PREMIER VEIN & BODY by SCHWARTZ

PATIENT INFORMATION

NAME_____
LAST FIRST M.I.

ADDRESS_____

CITY_____STATE_____ZIP_____

HOME PHONE_____CELL_____

EMAIL_____

Preferred method of contact_____

Ok to leave a message Yes_____ No_____

AGE _____ DATE OF BIRTH _____

SOCIAL SECURITY NUMBER_____

OCCUPATION_____
(If retired, please list prior work above)

EMPLOYER_____

WORK PHONE_____

MARITAL STATUS_____

SPOUSE NAME_____

Spouse's phone #_____

Spouse's Employer _____

HEALTH INSURANCE

PRIMARY CARRIER_____

INSURANCE ADDRESS_____

INS. ID #_____

GROUP #_____

Policyholder's Name _____

Policyholder's DOB_____

Policyholder's SS #_____

Secondary Carrier_____

Insurance Address_____

Insurance ID#_____

Group #_____

Contact person other than your spouse

_____

Relationship _____Phone_____

FAMILY DOCTOR_____

NUMBER_____

REFERRING DOCTOR OR ANY OTHER MEDICAL DOCTORS YOU CURRENTLY SEE_____

PHONE NUMBER _____

NAME OF PREFERRED PHARMACY _____

TOWN/CITY_____PHONE NUMBER _____

YOUR FIRST VISIT IS A SCREENING / CONSULT WITH THE DOCTOR. IF YOU HAVE ANY QUESTIONS REGARDING THE INFORMATION ENCLOSED, PLEASE CALL OUR OFFICE.

List All Medications You Now Take, The Dose And How Often:

_____None

	Medication	Dose	Frequency
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

Drug Allergies_____

Do you have allergy to Latex _____
Do you Have A History of Allergy or Reaction to X-Ray Dye or Iodine? _____

SOCIAL HISTORY

Type of Work _____
Coffee _____ (cups per day) _____
Tobacco_____ (If yes how may packs per day)_____for_____ years
If yes had FP advised quitting or recommended cessation strategies?_____
Quit?_____ What Year?_____
Alcohol_____ Amount_____

FAMILY HISTORY

	Age	State of Health & Diagnosis	Age at Death and Cause of Death
Father			
Mother			
Brother(s)			
Sister(s)			

Father's Father_____
Father's Mother_____
Mother's Father_____
Mother's Mother_____

MEDICAL HISTORY

The following information will help your physician plan your care.

Appointment Date_____Name_____

Sex: Male_____ Female_____ Age_____ Date of Birth_____

Height: _____ Weight: _____

For What Problem Are you Seeking Care?_____

How Long Has It Been Present?_____

Are you currently wearing compression stockings/hose?_____

If Pain Is Present, Please Describe How Often:_____

Severity (1=Minimal to 10=Severe)_____

Quality/Symptoms (Sharp, Dull, Cramps, Burning, Etc.)_____

_____

What Makes Pain Better?_____

What Makes Pain Worse?_____

Approximate Date and Hospital of Last visit/test:

EKG_____Chest X-Ray_____Screening for Osteoporosis (females)_____

Blood Work_____ Carotid Ultrasound_____ Urinary Incontinence (females)_____

Arteriogram_____ Cardiac Cath_____ Influenza Vaccine(if over 50)_____

Mammogram_____Colonoscopy_____ Fecal occult blood test _____

Pap Smear_____ Have you ever received a pneumococcal vaccination?_____

Check and/or List all Illnesses you have been treated for in the Past and Present:

____None	_____Heart Attack	_____Angina	_____Diverticulitis
____Heart Murmur	_____Mitral Valve Prolapse	_____High Blood Pressure	_____Chrohn's Disease
____Stroke	_____Asthma	_____Low Blood Pressure	_____Ulcerative Colitis
____Blood Clots	_____Stomach Trouble/Ulcer	_____Bleeding Disorder	_____Hepatitis
____COPD	_____Emphysema	_____Kidney Problems	_____Seizures
____Bladder	_____Arthritis	_____Diabetes	_____Tuberculosis
____Cancer	_____Depression	_____Cirrhosis	_____Back pain

____Other_____

____Other_____

Check and/or List All Surgeries You Have Had:

____None	____Appendix	____Tonsils	____Colon Surgery
____D & C	____Tubal Ligation	____Hernia	____Thyroid Surgery
____Cataract	____Heart Surgery/Bypass	____Ulcer Surgery	
____Pacemaker	____Prothesis	____Plates, Pins, Screws in Bones	

____Other _____

LATEX ALLERGY SCREENING AND QUESTIONNAIRE

Name_____ Social Security/Employee ID#_____

Have you ever suffered from:	Yes	No	If yes, please explain
> Allergic rhinitis, conjunctivitis			
> Asthma, chronic bronchitis			
> Eczema, hives, unexplained rash			
> Hay fever, sinus problems			
> Reactions to bandaids or adhesive tape			
Have you reacted from handling:	Yes	No	If yes, please explain:
* Poinsettia plant			
* Balloons, rubber gloves, other rubber products			
* Elastic or other stretchy fabric or clothing			
* Elastic bandages			
Have you had the following after a dental visit:	Yes	No	If yes, please explain:
• Itching, tearing			
• Sneezing, runny nose			
• Unexplained fatigue, drowsiness			
• Facial swelling, itchiness, redness			
Have you ever reacted after eating:	Yes	No	If yes, please explain:
➢ Avocados			
➢ Bananas			
➢ Tropical fruit, kiwi, papayas			
➢ Chestnuts			
Have you had:	Yes	No	If yes, please explain:
▪ Many surgeries			
▪ Many urinary catheters			
▪ Spina bifida			
▪ Many drug and/or environmental allergies			
❖ **IF YOU ARE SENSITIVE TO NATURAL LATEX RUBBER, HAVE YOU BEEN TESTED?**	Yes	No	If yes, please explain:
❖ **DO YOU WEAR A MEDIC ALERT BRACELET?**			
❖ **HAVE YOU BEEN TOLD BY A DOCTOR THAT YOU ARE ALLERGIC TO LATEX?**			
❖ **DOES YOUR JOB INVOLVE FREQUENT CONTACT WITH LATEX PRODUCTS?**			

Premier Vein & Body by Schwartz

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care. If you have medical insurance, we are qualified to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Vein Surgery Patients: As a courtesy, we will send your photos and medical information to your insurance company. The letter will request that your insurance company send you a letter stating whether these procedures/supplies are covered and how much they will pay. This letter is normally sent out within 1-2 weeks of your first visit to our office. If you do not hear from your insurance company within 6-8 weeks, we recommend that you contact them for their response. We have no control over whether they respond to this request. (This letter will not be sent to Medicare or secondary insurance).

Payment for services not covered by insurance is due at the time services are rendered unless payment arrangements have been approved in advance by our management. All other balances must be paid within 30 days of the balance becoming the patient's responsibility. Returned checks and balances older than 30 days will be subject to additional collection fees and interest charges of **2% per month**.

**** We require at least TWO (2) WEEK notice for all surgery cancellations or reschedules. A $200 fee will be charged if TWO (2) WEEK notice is not provided, and increased to a $500 fee for any cancellation or reschedule within 48 HOURS (2 business days) of the scheduled procedure or appt. We require 48 HOURS (2 business days) notice for spider vein and/or all other treatment session cancellations or reschedules, or a $100 fee will be charged**

**** Initial consultations, which are not cancelled within 48 hours, will not qualify for the courtesy/complimentary screening.**

**** _____(Initial) Venous Duplex Ultrasound examination is a separate charge and is NOT included with the complimentary screening.**
Your visual vein screening evaluation and subsequent discussion with the physician is complimentary. However, if a patient presents with symptoms of varicose veins, a diagnostic ultrasound test will be medically necessary to determine the source of the diseased varicose veins, and will be billed as a separate charge to your insurance company. Depending on your insurance plan you may owe ALL or a portion of the claim.

You must realize, however that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most insurance companies. This statement does not apply to insurance companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. Please contact your insurance for verification of participating coverage.
5. For Medicare Risk Plan HMO patients, we do not participate with your HMO, therefore you will be responsible for all charges out of Pocket.
6. For Medicare patients, we do accept assignment with Medicare. Therefore, we will file your vein surgery claims, and Laser and Sclerotherapy claims for symptomatic varicose veins to Medicare and you will be responsible for the Medicare co-insurance amount And deductible. You will be responsible for payment of any non-covered services/supplies and no claim will be sent to Medicare.
7. **Any insurance payment paid to you by your insurance company must be paid to Premier Vein & Body within one (1) week of Receipt.**
8. Self payment arrangements will be void if insurance is later presented or insurance covers procedure(s).

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment on your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of you account.

I hereby request that payment of authorized Medicare/Insurance Company benefits be made directly to Premier Vein & Body for any services furnished to me by its physicians. I authorize release to the Health Care Financing Administration or said insurance company and its agents any medical information about me needed to determine these benefits or benefits payable for related services.
I have read and fully understand the above statements regarding payment policies, and agree that I am responsible for any fees incurred on account of services provided to me.

Print Name: _____ Patient/Guarantor's Signature: _____

Witness signature: _____ Date: _____

ACKNOWLEDGEMENT FORM

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Premier Vein & Body **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the content of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____ **Date:** _____

If not signed by patient, please indicate relationship to patient_____

Witnessed by: _____

If the patient refuses to sign, indicate your attempt to obtain a signature below.

[ ] Patient refused to sign this Acknowledgement

Employee Name: _____Date:_____Time:_____

Language:_____ [ ] Declined to answer **Race:** _____ [ ] Declined to answer

Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ]Declined to answer

I acknowledge that I have disclosed my complete medical history and the above is a complete and accurate representation of my medical and psychological status.

I, _____, represent to the physicians and staff that I am at least 18 years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize a history examination by my doctor and such assistant or staff as may be assigned by him/her.

I understand that photography is a necessary part of planning and evaluating cosmetic procedures. I authorize the taking of photographs at the direction of my physician or physician delegate and under such conditions as may be approved by him/her. It is understood the use of photographs is for illustrating the medical procedure and demonstration of treatment outcomes. It is also understood that the use of the photographs will in no way reveal the patient's name.

Signature:_____ Date:_____

Witness:_____ Date:_____

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Cancellation Policy

For cosmetic or aesthetic treatment sessions, such as Sclerotherapy, SculpSure, Venus Freeze/Viva, Laser/Skin, miraDry, and Botox/Fillers cancellations:

We appreciate 48 hours (2 business days) notice of cancellation so that we may work with another patient if you are unable to keep the appointment for your treatment session. Treatment appointments cancelled with less that 48 hours notice or No-shows, will incur a $50 - $100 fee.

For Laser Ablation Vein surgery cancellations:

We appreciate 2 weeks notice of cancellation for Vein Surgeries so that we may work with another patient during your scheduled time. Surgery cancelled with less that 2 weeks notice will incur a $200 fee. Surgery cancelled with less than 48 hours (2 business days) notice or No-shows, will incur a $500 fee.

For Tickle Lipsuction/Body Contouring Surgery cancellations:

We appreciate 2 weeks notice of cancellation for Lipo and Body Contouring Surgeries so that we may work with another patient during your scheduled time. Surgery cancelled with less than 2 weeks notice will incur a $500 fee on your credit card. Surgery cancelled with less than 48 hours (2 business days) notice or No-shows, will forfeit the deposit paid at time of scheduling.

Patient Signature: _____ *Date:* _____

Credit/Debit Card On-File Authorization Policy

At *Premier Vein & Body by Schwartz*, our financial policy requires that a credit or debit card be placed on file prior to being seen by our providers. This allows us to provide ease of payment for the patient responsibility portion of services that your insurance doesn't cover, but for which you are liable, as well as for other financial responsibilities, such as No-Show or Late Cancellation fees. Co-pays are not included in this process and will be collected at the time services are rendered.

Your credit card information is kept confidential and secure, and no personal medical information is stored with it. For insurance claims, we will file your claim to your insurance company. After your insurance company processes your claim, the billing department will mail a statement to the address on file that will provide you with your current balance. Should you prefer to pay directly by check or other means, or wish to arrange a monthly installment plan, or have questions concerning your bill, **you must contact our business office prior to the due date** listed on the statement.

Payments to your credit card will only be processed if payment and/or arrangements are not received by the due date, and only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has been paid and posted to your account. Furthermore, an "outstanding balance" charge of 2 % of the total bill will charge for each month that the bill remains unpaid.

Please circle: AMEX VISA MASTERCARD DISCOVER

Credit Card Number:_____
Expiration Date: _____/_____
CVV: _____
Cardholder Name: _____
Billing Address: _____
City/State/Zip: _____

PLEASE SIGN: I (we), the undersigned, hereby authorize and request *Premier Vein & Body by Schwartz* to charge my credit card, indicated above, for balances due for services rendered and amounts identified as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by *Premier Vein & Body by Schwartz*, and includes No-Show or Late Cancellation fees. The authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must provide 60-day notification to *Premier Vein & Body by Schwartz* in writing, and my account must be in good standing.

Patient Name (Print): _____ ***Date:*** _____

Patient/Legal Guardian Signature: _____

VARICOSE/SPIDER VEIN TREATMENT INFORMATION

(Patient Copy)

General Information:

- Bring a pair of shorts with you to each visit.
- Once you receive compression hose, **try them on before washing and bring them with you to each visit**.
- **Do not wear any lotion on your legs the day of treatment *******
- On average, each spider vein requires 3 to 5 treatments before resolution.
- Fees reflect a 20-30 minute session.
- **Laser and Photoderm patients: NO sun exposure or tanning bed use for 4 weeks prior to treatments, and no artificial tanner use for 2 weeks prior to treatments.**

Vein Surgery Patients: (You will need a driver to bring you and drive you home.)

Pick up prescriptions the day before surgery at your pharmacy and take as instructed.

- No one other than the patient and medical staff are allowed in the surgery room.
- You may resume normal activities 2 days after surgery.
- You may resume exercise after 1 week.
- Do not swim or use a hot tub for 2 weeks after surgery.
- **Do not take aspirin, aspirin products, or Vitamin E supplements for 5 days before surgery. If you are on coumadin – quit taking seven (7) days prior**.
- You should eat a normal breakfast before coming in for surgery. You can also take all normal medicines except the aspirin products**.**
- **Take the valium (diazepam) 30 minutes prior and DO NOT DRIVE!! BRING THE REMAINING VALIUM WITH YOU TO YOUR APPOINTMENT.**

Insurance/Billing Information:

- Please direct insurance questions to Kathy at 913-451-8346.
- Our office will submit pre-determinations if insurance requires it.
- Spider vein treatments, compression hose, and medications must be paid in full at the time of visit. Please request a receipt if you would like to submit the claim to your insurance company.
- At the patients' request, a pre-determination of benefits letter will be sent to the insurance company. This letter requests that you be notified in writing as to whether the surgery procedure will be covered. It is up to the patient to follow up with their own insurance company if you do not get a response. **We require the patient to pay the remaining left on their deductible at the time of surgery.** We will then bill your insurance.
- **It is expected that if your insurance company sends payment to you directly, you will mail the check with the EOB to our office promptly. Once we receive payment, any office discounts that apply will be offered at that time.**

Cancellation Policy – NO EXCEPTIONS

- A **$200 fee** will be charged if TWO (2) WEEK notice is not provided, and increased to a **$500 fee** for any cancellation or reschedule within 48 HOURS (2 business days) of scheduled procedure or apt.
- 48 Hour notice (2 business days) must be given for cancellation or reschedule of any treatment or a **$100.00 fee** will be charged.
- Initial screenings which are not cancelled within 48 hours will not qualify for the courtesy/complimentary screening.

Price list PER PROCEDURE: (Prices are subject to change without notice)

Sclerotherapy - First Treatment	$675.00 + Dermaka cream $32.00
Sclerotherapy (follow up sessions)	$375.00
*Ultrasound	$450.00

***A Venous Duplex Ultrasound examination is a separate charge and is NOT included in the complimentary screening**

Compression Hose

$40.00 Knee-high	$65.00 20-30 mmHg compression
$50.00 Thigh-high/Pantyhose	$85.00 20-30 mmHg Sheer