607 Highway 466 Lady Lake, FL 32159
Phone: 352-259-4117
Fax: 352-259-2462

New Patient Questionnaire

Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____

Date of birth: _____ SSN: _____ - _____ - _____

Marital Status: _____ Driver's License #: _____ State: _____

Email: _____

Mailing address if different from above:

Street: _____

City: _____ State: _____ Zip: _____

Person Responsible for Account: _____ Relationship to Patient: _____

Name of Responsible Person (if other than patient): _____

Date of birth: _____ SSN: _____ - _____ - _____

Phone: _____

In case of emergency, contact: _____

Relationship to Patient: _____

Phone: _____

Primary Care Physician: _____ Phone #: _____

How did you hear about us?

- □ Doctor's office: _____
- □ Friend: _____
- □ Advertisement: _____
- □ 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. Dusk Gosney, 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, 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: (Please circle appropriate):

Redness	Pain	Numbness	Heaviness
Swelling	Itchiness	Tingling	Cramping
Aching	Restless legs	Tired-feeling	

Cosmetic reasons: _____

How long have you been concerned about your veins? _____

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 mo.

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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 Messages: _____ Do not leave a message other than to "return call"

_____ You 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. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____
4. _____ Relationship: _____

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.*

_____ _____

Patient Signature *Date*

_____

Printed Patient Name

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*

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.

_____ _____

Patient Signature *Date*

_____

Printed Patient Name

FINANCIAL POLICY STATEMENTS

Thank youfor 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 anyfurther 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 yourfinancial 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

At Physicians Vein Care, our focus is on restoring and maintaining the health of your legs. While many people naturally connect healthy legs with how they look, appearance is often only one visible sign of an underlying vein condition.

As vein health improves, cosmetic appearance may improve as well. However, we want to be very clear: our care is not cosmetic in nature, and cosmetic improvement is not the reason we recommend treatment. We do not provide cosmetic vein treatment as a primary service. If your only goal is cosmetic improvement, you should seek care from a phlebologist, dermatologist, or another physician who specializes in cosmetic vein procedures.

That said, because the appearance of surface veins can sometimes reflect what is happening beneath the skin, we may treat certain superficial vein abnormalities as part of evaluating and managing underlying venous disease. If any veins that might be considered "cosmetic" are treated or removed, whether intentionally or incidentally, this should be understood as secondary to your primary medical treatment. It should not be interpreted as a reason to pursue current or future procedures for cosmetic purposes.

It is also important to understand that veins can recur over time, and cosmetically undesirable changes may still occur even when treatment is performed appropriately and with the best possible technique.

Please take time to carefully read the disclosure form each time you undergo a procedure, and ask any questions you may have before signing your consent. As always, your health remains our highest priority.

Best regards,

Dr. Dusk Gosney

I have read and acknowledge understanding of the above.

_____ _____

Patient signature *Date*

_____

Print Name

NO SHOW & CANCELLATION POLICY

Patient Name: _____ Date of Birth: _____

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*

_____

Print Name

COMPRESSION HOSE POLICY

As part of your treatment, you will be required to wear compression garments for 24 to 72 hours after each procedure. Some patients may already have compression stockings from prior conservative treatment. If you still have a pair that fits properly and remains in good condition, you will not need to purchase additional garments. Please bring them with you to each treatment appointment.

If your compression stockings have been lost, damaged, or no longer fit appropriately, you will need to obtain a new pair. Because the same stockings will be used after multiple treatments, they should be kept available throughout the course of your care. Washing them between treatments is optional unless you prefer to do so.

We are happy to provide a prescription for compression stockings if you would like to purchase them through a local medical supply company.

Unfortunately, **Medicare and/or commercial insurances 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**. If you are 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.

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

Thank you,

Dr. Dusk Gosney

_____ _____

Patient signature *Date*

_____

Print Name