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

SS #:	Gender:	Date of Birth: / /

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

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:	Your email Address:

Referred by:
□ Physician
Name: ____________________ Location: ________________
□ Insurance Plan
□ Family/Friend
□ Advertisement
□ Website
□ Other: ____________________

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

INSURANCE INFORMATION

Primary Insurance:

Subscriber's Name:	Subscriber's DOB: / /
Subscriber's Employer:	Relationship to Subscriber:

Co-payment: $	Insurance ID #:	Insurance Group #:

Secondary Insurance:

Subscriber Name:	Subscriber's DOB: / /
Subscriber's Employer:	Relationship to Subscriber:

Co-payment: $	Insurance ID #:	Insurance Group #:

EMERGENCY CONTACT

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:________________

VENOUS HISTORY

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 □ Face
□ Other: _______________
* Varicosities of the genital area:
Do you prefer same sex staff when being examined/treated by physician?
□ Yes □ Doesn't matter

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	______________________
Venous ultrasound	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 ALL operations you have had:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

PATIENT HEALTH ASSESSMENT QUESTIONNAIRE

Please list any physical limitations: ____

Please list any hearing, vision or reading issues: ______________________________________

Do you have an Advanced Directive? □ Yes □ No

HEALTH SCREENINGS: When?

Pneumonia vaccine	Yes	No	________________
Covid vaccine	Yes	No	________________
Flu vaccine	Yes	No	________________
Colonoscopy	Yes	No	________________
Mammogram	Yes	No	________________

MEDICATIONS & SUPPLEMENTS

Your local Pharmacy: ______________________ Location: __________________________________

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"**.

________________	________________	________________
________________	________________	________________
________________	________________	________________
________________	________________	________________

ALLERGIES:

Are you allergic to latex? ◻ Yes ◻ No

Allergies: ____

PAST MEDICAL HISTORY

Have you ever had any of the following?

			When?				When?
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
Heart Disease	Yes	No	__________
High Blood Pressure	Yes	No	__________
Diabetes	Yes	No	__________
Stroke	Yes	No	__________

Your personal Habits:	Do you?	
Exercise regularly	Yes	No
How often? ____________		
Smoke/Use tobacco	Yes	No
How much? ____________		

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Cancer	Yes	No	___________
Thyroid Disease	Yes	No	___________
Clotting Disorder	Yes	No	___________
Varicose Veins	Yes	No	___________
DVT/PE	Yes	No	___________

Use tobacco in the past?	Yes	No
Drink alcohol?	Yes	No

How much? ______________

Females ONLY

How many pregnancies have you had? _______

REVIEW OF SYSTEMS

Do you CURRENTLY have any of the following?

			WHEN?
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	Yes	No	___________
Ringing in ears	Yes	No	___________
Sinus problems	Yes	No	___________
Hoarseness	Yes	No	___________
Sore throat	Yes	No	___________
CARDIAC			
Atrial fibrillation	Yes	No	___________
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	___________
Hypertension	Yes	No	___________
RESPIRATORY			
Breathing difficulty	Yes	No	___________
COPD	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	___________

Coughing blood	Yes	No	____________
Wheezing	Yes	No	____________
GASTRO			
Abdominal pain	Yes	No	____________
Gallbladder problems	Yes	No	____________
Gastric reflux	Yes	No	____________
Hemorrhoids	Yes	No	____________
Liver disease	Yes	No	____________
Change of stool color	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	____________

VEINS QUALITY OF LIFE

1. During the past 4 weeks, how often have you had any of the following leg problems?					
	Every day	Several times a week	About once a week	Less than once a week	Never
Heavy legs	1	2	3	4	5
Achy legs	1	2	3	4	5
Swelling	1	2	3	4	5
Night cramps	1	2	3	4	5
Heat or burning sensation	1	2	3	4	5
Restless leg	1	2	3	4	5
Throbbing	1	2	3	4	5
Itching	1	2	3	4	5
Tingling sensation	1	2	3	4	5

2. At what time of day is your leg problem most intense?(choose only one)

1. On waking 2. At mid-day 3. At the end of the day
4. During the night 5. At any time of day. 6. Never

3. Compared to a year ago, how would you rate your leg problem now? (choose only one)

1. Much better 2. Somewhat better 3. About the same
4. Somewhat worse 5. Much worse 6. I didn't have leg problems

4. Does your leg problem now limit you in these activities? If so, how much?				
	I do not work	Yes, limited a lot	Yes, limited a little	No, not at all
Daily work activities	0	1	2	3
Daily home activities(housework)		1	2	3

Social or leisure activities in which you are standing for long periods of time(parties, weddings)	1	2	3
Social or leisure activities in which you are sitting for long periods of time(movies, traveling	1	2	3

5. During the past 4 weeks, to what extent has your leg problem interfered with your normal social activities? (choose only one)

1. Not at all
2. Slightly
3. Moderately
4. Quite a bit
5. Extremely

6. How much leg pain have you had during the past 4 weeks? (choose only one)

1. None
2. Very mild
3. Mild
4. Moderate
5. Severe
6. Very severe

7. During the past 4 weeks, have you had any of the following problems with your work or daily activities as a result of your leg problem?		
	Yes	No
Cut down on the amount of time you spent on work or other activities.	1	2
Accomplished less than you would like.	1	2
Were limited in the kind of work or other activities.	1	2
Had difficulty performing work or other activities.	1	2

8. These questions are about how you feel and how things have been going with you during the last 4 weeks. Please give one answer that comes closest to the way you were feeling during the last 4 weeks.						
	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
Have you felt concerned about the appearance of your legs?	1	2	3	4	5	6
Have your felt irritable?	1	2	3	4	5	6
Have you felt like a burden to your friends or family?	1	2	3	4	5	6

Have you been worried about bumping into things?	1	2	3	4	5	6
Has the appearance of your leg(s) influenced your choice of clothing?	1	2	3	4	5	6

ADVANCED DIRECTIVE DECLARATION
(To be completed ONLY if you are 60 years of age of older)

I, ______________________________, being of sound mind, willfully and voluntarily make this declaration to be
Name

followed if I become incompetent. This declaration reflects my firm settles commitment to refuse life-sustaining treatment under the circumstances indicated below.

I direct my attending physician to withhold or withdraw life sustaining treatment that serves only to prolong the process of dying if I should be in a terminal condition or in a state of permanent unconsciousness.

I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing life-sustaining treatment.

In addition, if I am in the condition described above, I feel especially strongly about the following forms of treatment.

I DO	I DO NOT	
□	□	Want cardiac resuscitation.
□	□	Want mechanical respiration.
□	□	Want feeding tube.
□	□	Want other artificial or invasive form of nutrition (food).
□	□	Want other artificial or invasive form of hydration (water).
□	□	Want blood or blood products.
□	□	Want any form of surgery.
□	□	Want any invasive diagnostic tests.
□	□	Want kidney dialysis.
□	□	Want antibiotics.
□	□	Want other:

I realize that if I do not specifically indicate my preference regarding any of the forms of treatment listed above, I may receive that form of treatment.

Other instructions:

I DO	I DO NOT	
□	□	Want to donate my organs upon death.
□	□	Want to designate a surrogate to make medical treatment decisions for me if I should be incompetent in a terminal condition or in a state of permanent unconsciousness. Surrogate (name and address):

Signature: ____ Date: _____________________

The above-named individual or a person on behalf of and at the direction of the individual knowingly and voluntarily signed this writing by signature or mark in my presence.

Witness's Signature: _____________________________________ Date: ______________________

FINANCIAL POLICIES

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 Policy

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____________________

Cancellation Policy

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

Patient/Guarantor Signature _________________________________ Date____________________

High Deductible Healthcare Plan Policy

Advanced Vein and Laser Center has adopted a new payment policy. 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 reserve the right to send your account to collections. This agreement was signed within your new patient packet.

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

I have read and understand the above policy regarding the high deductible healthcare plan policy.

Patient/Guarantor Signature ____________________________________ Date____________________

INFORMED CONSENTS

Photos

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/Guarantor Signature ____________________________________ 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/Guarantor Signature ____________________________________ Date____________________

Telemedicine Services

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists. And/or subspecialists. The information may be used for diagnosis, therapy, follow-up and education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and visual
- Output data from medical devices and sound and video files
- Telephone consultation

Electric systems used will incorporate network and software security protocols to protect the confidentiality and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

Your **telemedicine** visit gives you and your provider the ability to evaluate your legs and surgical puncture sites, review your ultrasound report and post procedural care, and allows you to ask questions all at a safe distance in the convenience of your home (must have visual capability and **wear shorts**).

Your **telephone consult** allows you to speak with a medical provider over the phone to address your concerns or for medical guidance.

Risks:

As with any medical procedure, there are potential risks associated with use of telemedicine. These risks include, but not limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the provider

- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment

- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

- I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual when he/she is located at a different location or site than I am.
- I understand that the **telemedicine** visit will be done through a two-way video link-up.
- I understand that I may request a **telephone consultation** with a provider and will be a **telephone- to- telephone** communication.
- I understand that the laws that protect privacy and the confidentiality of medical information including (HIPPA) also apply to telemedicine or telephone consult.
- I understand that my insurance will be billed and that I will be responsible for any copayments or coinsurances that apply to my telemedicine or telephone consult visit.
- I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without effecting my right to future care or treatment.
- I understand that by signing this form that I have read the risks and benefits of telemedicine and/or telephone consultation and that I am consenting to receive health care services via telemedicine or telephone consult.

Patient/Guarantor Signature ___________________________________ Date____________________

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.

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