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 □ Advertisement
Name of Physician: _____ Where: _____
□ Insurance Plan □ Website
□ Family/Friend □ 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?

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	_____
Cancer	Yes	No	_____
Thyroid Disease	Yes	No	_____
Clotting Disorder	Yes	No	_____
Dementia	Yes	No	_____
DVT/PE	Yes	No	_____
Other _____			_____

Your personal Habits:	**Do you?**	
Exercise regularly	Yes	No
How often? _____		
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? _____

How many deliveries have you had? _____

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Name: _____ ID#: _____

REVIEW OF SYSTEMS – CURRENT/ACTIVE PROBLEMS

CONSTITUTION			**WHEN?**
Appetite loss	Yes	No	_____
Fatigue	Yes	No	_____
Fevers	Yes	No	_____
EYES			
Retinal problems	Yes	No	_____
Blurred vision	Yes	No	_____
Diminished vision	Yes	No	_____
Double vision	Yes	No	_____
Vision loss	Yes	No	_____
ENT			
Discharge from ears	Yes	No	_____
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	_____
Congenital heart disease	Yes	No	_____
Dizziness	Yes	No	_____
Leg pain when walking	Yes	No	_____
Calf pain when walking	Yes	No	_____
Palpitations	Yes	No	_____
Swelling of ankles	Yes	No	_____
RESPIRATORY			
Bronchitis	Yes	No	_____
Breathing difficulty	Yes	No	_____
COPD	Yes	No	_____
Coughing blood	Yes	No	_____
Pneumonia	Yes	No	_____
Wheezing	Yes	No	_____
GASTRO			
Abdominal pain	Yes	No	_____
Gallbladder problems	Yes	No	_____
Gastritis	Yes	No	_____
Hemorrhoids	Yes	No	_____
Jaundice	Yes	No	_____
Liver disease	Yes	No	_____
Gastric reflux	Yes	No	_____
Change of stool color	Yes	No	_____
Bloody stools	Yes	No	_____
Painful swallowing	Yes	No	_____
Bloody vomit	Yes	No	_____

GU			**WHEN?**
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	_____
Rash	Yes	No	_____
NEURO			
Ataxia	Yes	No	_____
Fainting	Yes	No	_____
Headache	Yes	No	_____
Migraine	Yes	No	_____
Memory lapses	Yes	No	_____
Numbness	Yes	No	_____
Paralysis	Yes	No	_____
Seizures	Yes	No	_____
Unclear speech	Yes	No	_____
Stroke	Yes	No	_____
Weakness	Yes	No	_____
PSYCH			
Anxiety	Yes	No	_____
Confusion	Yes	No	_____
Delusions	Yes	No	_____
Depression	Yes	No	_____
ENDOCRINE			
Diabetes w/ Insulin	Yes	No	_____
Diabetes w/o Insulin	Yes	No	_____
Intolerance to cold	Yes	No	_____
Thyroid disease	Yes	No	_____
HEMA/LYMPH			
Anemia	Yes	No	_____
Bleeding/clotting disorder	Yes	No	_____
Bruising easily	Yes	No	_____
IMMUNIZATIONS			
Pneumonia vaccination	Yes	No	_____
SCREENINGS			
Colonoscopy	Yes	No	_____

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Name: _____ ID#: _____

In the past 12 months, . . .

☐ Y ☐ N	Fell two or more times.	☐ Y ☐ N	Took medication that caused me to feel dizzy or light headed.
☐ Y ☐ N	Was injured by a fall that limited my regular activities for at least one day.	☐ Y ☐ N	Took 9 or more different medications.
☐ Y ☐ N	Saw a doctor because I had a fall.	☐ Y ☐ N	Stopped some of my regular activities.
☐ Y ☐ N	Found it hard to climb stairs or walk a short distance.	☐ Y ☐ N	Have been taking a calcium supplement regularly. If "Yes", how much per day:
☐ Y ☐ N	Had trouble getting up from a soft chair.	☐ Y ☐ N	Have had my vitamin D level checked.
☐ Y ☐ N	Have been unable to stand on one foot for 12 seconds without losing my balance.	☐ Y ☐ N	Exercised regularly
☐ Y ☐ N	Trouble with my eyesight.	☐ Y ☐ N	Had 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:_____

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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**

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PHOTO CONSENT

Subject to the conditions herein, 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. I understand that the picture of my face will not be used for any purpose other than in office chart recognition and confirmation of identity. I understand that the purpose of pictures of my legs is to track progress of my treatments and healing. These pictures will never be used for any marketing purposes unless an additional release is presented to and signed by me.

_____ _____

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.

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.