Current Medical History (i.e.; Hypertension, diabetes etc...)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Please list any Surgical History: _________________________________________________

________________________________________________________________________

Reasons you are seeking treatment for your veins: **Medical reasons**_________ if so, do your legs ever become (Please circle appropriate): Red Swollen Aching Painful Itchy Numb Restless Tingle Tired Heavy Cramp **Cosmetic reasons:** _______________

How long have you had the veins you are concerned about?___________________________

Did your veins develop during a pregnancy? Yes___________ No ___________________

Does prolonged sitting or standing aggravate your veins? Yes__________ No ___________

Are your veins getting worse? Yes _________ No _________________

Have you ever been treated for a blood clot in your legs, if yes when and which leg?

________________________________________________________________________

Have you ever had treatment for your veins, if yes, where and what type of treatment?

________________________________________________________________________

Do you or have you ever worn compression hose, if yes when and which leg?

________________________________________________________________________

Note: Many Insurance require a trial period of conservative therapy such as leg elevation, rest and/or compression hose for 3 to 6 months.

# Physicians Vein Care

## Addition to HIPAA Notice of Privacy Practices

### PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal healthcare information is protected for privacy. The privacy rule was also created in order to provide a standard for certain healthcare providers to obtain their patients' consent for use and disclosure for health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect the privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about your treatment, payment, or healthcare operation in order to provide healthcare that is in your best interest.

There are times you may wish other family members and friends to inquire about your appointments or have access to your medical information. We will not release any information unless you have listed them below. If you wish to allow messages other than just to return our calls on your message recorder, please indicate this also.

***Recorded Message*** No ________ Do not leave a message other than to "return call"

YES _______ May leave a message regarding medical information

List any family members or others you wish to have access to your records, for example, who may call us regarding your condition or call for you. **We will not release information to spouses**

**or your children unless they are listed here.** (We will require signed releases by you for anyone wanting access to your records other than the insurance companies you have listed on file, your healthcare provider necessary to your care, or persons listed below).

**NAMES ALLOWED TO RECEIVE MEDICAL INFORMATION & HOW RELATED:**

1.______________________________ Relation: ______________________

2. ______________________________Relation:______________________

3.______________________________Relation:______________________

4.______________________________Relation:______________________

I, ______________________________, acknowledge that I have received a copy of Physicians Vein Care's Notice of Privacy Practices. This notice describes how Physicians Vein Care may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I have regarding my protected health information. I also understand I may revoke this authorization at any time, and receive a copy of this authorization.

**PRINTED NAME** ______________________________

**SIGNATURE** ______________________________ **DATE**______________

## Consent for Photography

For the purpose of documenting my progress and response to treatment, I give permission to take photographs. I understand these photos may need to be developed by an outside photo processor due to documentation requests from my insurance company. Photos **will not** be used for advertising or other uses without my additional written authorization.

**SIGNATURE**______________________________**DATE**______________

## Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand Physicians Vein Care's *Notice of Privacy Practices* containing a description of the uses and disclosures of my health information, certain restrictions on the use and disclosure of my healthcare information, and rights I have regarding my protected health information. I further understand that Physicians Vein Care may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy of Physicians Vein Care's *Notice of Privacy Practices*.

________________________________________

Printed Patient Name

________________________________________ ____________________

Patient Signature Date

If completed by patient's personal representative, please print name and sign below.

________________________________________ ____________________

Printed Patient Personal Representative Name Relationship to Patient

________________________________________ ____________________

Patient Personal Representative Signature Date

# <u>PhysiciansVeinCare</u>

**John D. Burress, D.O.**

## <u>FINANCIAL POLICY STATEMENTS</u>

*Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. In order to reduce confusion and misunderstanding between you and the practice, we have adopted the following financial policy, which we require that you read, agree to, and sign prior to any treatment. If you have any further questions about the policy, please discuss this with our patient finance counselor. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.*

- **YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY; THE DOCTOR IS NOT INVOLVED.**

- **AS A COURTESY,** we will file your insurance claim for you if you assign the benefits to the doctor; in other words, you agree to have your insurance company pay the doctor directly. **IF YOUR INSURANCE COMPANY DOES NOT PAY THE PRACTICE WITHIN FORTY-FIVE (45) DAYS OF FILING, YOU WILL BE RESPONSBLE FOR FULL PAYMENT.**

- We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service. **WE WILL COLLECT THE COPAYMENT WHEN YOU ARRIVE FOR YOUR APPOINTMENT.** If your insurance plan denies payment, the remaining balance will be your responsibility.

- If you have insurance coverage with a **PLAN** that **WE DO NOT HAVE A PRIOR AGREEMENT,** we will prepare and send the **CLAIM** for you on an **UNASSIGNED BASIS.** This means your insurer will send payment directly to you. **THEREFORE, OUR CHARGES FOR YOUR CARE AND TREATMENT ARE DUE AT THE TIME OF SERVICE.**

- Unless other arrangements have been made in advance, by either you or your health coverage carrier, **FULL PAYMENT IS DUE AT THE TIME OF SERVICE.** For your convenience, we will accept **CASH, CHECKS, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS,** and **DEBIT CARDS.**

- All health plans are not the same and do not cover the same services. In the event your health plan determines a **SERVICE or SERVICES NOT COVERED,** you will be responsible for the complete charge. **PAYMENT IS DUE AT THE TIME OF SERVICE.**

- For all services rendered to minor patients, the parent or legal guardian who is accompanying the minor patient is responsible for payment at the time of service.

- Ancillary services provided by this practice (e.g. ultrasound, laboratory) may be subject to additional financial policy statements.

- In order to provide the best possible service and availability to all of our patients, please call us as early as possible if you need to cancel or reschedule your appointment.

***I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms can be amended from time-to-time by the practice.***

_______________________________________________

*Signature of Patient or Responsible Party if a Minor* *Date*

_______________________________________________

*Signature of Co- responsible Party*

_______________________________________________

*Please Print the Name of the Patient*

# COSMETIC WAIVER

Here at Physicians Vein Care, our goal is to return your legs to a healthy state. For the lay-person, healthy legs are often strongly associated with cosmetic appearance. Indeed, sometimes the way a leg looks is a strong indication of your overall health, but in general, cosmetic appearance is just "skin deep".

Cosmetic appearance often improves due to improvements in the overall vein health, but to be very clear, we are not in any way inferring to you that the reason to have these procedures done is for cosmetic results. We are not here for cosmetic vein care. If that is the sole reason for your visit you should seek out the care of a phlebologist, dermatologist or other doctor who specializes in cosmetic vein treatment. Because the way the surface of the skin is so closely associated with success of the 'invisible' endovenous procedure, we do remove some superficial venous anomalies in an effort to monitor reoccurrences of deeper veins. If we do remove some of the veins considered 'cosmetic', either by chance or on purpose, we must reinforce to you that this is incidental to your main treatment and certainly should not be considered an inducement to undergo current or future treatment. If cosmetic veins are removed, they can reoccur. In addition, cosmetically undesirable effects can occur even under the best attempts to "fix" a vein.

It is important to thoroughly read the disclosure you sign each time you undergo a procedure and ask any questions you have before you sign and consent to treatment. As always, your health is our PRIORITY.

Best regards,

Dr. John Burress

*I have read and acknowledge understanding of the above.*

*Patient signature*________________________ *Print Name*________________________ *Date*________

# PhysiciansVeinCare

## No Show & Cancellation Policy

Patient Name: ______________________________ Date of Birth: ________________

Dear Patient,

Due to the specialized nature of the procedures we perform, as well as the amount of time which is reserved in your name for the dedicated procedure, Physicians Vein Care has instituted a formal policy regarding cancellations and "no shows". To help our patients, we will call to confirm your appointment up to two days before your scheduled appointment. We understand that sometimes you need to cancel or reschedule your appointment. If you cannot come to your appointment on the scheduled day and time, you are expected to contact our office no later than twenty four (24) hours in advance. If you do not call to cancel your appointment within the given time, it will be considered a No-Show Visit. Every no-show visit will be recorded in your medical record, and the following administrative fee will be assessed to your account:

**First occurrence:** Patient will be sent a letter or called. No fine assessed.

**Second occurrence:** Patient will be charged $50.00. (This fee is the patient's responsibility. It is not reimbursable by insurance.)

**Third occurrence:** Patient will be charged the full price of the scheduled office visit/procedure. (This fee is the patient's responsibility. It is not reimbursable by insurance.) Patient may be discharged from the practice. The decision whether or not to discharge you will be at your doctor's discretion.

Our aim is to open otherwise unused appointments for our patients, not to collect missed appointment fees. If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you may have. We thank you in advance for your cooperation and understanding. By signing below, you acknowledge that you have been presented with the above policy.

______________________________ ________________

Patient Signature Date

______________________________ ________________

Patient Name Printed Witness

# Compression Hose

As we discussed, you will be required to wear compression for 24-48 hours after **each** treatment. Many of you still have compression hose from your conservative treatment efforts. *If you still have a pair which fit you well and that you are comfortable with you will not need any further compressive garments.* You will need to bring them with you to each and every treatment. If your compression hose have been lost, torn or if they no longer fit you appropriately you will need to purchase new hose. You will need to reuse your hose multiple times as we will be putting them on after every treatment. You do not need to wash them in between treatments unless you so choose. We will be happy to provide you with a prescription to purchase a pair at a local medical supply company.

- Unfortunately, **Medicare and/or commercial insurance do not pay for compressive garments.**

As a service to our patients we can fit you with an appropriate sized compression hose at the time of your procedure and charge only our cost and handling, which is currently $33.00 for one leg. Technically, you only need 1 stocking at a time for these procedures, not a pair, but medical supply companies rarely sell them in anything other than a pair. Purchasing just the one is a significant cost savings to you as most compression garments run approximately $100.00 or more per pair. If you're interested in this please be aware that this is an up front, out-of-pocket expense and will not be covered by your insurance company. Please be aware that this is not a profit making enterprise for us, we are just trying to help our patient economically.

We will be happy to explain any questions that you may have, please ask Dawn or one of the staff.

Thank you and good health to you always,

Physicians Vein Care

_____ No thank you, I have my own compression hose and will bring them to each procedure.

_____ Yes, I would like to have a prescription in order to get my compression garments outside of the clinic.

_____ Yes I would like to have the clinic provide me with my compression hose. I understand that this would be at my expense.

Patient Signature: ______________________________