Fort Myers Vein SPECIALISTS

New Patient Registration

Today's Date:	Family Doctor:	Family Doctor Phone #:
Pharmacy:	Pharmacy Phone #:	How did you hear about us? ☐ FortVein.com ☐ Advertisement ☐ Facebook ☐ Google ☐ Referred by:
*Email Address:		

PATIENT INFORMATION

Last Name, First Name, Middle		Date of Birth:
Address:		
City:	State:	Zip Code:
Social Security #:	Home Phone #:	Cell Phone #:
Occupation:	Employer:	Employer #:

INSURANCE INFORMATION

Please provide your insurance card and driver's license to the receptionist.

Primary Insurance:		Primary Insurance Phone #:
Subscriber's Name:	Subscriber's SSN:	Subscriber's DOB:
Member ID #:	Patient's Relationship to Subscriber:	Specialist Co-pay:
Secondary Insurance(if applicable):		

IN CASE OF AN EMERGENCY

NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER

The above information is true to the best of my knowledge I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Florida Vein Care Specialists or insurance company to release any information required to process my claims.

Print Name _____ Patient Signature _____ Date _____

*By providing your email address you agree to recieve appointment confirmation via email in addition to a phone call reminder. You are also opting in to receive future emails from Fort Myers Vein Specialists that may include post op follow-up, promotions and upcoming events. We do not sell your information and you can unsubscribe at any time.

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Health History

Today's Date:	
Patient Name:	What, if any, prior treatment have you received?
Reason for visit today:	How long have you had this problem?

MEDICAL HISTORY Please check the box if you have experienced and/or have been treated for any of the following:

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Stroke
- ☐ Heart Attack
- ☐ Bleeding Disorder
- ☐ High Cholesterol
- ☐ Asthma/COPD/Emphysema
- ☐ Liver Problems
- ☐ Anemia
- ☐ Kidney/Bladder/Urine Tract Problems
- ☐ Congestive Heart Failure
- ☐ Blood Clots/Deep Vein Thrombosis
- ☐ Blood Transfusions
- ☐ Digestive Disorders
- ☐ Thyroid Disorder
- ☐ Epilepsy/Seizure Disorder
- ☐ Depression/Anxiety /Mood Disorder
- ☐ Glandular/Hormonal Problems
- ☐ Other:

SURGERIES Please list below the type and date of any surgeries you have had.

TYPE OF SURGERY	DATE

CURRENT MEDICATIONS Please list any medications that you are currently taking.

_____

_____

DRUG ALLERGIES Please list any known drug allergies.

_____

_____

SOCIAL HISTORY

ALCOHOL USE: _____YES _____ NO IF YES, HOW OFTEN?_____

TOBACCO USE: _____YES _____ NO IF YES, HOW OFTEN?_____

CONTINUED ON THE NEXT PAGE.

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Health History continued

FAMILY HISTORY

Please check if any of the following apply to anyone in your immediate family.
If yes, please indicate what family member.

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Stroke
- ☐ Heart Attack
- ☐ Bleeding Disorder
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Other:

CURRENT MEDICAL

Please check if you have experienced and/or have been treated for any of the following:

- ☐ Tightness or Pain in Chest
- ☐ Joint Stiffness, Swelling or Pain
- ☐ Sudden Heartbeat Changes
- ☐ Muscle Weakness, Cramps or Pain
- ☐ Shortness of Breath
- ☐ Memory Loss or Confusion
- ☐ Difficulty Walking
- ☐ Numbness/Tingling of Face, Arms. Hands, Legs or Feet
- ☐ Dizziness or Fainting
- ☐ Swelling of Face, Legs, Ankles, Feet or Hands
- ☐ Loss of appetite
- ☐ Swollen Glands
- ☐ Recent Weight Change
- ☐ Tremors
- ☐ Nausea/Vomiting
- ☐ Back Pain
- ☐ Convulsions or Seizures
- ☐ Stomach Pain
- ☐ Frequent or Recurrent Headaches
- ☐ Change in Bowl Movements
- ☐ Easily Bruise or Bleed
- ☐ Constipation, Diarrhea, or Blood in Stool
- ☐ Slow to Heal after Cuts
- ☐ Excessive Thirst
- ☐ Bleeding Gums
- ☐ Frequent Urination
- ☐ Nose Bleeds
- ☐ Trouble Sleeping
- ☐ Dry Skin
- ☐ Fatigue
- ☐ Heat or Cold Intolerance
- ☐ Nervousness, Depression or Anxiety

Print Name _____ Patient Signature _____ Date _____

Fort Myers Vein SPECIALISTS

PATIENT FINANCIAL RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.
- If you are scheduled for an ultrasound appointment and do not show there will be a $50 charge to your account.
- $250 cancellation fee for prodecures. 24 HOUR NOTICE IS REQUIRED.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to Fort Myers Vein Specialist on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize Fort Myers Vein Specialist to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. MEDICARE REQUEST FOR PAYMENT

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Fort Myers Vein Specialist. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services. Signature of Patient, Authorized Representative or Responsible Party Date Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient

_____ _____

Signature of Patient, Authorized Representative or Responsible Party Date

_____ _____

Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient

Fort Myers Vein SPECIALISTS

NOTICE OF PRIVACY PRACTICES

Fort Myers Vein Specialist
4961 Royal Gulf Circle
Fort Myers, FL 33966

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our office.

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How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a electronic health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business

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NOTICE OF PRIVACY PRACTICES continued

associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk

Fort Myers Vein SPECIALISTS

NOTICE OF PRIVACY PRACTICES continued

of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

18. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

19. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/ record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

20. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate information.

21. Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment, 2) for training our staff, students and other trainees, 3) to defend ourselves if you sue us or bring some other legal proceeding, 4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, 5) in response to health oversight activities concerning your psychotherapist, 6) to avert a serious and imminent threat to health or safety, or 7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.

22. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that

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NOTICE OF PRIVACY PRACTICES continued

information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices. Changes to this Notice of Privacy Practices We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

_____ _____

Patient Signature Date

Primary Provider: Jared Reiss PA-C
Fax: (321) 421-0393

Fort Myers Vein SPECIALISTS

PROCEDURE CONSENT

Patient: _____ DOB: _____ Date: _____

Endoluminal Venous Ablation [ ] Left Leg [ ] Right Leg [ ] Bilateral
During this procedure, local anesthesia is injected around the targeted vein. A small fiber catheter will be placed into the vein under ultrasound guidance. Laser energy is delivered to the target vein selectively. A compression dressing will be applied and stockings will be required to be worn according to post op information sheet.

Stab Phlebectomy [ ] Left Leg [ ] Right Leg [ ] Bilateral
During this procedure, local anesthesia will be injected in the previously marked areas. Multiple small 2-3 mm incisions will be made along the targeted veins and they will be gently removed. A compression dressing will be applied and stockings will be to be worn according to post op information sheet.

Sclerotherapy/ Veingogh [ ] Left Leg [ ] Right Leg [ ] Bilateral
During this procedure, small spider or varicose veins will either be injected with sclerosing solution or treated with a laser or both. A compression dressing may be applied, if so stockings should be worn according to post op information sheet.

Risks and Discomfort
If the patient undergoes endoluminal venous ablation, stab phlebectomy, and/or sclerotherapy the symptoms of varicose veins and/or cosmetic results may improve, remain the same, or worsen. The potential side effects are thermal injury (burning to the overlying skin or surrounding tissue), bleeding from the perforation of a vein, deep vein thrombosis (blood clot), breaking the laser fiber, superficial phlebitis (inflammation of the vein), hyperpigmentation (darkening of the overlying skin), or neovascularization (growth of a vein). Problems and side effects that are not known or are not common, may also occur. Most commonly the procedure may cause dizziness, bleeding, discomfort, pain, and rarely infection. Any invasive procedure carries the risk of infection, bleeding, organ damage and/or death. Local anesthesia is used to minimize discomfort but may not be completely effective in preventing significant procedural pain. Rarely, patients can have an allergic reaction to local anesthesia such a Lidocaine. There is no guarantee that the patient will receive any medical benefit as the result of endoluminal venous ablation, stab phlebectomy, and/or sclerotherapy. It is possible that the condition may remain the same or worsen. It is possible for varicose veins and spider veins to occur at a later date.

Potential Complications Of Not Undergoing Treatment
Potential complications of not undergoing treatment are often limited to merely worsening of the condition such as increased number of veins, enlargement of existing veins, occurrence of new veins, and/or worsening of the symptoms or appearance of the veins. In the case of a large varicose vein, spontaneous superficial phlebitis or bleeding may occasionally occur. Patients with varicose veins associated with underlying venous insufficiency may develop chronic ankle swelling and/or skin change such as eczema, hyperpigmentation, and skin ulcers.

Alternative Treatment
Since varicose veins and spider veins are not life threatening, treatment is not mandatory. Some patients may get adequate relief by wearing compression stockings. Alternative treatment to varicose veins include surgical ligation and stripping.

Potential Benefits
The potential benefits of the procedure are the reduction in size of treated veins, improvement in appearance of the vein, and improvement or resolution of varicose symptoms such as swelling, heaviness, itching, aching and bleeding. By signing below, I acknowledge that I have read and understand the above and I have been adequately informed of the nature, intent, purpose, and significant risk and consequences of endoluminal venous ablation, stab phlebectomy, and/or sclerotherapy. I have been given ample opportunity to ask questions about my conditions and options and I authorize taking and usage of photographs and/or video to document clinical courses: [ ]Yes [ ]No

Patient Signature: _____ Date: _____ Time: _____
Witness Signature: _____ Date: _____ Time: _____
Provider Signature: _____ Date: _____ Time: _____