Patient Information Form

Name: _____ Date: _____

Address: _____

_____

Date of Birth: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Employer: _____

Primary Care Physician: _____

Medications: _____

_____

_____

_____

Allergies _____

Circle if you have any of the following symptoms:

Shortness of breath	Asthma	Diabetes	Chest Pain
Headache	Liver disease	Thyroid	Irregular heart beat
Seizures	Anemia	Depression	Arthritis

VEIN HISTORY FORM

MIDDLETOWN VEIN & AESTHETIC CENTER

Name: _____ Date: _____

Age: _____ Sex: M / F

Please answer the following questions

1. Which leg(s) would you like us to evaluate today? ☐ Right ☐ Left ☐ Both

2. Have you ever had your veins evaluated before? Yes No
   If so, when and where? _____

3. Have you ever had surgery on your legs for a venous or arterial problem(s)? Yes No
   If yes, what type of surgery and when? _____

4. Have you ever had vein stripping or ligation surgery? Yes No
   If yes, when and which leg? _____

5. Have you ever had Sclerotherapy, Laser (EVLT) or Radiofrequency (CLOSURE) treatments? Yes No
   If yes, when and which leg? _____

6. Have you ever had a blood clot in your legs? Yes No
   If yes, when and which leg? _____

7. Do you currently wear or have previously worn compression hose stockings? Yes No
   If yes, for how long and what level of compression? _____

8. Do you currently take analgesics (e.g. Ibuprofen, Aleeve, etc,) on a regular basis to help reduce the pain in your legs? Yes No

9. Have you gained or lost a significant amount of weight (e.g. 15-20 lbs) in the past year? Yes No

10. Were you referred to us by a physician? _____ Yes No
    If yes, by whom? _____

11. Did you hear about us through a newspaper? Yes No
    If yes, which newspaper? _____

Please circle the appropriate answer.

1. Does anyone in your family have varicose veins, spider veins, leg ulcers or swollen legs?
   Father ……Yes No
   Mother ……...Yes No
   Brother(s) ……...Yes No
   Sisters(s) ……...……..Yes No
   Other _____

2. Do you experience any of the following?
   a. Aching/pain in your legs…….….Yes No
   b. Heaviness in your legs…….….Yes No
   c. Tiredness/fatigue in your legs……..…Yes No
   d. Itching/burning in your legs……Yes No
   e. Cramping discomfort in your legs?……..……..…..Yes No
   f. Restless legs ……....Yes No
   g. Throbbing in your legs……..…….....Yes No
   h. Leg ulcers ……Yes No
   i. Other _____
      _____

3. Have your symptoms or the appearance of veins on your legs gotten worse in the past 6 months? Yes No

4. Do you find that elevating your legs helps reduce the pain? Yes No

5. Do you wear a support hose prescribed by a doctor Yes No
   If yes, what level of compression? _____

6. Have your leg problems affected your work or home activities? Yes No
   If yes, how so? _____

8. Do you have any allergies? Yes No
   If so, list them _____

9. Do you take any blood thinners, aspirin, ibuprofen, vitamin E or iron supplements on a regular basis? If yes, which medication(s)? _____ Yes No

10. Are you taking birth control pills? Yes No
    If yes, please list name(s) _____

11. Are you taking the antibiotic Minocycline? Yes No

12. What is your occupation: _____

13. If you are interested in learning about any of our Aesthetic services, please circle:
    Botox, Juvederm, Kybella, Latisse, Laser hair removal, Laser skin rejuvenation, Cosmetic vein work

Signed: _____ Date: _____

*Patient Name:*_____ *Date of Service*:_____

Guilford Radiology **Middletown Vein and Aesthetic Center**

Consent For Treatment and Release of Information and Acknowledgment

Consent For Treatment: I hereby authorize the physicians of Radiologic Associates of Middletown in charge of my care to administer such treatment and medication as may be deemed necessary or advisable in the treatment and diagnosis of my condition.

Authorization For Release Of Information for Treatment & Payment: I consent to the use and/or disclosure of my health information to any person or organization for the purpose of treatment, including coordinating my continuing care and as otherwise authorized by law, conducting certain healthcare operations.

Financial Agreement: I understand that I am obligated to pay the account of Radiologic Associates of Middletown in accordance with the regular rates and terms of the organization. I owe and agree to pay Radiologic Associates for any and all charges *not* paid by insurance benefits. If my account is not paid, I will pay all court costs, attorney's fees and other costs incurred by Radiologic Associates to collect the balance owed. I also authorize payment directly to Radiologic Associates for services performed.

Assignment Of Insurance Benefits: In consideration for services rendered or to be rendered, I hereby assign to Radiologic Associates all insurance benefits, without limitation, Medicare or Medicaid benefits, to cover such services. In connection with such assignment, Radiologic Associates is hereby authorized to contact my insurance carrier on my behalf and to obtain any and all such information as may be necessary to process any insurance claim related to my treatment.

Insurance Information: I understand that it is my responsibility to provide the correct Health Insurance Information to the provider of services. I further understand that if I provide the *incorrect* Health Insurance Information, I will be held liable for services not paid due to this error.

_____

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ, UNDERSTOOD, AND AGREES TO THE FOREGOING, AND IS THE PATIENT OR HIS/HER REPRESENTATIVE

Signature:_____ **Date:**_____

Signature of Patient or Person Granting Authorization on Behalf of Patient

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers whom may be involved in that treatment, directly or indirectly.

- Obtain payment from third party payers.

- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have had the opportunity to review your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Middletown Vein and Aesthetic Center has the right to change its *Notice of Privacy Practices* from time to time and that I may contact Middletown Vein and Aesthetic Center and Radiologic Associates of Middletown at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed in order to carry out treatment, payment, or health care operations.

Patient Name: _____

Signature: _____

Date: _____ / _____ / _____

MIDDLETOWN VEIN & AESTHETIC CENTER

Photo/Video Release Form for Vein Treatment

Participants Name: _____

I hereby authorize Middletown Vein and Aesthetic Center to publish the photographs taken of me for use in publications and website. I understand that the photos and or videos will not include my face but rather strictly of the treated areas of my leg(s). I acknowledge that since my participation in publications and websites produced by Middletown Vein and Aesthetics is voluntary, I will receive no financial compensation. I further agree that my participation in any publication and website produced by Middletown Vein and Aesthetics confers upon me no rights of ownership whatsoever. I release Middletown Vein and Aesthetics, its contractors and its employees from liability for any claims by me or any third party in connection with my participation.

Signature in agreement: _____

www.ctveins.com