



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 191 Leader Heights Road, York, PA 17402, which is on the corner of Security Drive and Leader Heights Road. If you require further directions to locate our office, please call (717) 741-2214, 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. Heird by calling (717) 741-2214 option 3.

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. Heird and Staff at Advanced Vein & Laser Center





**PLEASE ARRIVE 15 MINUTES PRIOR TO YOUR NEW PATIENT APPOINTMENT TIME**

Today's date: / /		Social Security #:	Gender:	Date of Birth: / /	
Last Name:		First Name:	Middle Name:	Previous/Maiden Name:	
Street Address:		City:		State:	Zip Code:
Preferred Contact Phone number:			Alternate Contact Phone Number:		
Employer:			Occupation:		
Family Doctor:			Email Address:		
Referred by: <input type="checkbox"/> Physician Name of Physician: _____		<input type="checkbox"/> Advertisement Where: _____			
<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Website			
<input type="checkbox"/> Family/Friend		<input type="checkbox"/> Other: _____			
Race: <input type="checkbox"/> Caucasian		<input type="checkbox"/> Black/African American		<input type="checkbox"/> Native American	
<input type="checkbox"/> Asian		<input type="checkbox"/> Hispanic/Latino		<input type="checkbox"/> Unspecified	
<b>INSURANCE INFORMATION</b>					
<b>Primary Insurance:</b>					
Subscriber's Name:		Subscriber's Social Security #:		Subscriber's DOB: / /	
Subscriber's Employer:		Relationship to Subscriber:			
Co-payment: \$		Insurance ID #:		Insurance Group #:	
<b>Secondary Insurance:</b>					
Subscriber Name:		Subscriber's Social Security #:		Subscriber's DOB: / /	
Subscriber's Employer:		Relationship to Subscriber:			
Co-payment: \$		Insurance ID #:		Insurance Group #:	
<b>IN CASE OF EMERGENCY</b>					
Name:			Relationship to patient:		
Home Phone #:		Cell Phone #:		Work Phone #:	



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191 Leader Heights Road | York, Pennsylvania 17402 | P 717.741.2214 | F 717.741.2204



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:** \_\_\_\_\_

Name: \_\_\_\_\_ ID#: \_\_\_\_\_

How long have you had your symptoms? \_\_\_\_\_

Where are the veins you are seeking a medical opinion for located?  Leg(s) Right / Left / Both

Chest  Other \_\_\_\_\_

Please check the box next to the symptoms that apply to you and how often?

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

At what time of the day do your leg symptoms bother you the most? \_\_\_\_\_

In the past 4 weeks, to what extent has your leg problems interfered with your daily living \_\_\_\_\_

Has your leg symptoms effected any of the following and how?

Sleep \_\_\_\_\_

Work \_\_\_\_\_

Sports \_\_\_\_\_

Daily activity \_\_\_\_\_

Social life \_\_\_\_\_

**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: \_\_\_\_\_





**PATIENT HEALTH ASSESSMENT QUESTIONNAIRE**

Name: \_\_\_\_\_ ID#: \_\_\_\_\_

Please list any hearing, vision or reading issues: \_\_\_\_\_

Do you have an Advanced Directive?      Yes      No

What Pharmacy do you use: \_\_\_\_\_ Address \_\_\_\_\_

Please bring a list of all your vitamins, supplements, over the counter medications and prescription medications, including the dose and strength, to your appointment or list them below. If you currently do not take any of the above, please write "NONE".

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are you allergic to latex?      Yes      No

Allergies: \_\_\_\_\_

**PAST MEDICAL HISTORY**

**Have you ever had any of the following?**

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:	Yes	No	Relationship	Your personal Habits:	Do you?
Heart Disease	Yes	No	_____	Exercise regularly	Yes    No
High Blood Pressure	Yes	No	_____	How often?	_____



# AVLC

**ADVANCED VEIN & LASER CENTER**  
*The Experienced Approach to Vein Health*

Diabetes Yes No \_\_\_\_\_  
 Stroke Yes No \_\_\_\_\_  
 Cancer Yes No \_\_\_\_\_  
 Thyroid Disease Yes No \_\_\_\_\_  
 Clotting Disorder Yes No \_\_\_\_\_  
 Varicose Veins Yes No \_\_\_\_\_  
 DVT/PE Yes No \_\_\_\_\_

Smoke/Use tobacco Yes No  
 How much? \_\_\_\_\_  
 Use tobacco in the past? Yes No  
 Drink alcohol? Yes No  
 How much? \_\_\_\_\_

**Females ONLY**  
 How many pregnancies have you had? \_\_\_\_\_

**REVIEW OF SYSTEMS – CURRENT/ACTIVE PROBLEMS**

**CONSTITUTION**

Appetite loss Yes No \_\_\_\_\_  
 Fatigue Yes No \_\_\_\_\_  
 Fevers Yes No \_\_\_\_\_

**EYES**

Blurred vision Yes No \_\_\_\_\_  
 Diminished vision Yes No \_\_\_\_\_  
 Double vision Yes No \_\_\_\_\_  
 Vision loss Yes No \_\_\_\_\_

**ENT**

Hearing loss \_\_\_\_\_  
 Ringing in ears Yes No \_\_\_\_\_  
 Sinus problems Yes No \_\_\_\_\_  
 Hoarseness Yes No \_\_\_\_\_  
 Sore throat Yes No \_\_\_\_\_

**CARDIAC**

Atrial fibrillation \_\_\_\_\_  
 Chest pain Yes No \_\_\_\_\_  
 Chest discomfort Yes No \_\_\_\_\_  
 Dizziness Yes No \_\_\_\_\_  
 Leg pain when walking Yes No \_\_\_\_\_  
 Palpitations Yes No \_\_\_\_\_  
 Swelling of ankles Yes No \_\_\_\_\_

**RESPIRATORY**

Breathing difficulty Yes No \_\_\_\_\_  
 COPD Yes No \_\_\_\_\_  
 Coughing blood Yes No \_\_\_\_\_  
 Wheezing Yes No \_\_\_\_\_

**GASTRO**

Abdominal pain Yes No \_\_\_\_\_  
 Gallbladder problems Yes No \_\_\_\_\_  
 Gastritis Yes No \_\_\_\_\_  
 Hemorrhoids Yes No \_\_\_\_\_  
 Liver disease Yes No \_\_\_\_\_  
 Gastric reflux Yes No \_\_\_\_\_  
 Change of stool color Yes No \_\_\_\_\_

Yes No \_\_\_\_\_

**WHEN?**

**GU**

Blood in urine Yes No \_\_\_\_\_  
 Kidney disease Yes No \_\_\_\_\_  
 Renal failure Yes No \_\_\_\_\_  
 Excessive urination Yes No \_\_\_\_\_  
 Decreased urination Yes No \_\_\_\_\_  
 Painful urination Yes No \_\_\_\_\_

**MUSCLE/SKELETAL**

Bone/Joint deformity Yes No \_\_\_\_\_  
 Limitations of movement Yes No \_\_\_\_\_  
 Muscle aches Yes No \_\_\_\_\_  
 Back pain Yes No \_\_\_\_\_

**SKIN**

Dryness Yes No \_\_\_\_\_  
 Itchy skin Yes No \_\_\_\_\_  
 Changes in moles Yes No \_\_\_\_\_

**NEURO**

Confusion Yes No \_\_\_\_\_  
 Depression Yes No \_\_\_\_\_  
 Fainting Yes No \_\_\_\_\_  
 Headache Yes No \_\_\_\_\_  
 Migraine Yes No \_\_\_\_\_  
 Memory lapses Yes No \_\_\_\_\_  
 Numbness Yes No \_\_\_\_\_  
 Seizures Yes No \_\_\_\_\_  
 Stroke Yes No \_\_\_\_\_  
 Weakness Yes No \_\_\_\_\_

**ENDOCRINE**

Diabetes w/ Insulin Yes No \_\_\_\_\_  
 Diabetes w/o Insulin Yes No \_\_\_\_\_  
 Thyroid disease Yes No \_\_\_\_\_

**HEMA/LYMPH**

Anemia Yes No \_\_\_\_\_  
 Bleeding/clotting disorder Yes No \_\_\_\_\_  
 Bruising easily Yes No \_\_\_\_\_

**WHEN?**





### Screenings

Have you had any of the following?

Pneumonia Vaccine	Yes	No	<b>When:</b>
Flu Vaccine	Yes	No	<b>When:</b>
Covid Vaccine	Yes	No	<b>When:</b>
Mammogram	Yes	No	<b>When:</b>
Colonoscopy	Yes	No	<b>When:</b>

### In the past 12 months, . .

- |                            |                            |   |                            |                            |  |
|----------------------------|----------------------------|---|----------------------------|----------------------------|--|
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Fell two or more times.   | <input type="checkbox"/> Y | <input type="checkbox"/> N | Took medication that caused me to feel dizzy or light headed.                |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Was injured by a fall that limited my regular activities for at least one day.  | <input type="checkbox"/> Y | <input type="checkbox"/> N | Took 9 or more different medications.  |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Saw a doctor because I had a fall.  | <input type="checkbox"/> Y | <input type="checkbox"/> N | Stopped some of my regular activities.                                       |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Found it hard to climb stairs or walk a short distance.                         | <input type="checkbox"/> Y | <input type="checkbox"/> N | Have been taking a calcium supplement regularly. If “Yes”, how much per day: |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Had trouble getting up from a soft chair.                                       | <input type="checkbox"/> Y | <input type="checkbox"/> N | Have not had my vitamin D level in my blood checked.                         |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Have been unable to stand on one foot for 12 seconds without losing my balance. | <input type="checkbox"/> Y | <input type="checkbox"/> N | Danced, exercised, or practiced Tai Chi at least 3 times a week.             |





- Y     N    Trouble with my eyesight.                       Y     N    Has my home checked for any dangers and modified as needed?
- Y     N    Felt dizzy or light headed after a big meal.

**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 \_\_\_\_\_

**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. The use and publication of the photographs in whole or in part, individually or in conjunction with other photographs, in any medium for any purpose including medical records, professional journals, medical textbook, art, illustration, promotion, advertising or trade.
2. 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.
3. 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

**CANCELLATION POLICY**

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

\_\_\_\_\_  
PATIENT SIGNATURE FOR CANCELLATION POLICY

\_\_\_\_\_  
Date

July 16, 2020

Dear Valued Patient:

In the recent months, we have adopted new payment policies in our practice. We feel these policies are fair across the board for all of our patients. We would like to keep providing the exceptional care for other patients as we did for you. If you have a large deductible, you may be asked to pay a portion upfront if you are having procedures done in our office, but we are willing to work with you in any way we can if this is a financial hardship.

If at any time during your care at our practice, your balance owed becomes greater than \$1000, you will be asked to apply for CareCredit. This is a revolving line of credit that is interest free for up to 18 months with lower monthly payments than what we can offer you. If you are denied for CareCredit, you must provide us with documentation and we will set up payment arrangements for you but your balance will not be held for more than 18 months and can possibly incur finance charges.

If any payment during our repayment period is more than 30 days past due, we will be reserve the right to send your account to collections. This agreement was signed within your new patient packet.



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We are making these changes to keep providing care to our current patients and our new patients. We are asking that you apply for CareCredit and contact our office after you have done so. The web address is: [www.carecredit.com](http://www.carecredit.com)  
The Management of Advanced Vein and Laser Center

**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.

**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.**

