ADVANCED VEIN & LASER CENTER
veinsbegone.com

Dear ______________________________,

APPOINTMENT DATE AND TIME: ____

As a courtesy, we will notify you of your appointment time prior to your visit.

Welcome to our office, and thank you for selecting our practice for your vein and laser needs. This letter is to introduce you to our office and some of our practice policies.

We are located at 896A Plaza Blvd. Lancaster, PA 17601. We are located across the street from JC Penney at the Park City Mall. If you require further directions to locate our office, please call (717) 295-8346, and a staff member will be happy to assist you.

Enclosed are patient information forms. **Please complete the forms and bring them with you to your appointment**. You will need to **arrive 15 minutes earlier than your scheduled appointment** so that we can review the forms. If you are unable to complete the enclosed forms, please bring them to your office visit, and a member of our staff will be happy to help you complete them. In this circumstance, you will need to arrive **30 minutes** prior to your scheduled appointment time.

Our staff works hard to stay on schedule by performing a thorough evaluation specific to each patient's needs. We apologize if this causes any delay in the appointment schedule. If you have questions prior to your scheduled visit, please call us, and we will be happy to assist you. Our office hours for phone calls and scheduling are Monday through Friday from 8:00 a.m. to 5:00 p.m. If you require medical assistance when the office is closed, you can reach Dr. Winand by calling (717) 295-8346.

Finally, we require 24-hour notice to cancel or reschedule an appointment. **Please call us as soon as possible if you will be unable to keep your upcoming appointment or would like to reschedule for another day. This will allow us to contact another patient who may wish to use your appointment time slot.**

Thank you, and we look forward to meeting you soon!

Dr. Winand and Staff at Advanced Vein & Laser Center

PLEASE ARRIVE 15 MINUTES PRIOR TO YOUR NEW PATIENT APPOINTMENT TIME

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Today's date: / /	Social Security #:	Gender:	Date of Birth: / /
Last Name: First Name:	Middle Name:		Previous/Maiden Name:
Street Address:	City:	State:	Zip Code:
Home Phone #:	Cell Phone #:	Work Phone #:	
Employer:	Occupation:		
Primary Care Provider:	Email Address:		

Referred by: □ Physician
Name of Physician: ______________
□ Insurance Plan
□ Family/Friend
□ Advertisement
Where: ______________
□ Website
□ Other: ______________

Race: □ Caucasian □ Black/African American □ Native American
□ Asian □ Hispanic/Latino □ Unspecified

INSURANCE INFORMATION

Primary Insurance:		
Subscriber's Name:	Subscriber's Social Security #:	Subscriber's DOB: / /
Subscriber's Employer:	Relationship to Subscriber:	
Co-payment: $	Insurance ID #:	Insurance Group #:
Secondary Insurance:		
Subscriber Name:	Subscriber's Social Security #:	Subscriber's DOB: / /
Subscriber's Employer:	Relationship to Subscriber:	
Co-payment: $	Insurance ID #:	Insurance Group #:

IN CASE OF EMERGENCY

Name:	Relationship to patient:	
Home Phone #:	Cell Phone #:	Work Phone #:

I authorize that the above information is correct and true to the best of my knowledge. I am also responsible for letting AVLC know of any changes in my personal information. I hereby authorize AVLC to release any information required to (but not limited to) my insurance company.

Patient/Guardian Signature: ______________________ **Date:** ____________

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Name: ______________________________ ID#: ______________

What is the reason for your visit today? ______________________________
How long have you had your symptoms? ______________________________
Where are the veins you are seeking a medical opinion for located? □ Leg(s) Right / Left / Both □ Face □ Chest □ Other __________

Please check the box next to the symptoms that apply to you:

□ Aching Pain	□ Cramps	□ Burning	□ Other __________
□ Dull Pain	□ Restlessness	□ Itching	
□ Sharp Pain	□ Tiredness	□ Swelling	
□ Throbbing	□ Heaviness	□ Leg Ulcer(s)	

VEIN HISTORY

Are your symptoms getting worse? Yes No
Are your symptoms affecting daily living activities? Yes No
If yes, how have they altered your daily living? ______________________________

____

What factors precipitate symptoms? ______________________________

____

What factors relieve your symptoms? ______________________________

____

Have you ever worn any type of compression stockings? Yes No
If yes, for how long? __________ months / years
Do you have a family history of varicose veins? Yes No
Do you have swelling after prolonged standing? Yes No
Have you ever tried over-the-counter medication for relief of you symptoms? Yes No
If yes, for how long? __________ months / years

Do you have now or have you ever had any of the following?			**When?**
Phlebitis	Yes	No	__________
Deep Vein Thrombosis (DVT)	Yes	No	__________
Pulmonary Embolus (PE)	Yes	No	__________
Bleeding from veins	Yes	No	__________
Sclerotherapy	Yes	No	__________
Venogram	Yes	No	__________
Vein surgery	Yes	No	__________
Hemorrhoids	Yes	No	__________
IV drug use	Yes	No	__________
Clotting Disorder	Yes	No	__________
Cellulitis	Yes	No	__________

PAST SURGICAL HISTORY

Please list any operations you have had:

____

____

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PATIENT HEALTH ASSESSMENT QUESTIONNAIRE

Name: ______________________ ID#: __________

Please list any hearing, vision or reading issues: ______________________

Do you have an Advanced Directive? Yes No

Please bring all of your prescription medicines and over-the-counter vitamins and supplements to your appointment, OR list all prescription and over the counter medications, supplements and vitamins you take, including the dose or strength.

______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

Are you allergic to latex? Yes No

Allergies: ______________________

Pharmacy Name ______________________ Phone # __________

PAST MEDICAL HISTORY

Have you ever had any of the following?

Condition			Condition		
Heart Disease	Yes	No	Hepatitis	Yes	No
High Blood Pressure	Yes	No	Eczema/Psoriasis	Yes	No
Chest Pain	Yes	No	Venereal Disease/STD	Yes	No
Glaucoma	Yes	No	Arthritis	Yes	No
Thyroid Disease	Yes	No	Depression	Yes	No
Lung Disease	Yes	No	Diabetes (Type)	Yes	No
Asthma	Yes	No	Stroke	Yes	No
Epilepsy	Yes	No	Blood Disease/Anemia	Yes	No
Cancer (Location)	Yes	No	Gallbladder Disease	Yes	No
Ulcers (Location)	Yes	No	Back Disorder	Yes	No
Colitis	Yes	No	Gastric Reflux	Yes	No
HIV/AIDS	Yes	No	History of Falls	Yes	No
Bruising Easily	Yes	No	Other: __________		

FAMILY/SOCIAL HISTORY

Do you have a family history of:			**Relationship**	**Your personal Habits:**	**Do you?**	
Heart Disease	Yes	No	________	Exercise regularly	Yes	No
High Blood Pressure	Yes	No	________	How often? ________		
Diabetes	Yes	No	________	Smoke/Use tobacco	Yes	No
Stroke	Yes	No	________	How much? ________		
Cancer	Yes	No	________	Use tobacco in the past?	Yes	No
Thyroid Disease	Yes	No	________	Drink alcohol?	Yes	No
Clotting Disorder	Yes	No	________	How much? ________		
Dementia	Yes	No	________	**Females ONLY**		
DVT/PE	Yes	No	________	How many pregnancies have you had? ______		
Other ________			________	How many deliveries have you had? ______		

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Name: ______________________ ID#: ______________

REVIEW OF SYSTEMS – CURRENT/ACTIVE PROBLEMS

CONSTITUTION			WHEN?	GU			WHEN?
Appetite loss	Yes	No	______	Blood in urine	Yes	No	______
Fatigue	Yes	No	______	Kidney disease	Yes	No	______
Fevers	Yes	No	______	Renal failure	Yes	No	______
EYES				Excessive urination	Yes	No	______
Retinal problems	Yes	No	______	Decreased urination	Yes	No	______
Blurred vision	Yes	No	______	Painful urination	Yes	No	______
Diminished vision	Yes	No	______	**MUSCLE/SKELETAL**			
Double vision	Yes	No	______	Bone/Joint deformity	Yes	No	______
Vision loss	Yes	No	______	Limitations of movement	Yes	No	______
ENT				Muscle aches	Yes	No	______
Discharge from ears	Yes	No	______	Back pain	Yes	No	______
Hearing loss	Yes	No	______	**SKIN**			
Ringing in ears	Yes	No	______	Dryness	Yes	No	______
Sinus problems	Yes	No	______	Itchy skin	Yes	No	______
Hoarseness	Yes	No	______	Changes in moles	Yes	No	______
Sore throat	Yes	No	______	Rash	Yes	No	______
CARDIAC				**NEURO**			
Atrial fibrillation	Yes	No	______	Ataxia	Yes	No	______
Chest pain	Yes	No	______	Fainting	Yes	No	______
Chest discomfort	Yes	No	______	Headache	Yes	No	______
Congenital heart disease	Yes	No	______	Migraine	Yes	No	______
				Memory lapses	Yes	No	______
Dizziness	Yes	No	______	Numbness	Yes	No	______
Leg pain when walking	Yes	No	______	Paralysis	Yes	No	______
Calf pain when walking	Yes	No	______	Seizures	Yes	No	______
Palpitations	Yes	No	______	Unclear speech	Yes	No	______
Swelling of ankles	Yes	No	______	Stroke	Yes	No	______
RESPIRATORY				Weakness	Yes	No	______
Bronchitis	Yes	No	______	**PSYCH**			
Breathing difficulty	Yes	No	______	Anxiety	Yes	No	______
COPD	Yes	No	______	Confusion	Yes	No	______
Coughing blood	Yes	No	______	Delusions	Yes	No	______
Pneumonia	Yes	No	______	Depression	Yes	No	______
Wheezing	Yes	No	______	**ENDOCRINE**			
GASTRO				Diabetes w/ Insulin	Yes	No	______
Abdominal pain	Yes	No	______	Diabetes w/o Insulin	Yes	No	______
Gallbladder problems	Yes	No	______	Intolerance to cold	Yes	No	______
Gastritis	Yes	No	______	Thyroid disease	Yes	No	______
Hemorrhoids	Yes	No	______	**HEMA/LYMPH**			
Jaundice	Yes	No	______	Anemia	Yes	No	______
Liver disease	Yes	No	______	Bleeding/clotting disorder	Yes	No	______
Gastric reflux	Yes	No	______	Bruising easily	Yes	No	______
Change of stool color	Yes	No	______	**IMMUNIZATIONS**			
Bloody stools	Yes	No	______	Pneumonia vaccination	Yes	No	______
Painful swallowing	Yes	No	______	**SCREENINGS**			
Bloody vomit	Yes	No	______	Colonoscopy	Yes	No	______

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Name: ______________________ ID#: ______________

In the past 12 months, . . .

- ☐ Y ☐ N Fell two or more times.
- ☐ Y ☐ N Was injured by a fall that limited my regular activities for at least one day.
- ☐ Y ☐ N Saw a doctor because I had a fall.
- ☐ Y ☐ N Found it hard to climb stairs or walk a short distance.
- ☐ Y ☐ N Had trouble getting up from a soft chair.
- ☐ Y ☐ N Have been unable to stand on one foot for 12 seconds without losing my balance.
- ☐ Y ☐ N Trouble with my eyesight.
- ☐ Y ☐ N Felt dizzy or light headed after a big meal.
- ☐ Y ☐ N Took medication that caused me to feel dizzy or light headed.
- ☐ Y ☐ N Took 9 or more different medications.
- ☐ Y ☐ N Stopped some of my regular activities.
- ☐ Y ☐ N Have been taking a calcium supplement regularly. If "Yes", how much per day:
- ☐ Y ☐ N Have not had my vitamin D level in my blood checked.
- ☐ Y ☐ N Danced, exercised, or practiced Tai Chi at least 3 times a week.
- ☐ Y ☐ N Has my home checked for any dangers and modified as needed.

Patient Name-Please Print: ______________________ **DOB:**__________

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Patient Name-Please Print: ______________________________ **DOB:**__________

Advanced Vein and Laser Center appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

If a payment is not received within 30 days from the first patient statement or a payment plan is not established, your account will be turned over to the Credit Bureau of York. You will also be responsible for the fees incurred from your account being turned over to collections in addition to the balance of your account.

I have read the above policy regarding my financial responsibility to **Advanced Vein and Laser Center**. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Advanced Vein and Laser Center. The full and entire amount of bill incurred is ultimately my responsibility.

Patient Signature ______________________________ Date__________

Guarantor Signature ______________________________ Date __________
(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature ______________________________ Date__________

Self-Pay

I do not have health insurance and will be responsible for services rendered here at **Advanced Vein and Laser Center**. I agree to pay **Advanced Vein and Laser Center**, the full and entire amount of treatment given to me at each visit.

Patient/Guarantor Signature ______________________________ Date__________

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PERMISSION TO RELEASE DIAGNOSTIC/MEDICAL INFORMATION TO ANOTHER INDIVIDUAL

Effective Date:	
Print Patient's Full Name:	
Patient's Date of Birth:	ID#:

I give Advanced Vein & Laser Center permission to release diagnostic test results to, and discuss protected health information with, the following person(s):

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

I give Advanced Vein & Laser Center permission to leave any protected health information on an answering machine or voicemail.

□ Yes □ No

By signing this form I give Advanced Vein & Laser Center permission to send office correspondence to the address provided.

Indicate your relationship to the patient: □ Patient □ Patient Representative

Print Name (if other than patient):	
Signature:	Date:

This form is good for 1 year unless otherwise specified. If applicable, please specify alternative date:

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Notice of HIPAA Privacy Practices
PATIENT COPY – PLEASE KEEP FOR YOUR RECORDS

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can gain access to your individually identifiable health information. Please review it carefully.

1. Advanced Vein & Laser Center may use and disclose protected health information for treatment, payment, and health care operations. Examples of these include, but are not limited to, life insurance, physicals, referral to nursing homes, home health agencies, and/or referral to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers and collection agencies. Health care operations include, but are not limited to, internal quality control, accreditation processes, and assurance including auditing of records.
2. Advanced Vein & Laser Center is permitted or required to use or disclose protected health information without the individuals' written consent or authorization in certain circumstances, such as for public health requirements and court orders.
3. Advanced Vein & Laser Center will not make any other use or disclosure of a patient's protected health information without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.
4. Advanced Vein & Laser Center may at times contact the patient to provide appointment reminders or information regarding treatment alternatives or other health-related benefits and services that may be of interest to the individual patient. If this contact is made by phone and you are not available, a message will be left on your answering machine.
5. Advanced Vein & Laser Center will abide by the terms of this notice or the notice currently in effect at the time of the disclosure.
6. Advanced Vein & Laser Center reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains.
7. Advanced Vein & Laser Center will provide each patient with a copy of any revisions of its Notice of HIPAA Privacy Information at the time of the next visit, or at the last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our offices.
8. Any person/patient may file a complaint to the medical practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, or for further information, please contact the privacy officer at the following address and/or telephone number.

   Advanced Vein & Laser Center
   Attn: Privacy Officer
   896A Plaza Blvd. Lancaster, PA 17601

9. It is Advanced Vein & Laser Center's policy that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual noncompliance of the privacy standards.

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HIPAA CONSENT

I understand that as part of my health care, Advanced Vein & Laser Center originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:
I understand and have been provided with a *Notice of HIPAA Privacy Information* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice before signing this consent. I understand that the medical practice reserves the right to change its notice and practices and before implementation will mail a copy of any revised notice to the address I have provided upon request. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and that the medical practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the medical practice has already taken action in reliance thereon. I understand that my personal information will serve as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine health care operations, such as assessing quality and reviewing the competence of health care professionals

I request the following restrictions to the use or disclosure of my health information: ____________________

______________________________ ______________________________ ________________

PRINT NAME **PATIENT SIGNATURE for HIPPAA CONSENT** **Date**

AVLC

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PHOTO CONSENT

Subject to the conditions herein, I, the undersigned, hereby give my permission for use of photographs taken during the course of my treatment provided reasonable measures are taken to protect my identity and provided these photographs are used solely for ethical purposes which may include:

1. It is understood that the use of the photographs is for illustrating cosmetic procedures and demonstration of benefits. It is also understood that the use of the photographs will in no way reveal my identity.
2. The aforementioned photographs may be modified at the discretion of the facility, its clients, or agents to be more desirable. This will include, but will not be limited to, masking of the photographs to prevent identification or to cover private parts of the body.

______________________________ ______________

PATIENT SIGNATURE for PHOTO CONSENT **Date**

I, the undersigned hereby give my permission for photographs to be taken during the course of my treatment and be a part of my clinical medical record only to demonstrate the benefits of treatment and evaluate before and after pictures. My photographs will only be a part of my medical record and not used for any other purposes.

______________________________ ______________

PATIENT SIGNATURE for PHOTO CONSENT **Date**

______________________________ ______________

TLC Acceptance Signature for HIPPA/ PHOTO/Cancellation POLICY **Date**

CANCELLATION POLICY

Cancelled, No Call/No Show Appointments less than 24-hour notice will incur a $50 FEE

______________________________ ______________

PATIENT SIGNATURE FOR CANCELLATION POLICY **Date**

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We do not double-book patients — a practice which is common in most physicians' offices. Your booked appointment is dedicated to your time.

Your visit is reserved in advance so we can focus on your comprehensive care. Insurance companies expect physicians to double-book an average of 6 patients per hour, which would not allow us to provide our patients with the care we are known for. Since we do not overbook and schedule one patient at a time, your missed appointment represents a loss for our medical staff and to the center, therefore we require a 24-hour notice of cancellation for all appointments.

<u>As a reminder, please provide 24-hour notice if you wish to make a change to your appointment time in order to avoid a $50 fee.</u>