Patient Registration Form

Patient Name **Last** **First** **Middle Initial** **Sex:**

- ○ Male
- ○ Female

_____

Marital Status:

○ Single ○ Married ○ Divorced ○ Widowed

Home Address **City** **State** **Zip** **Home Telephone**

_____(____)_____

SSN **Driver's License #** **State Issued** **Birthdate** **Age**

_____

Occupation **Employer's Address** **Work Telephone**

_____(____)_____

Personal Email Address

_____

Name of Financially Responsible Person (if different from patient) **Relationship**

_____

Address (if different from patient) **Home Telephone** **Work Telephone**

_____(___)_____(___)_____

Family Physician **Referred by** **Address** **Reference #** **Telephone**

_____

Any Family Member treated here before? **Emergency Contact** **Telephone**

- ○ **Yes** _____
- ○ **No**

Who? _____

Acknowledgment of Notice of Privacy Practices

We are required by law to provide you with our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have been provided with a copy of our notice.

I acknowledge receipt of St Johns Vein Center's Notice of Privacy Practices. I hereby authorize St Johns Vein Center to share and/or discuss my medical information with the following individuals (family and/or friends)

*1.*_____ *2.*_____

_____ _____

Patient Signature Date

_____

Patient's Name (please print)

Introduction

At St Johns Vein Center, we are committed to treating and using protected health information about you responsibly. This notice of health information practices describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notification is effective January 1, 2012 and applies to all protected health information as defined by federal regulations.

If you have any questions about this notice, please contact Sonya Casey.

Understanding Your Health Record /Information

Each time you visit St Johns Vein Center, a record of your visit is made. Typically, this record contains your symptoms, examination notes, test results, and a plan for future care or treatments. This information, often referred to as your health or medical record, serves as a:

- Basis for planning our care and treatment.
- Means of communication among the many health professionals who contribute to your care.
- Legal documentation describing the care you received.
- Means by which you or a third party payer can verify that services billed were actually provided.
- Tool in educating health professionals.
- Source of data for medical research.
- Source of data for our planning and marketing.
- Tool with which we can access and improve the care we tender and the outcomes we achieve.

You're Health Information Rights

Although your health record is the physical property of St Johns Vein Center, the information belongs to you.

You have the right to:

- Obtain a paper copy of this Notice of Privacy Practices.
- Amend your health record as provided in 45 CFR 164.524.
- Inspect and copy your health record as provided for in 45 CFR 164.524.
- Obtain an accounting of disclosures of your health information as provided for in 45 CFR 164.524.

Our Responsibilities

St Johns Vein Center is required to:

- Maintain the privacy of your health information.
- Abide by the terms of this notice.
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- Notify you if we are unable to agree to a requested restriction.
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.

We are required by law to:

- Ensure that medical information that identifies you is kept private
- Give you this notice of our legal duties and privacy practices with respect to medical information about you
- Follow the terms of the notice that is currently in effect.

How we may use your health information:

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to the practice's office personnel who are involved in taking care of you at the office or elsewhere. We also may disclose

medical information about you to people outside our office who may be involved in your care after you leave the office, such as family members or others we use to provide services that are part of your care, provided you have consented to such disclosure. These entities include third-party physicians, hospitals, nursing homes, pharmacies, and clinical laboratories with whom the office consults or makes referrals.

- **For Payment.** We may use and disclose medical information about you so that the treatment and services you receive at our office may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about procedures you received at the office so your health plan will pay us or reimburse you for the services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
- **For Health Care Operations.** We may use and disclose medical information about you for medical office operations.

  These uses and disclosures are necessary to run our office and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services the office should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to our physicians, staff, and other office personnel for review and learning purposes.

- **Appointment Reminders.** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the office.
- **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.
- **Individuals Involved in Your Care or Payment for Your Care.** We may release medical information about you to a friend or family member who is involved in your medical care, provided you have consented to such disclosure. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.
- **As Required By Law.** We will disclose medical information about you when required to do so by federal, state, or local law.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Special Situations

- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Changes to this notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the office. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register, we will offer you a copy of the current notice in effect.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the office or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Sonya Casey at (904) 402-8346.** All complaints must be submitted in writing.

You will not be penalized or retaliated against for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.

Financial Policy

It is the policy of St Johns Vein Center to provide our patients with access to the highest quality patient care available. In order for us to do so, we must ensure that we are able to meet our operational expenses. We ask that you read, understand, and sign our Financial Policy prior to receiving treatment.

Payment at time of service

As a courtesy, we will bill your insurance for all services; however, we ask that you pay any portion of your costs not covered by your insurance due to deductibles, co-insurances or co-payments on the day of service. Insurance co-payments are mandated by your insurance company and MUST be paid at each visit. Patients with insurance claims pending will be sent statements for the full amount due until the account is satisfied. I agree that if the insurance company denies benefits for any reason, I am responsible for the full amount owed for services provided.

I request that payment of authorized insurance and Medicare benefits be made payable to the above practice on my behalf for services furnished to me. This assignment will remain in effect until revoked by me in writing. In the event that my account is turned over to a collection agency, I agree to pay all reasonable costs of collection and understand that I may no longer be a patient at this office. I understand and agree to pay a returned check charge of $25.00 for each check that is returned for any reason.

Missed appointments

Your scheduled appointment time is reserved just for you. We try not to overbook appointment times in order to provide excellent patient care and to be sure we have sufficient time to adequately examine you and to discuss your condition and treatment options in detail with you.

We will make every effort to accommodate your scheduling needs. In return, we ask that you help us by keeping your scheduled appointments, arriving on time and notifying us a minimum of twenty-four (24) hours in advance if you are unable to do so. When we receive advanced notice of cancellation, we are able to avoid lost revenue and misspent employee time, which keeps our overhead down and our fees reasonable. More importantly, we are able to accommodate other patients needing care. Failure to comply with this policy will necessitate the assessment of the following fees:

- **First missed appointment:** You will receive a letter stating this is your first missed appointment and that you have been charged a missed appointment fee ($50.00)
- **Second missed appointment:** You will receive a letter stating this is your second missed appointment and that you have been charged a missed appointment fee ($50.00)
- **Procedure/Ablation appointment:** You will be charged $150.00 fee for any procedure missed without prior cancellation
- **Further missed appointments:** Further missed appointments will require immediate payment of our Standard Fee for Doctor's Visit.

_____

Patient Signature **Date**

ST JOHNS VEIN CENTER
CONFIDENTIAL HEALTH HISTORY

PATIENT INFORMATION

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Referring Doctor or Primary Care Physician: _____

Reason for visit:

_____

SYMPTOMS

Do your legs, ankles or feet experience:

Aching/discomfort _____ Swelling_____

Cramping _____ Become tired/ heavy _____

Itching _____ Burning _____

Tingling_____ Numbness_____

Restless Leg(s)_____ Other_____

Please check any methods you have used:

☐ Warm Soaks ☐ Exercise ☐ Pain Meds ☐ Wraps ☐ Compression Support Hose ☐ Leg elevation

☐ Cold Packs ☐ Aspirin ☐ Walking ☐ Tylenol ☐ Ibuprofen ☐ Flexion/Extension of your feet

Other Methods: _____

Are you on your feet for long periods? **Yes / No** If so, how long? _____

In what capacity?_____

VEIN HISTORY

Is there a history in your FAMILY of spider or varicose veins? **Yes / No**

If so, please check and describe:

☐ Mother_____☐ Father_____☐Siblings_____ Grandparents_____

Have you ever had a blood clot anywhere in your body? **Yes / No**

If yes, please describe:_____

Is there a history in your FAMILY of blood clots (DVT), pulmonary embolism or clotting disorders? **Yes / No**

BLEEDING HISTORY (Please check all that apply)

☐ Aspirin Use ☐ Coumadin or other "blood thinner ☐ Plavix

Have you received blood-thinning medications such as heparin or lovanox before or after a procedure? **Yes / No**

Do you take antibiotics before dental or invasive procedures? **Yes / No**
Do you take iron pills or vitamins that contain iron? **Yes /No**
Do you have a communicable disease such as hepatitis or HIV? **Yes / No**
Do you have a hole in your heart such as Patent Foramen Ovale (PFO) or Atrial Septal Defect (ASD)? **Yes /No**

Do you have any allergies or sensitivities to medicines or tape? List all:

_____

MEDICATIONS: (Please list all medications, dose and reason)

_____
_____
_____
_____
_____

MEDICAL HISTORY (Please list **ALL** past or present medical problems)

_____
_____
_____
_____

PAST SURGICAL HISTORY (Please list ALL past surgeries and include year of procedure)

_____
_____
_____
_____

SOCIAL HISTORY
Do you smoke_____ packs per day for _____years. Quit (year)_____

Tell us what kind of work you do or did by completing the following sentence:

I work as a/an_____
(If you are retired, tell us what kind of work you did before retirement.)
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐Widowed

Number of pregnancies: _____

Have you ever had a miscarriage? Yes /No If yes, how many:_____

REVIEW OF SYSTEMS (please check all that apply)

Constitution: ☐ Weight Loss ☐ Weight Gain ☐ Night Sweats ☐ Fever

Skin: ☐ Change in size/color of moles ☐ Rash ☐ Bruising

Eyes: ☐ Decreased vision ☐ Double vision ☐ Blurred vision ☐ Glasses

ENMT: ☐ Pain Deafness ☐ Discharge ☐ Ringing in ears
☐ Sinus Drainage ☐ Nose bleed ☐ Hoarseness

Cardiac: ☐ Palpitations ☐ Chest Pain ☐ Shortness of breath
☐ Fatigue ☐ Swelling in feet/legs

Respiratory: ☐ Cough ☐ Production of sputum ☐ Coughing of blood ☐ Pain

Gastro: ☐ Painful swallowing ☐ Nausea ☐ Vomiting ☐ Vomit blood
☐ Indigestion ☐ Diarrhea ☐ Constipation ☐ Tarry Stools
☐ Yellow Jaundice ☐ Bloody Stools ☐ Change in BMs

Genito: ☐ Kidney/ Bladder disease ☐ Decreased urine stream
☐ Unable to urinate ☐ Painful urination ☐ Blood in urine

Musc/Skel: ☐ Weakness Trauma ☐ Limited Motion ☐ Bone/joint deformity

Neuro: ☐ Paralysis ☐ Weakness ☐ Seizure ☐ Fainting
☐ Headache ☐ Migraine ☐ Migraine with aura
☐ Numbness/tingling in extremities ☐ Head trauma

Psych: ☐ Anxiety / Depression ☐ Hallucinations

Endocrine: ☐ Change of Appetite ☐ Excessive thirst/urination ☐ Goiter

Hematology: ☐ Swollen lymph nodes ☐ Bleeding disorders

Immuno: ☐ Immune disorders ☐ Immunosuppressant

Signature: _____ **Date:** _____

St Johns Vein Center

Patient Name: **Date:**

Do you have any known drug allergies to the following products? Please circle.

LIDOCAINE	YES	NO
EPINEPHRINE	YES	NO
SODIUM BICARBONATE	YES	NO
HEPARIN	YES	NO
VALIUM	YES	NO
VICODEN	YES	NO
PERCOCET	YES	NO
PENICILLIN/ANTIBIOTICS	YES	NO
NITROGLYCERIN	YES	NO
LATEX	YES	NO
IODINE	YES	NO

Do you have any other known drug allergies? Please list.

_____

_____

Patient Signature: _____