Reeder Vein Institute

Steven F. Reeder, M.D. F.A.C.S.
Diplomate of the American Board of Venous & Lymphatic Medicine

Michael P. Darnell, M.D.
Diplomate American Board of Surgery

Name:_____Age:____ Birth Date:_____ Sex:_____

Address:_____ City:_____ Zip:_____

Employer:_____ Occupation:_____

Address:_____ Work Phone:_____

Home Phone:_____ Cell Phone:_____

Social Security no.:_____ Driver's License no.:_____

Email Address:_____

Best way to contact you. Please check from 1 to 4 (1 is best)
Home phone:___ Wk. Phone:___ Cell Phone:___ Email:___

Spouse:_____ Birth Date:_____

Employer:_____Occupation:_____

Address:_____ Work Phone:_____

Cell Phone:_____ Social Security no.:_____

Next of Kin or Friend_____ Relationship_____

Address:_____ Telephone no.:_____

Referring doctor: _____
Primary doctor (if different from your referring doctor): _____
May we send information regarding your treatment at Reeder Vein Institute to your referring physician and your primary physician for your medical records in their offices? _____

Insurance 1st:_____

Insurance 2nd:_____

Authorization to Release Information: I hereby authorize the Reeder Vein Institute to release any medical information to process a medical claim. I understand that I am financially responsible for any and all charges rendered at the time of office visit and that fees are collected on the day of the procedure. If for any reason it becomes necessary to initiate collections proceedings, I understand I am responsible for the cost of all treatments received, as well as any and all legal or collection fees Reeder Vein Institute incurs. **I agree to inform RVI of any changes in my insurance policy.**

Sign:_____Date:_____

CONFIDENTIAL HEALTH & VASCULAR HISTORY

PATIENT INFORMATION:

Name:_____Date:_____

Age:_____sex:_____height:_____weight:_____ Years with varicose/spider vein?_____

HOW DID YOU HEAR ABOUT US?

Referring Doctor:_____

PRIMARY CARE INFORMATION:

Primary Care Physician:_____ Phone:_____

VASCULAR SYMPTOMS AND HISTORY:

Please check if you have:

__Red spider veins	Lt__ Rt__	__Bulging veins	Lt__ Rt__
__Skin discoloration below your knee	Lt__ Rt__	__Flat bluish-green veins	Lt__Rt__
__Purple veins	Lt__ Rt__	__Diagnosis of vein disease	Lt__Rt__
__Purple vein network	Lt__ Rt__	__Leg ulcer	Lt__Rt__
__Abdominal veins		__Other:_____	

Do your legs or ankles:		Please describe:
__Ache or hurt?	Lt__ Rt__	_____
__Swell?	Lt__ Rt__	_____
__Cramp?	Lt__ Rt__	_____
__Become restless?	Lt__ Rt__	_____
__Become tired/heavy?	Lt__ Rt__	_____
__Itch?	Lt__ Rt__	_____
__other?	Lt__ Rt__	_____

Please check any methods you have used to relieve your leg discomfort:

__No Discomfort	__Warms Soaks
__Leg Elevation	__Cold Packs
__Exercise	__Pain Meds
__Flexion/Extension of your feet	__Aspirin
__Walking	__Tylenol
__Support Hose	__Ibuprofen
__Wraps	__Other Method:_____

Are you on your feet for long periods?_____ In what capacity?_____

Does walking/exercise relieve your discomfort or make it worse?_____
Have you been treated for your veins before?_____

By whom?_____ When?_____

What method?

__Injections	Lt__ Rt__	__Ultrasound-Guided Injections	Lt__ Rt__
__Stripping	Lt__ Rt__	__Radiofrequency Closure	Lt__ Rt __
__Ambulatory Phlebectomy	Lt__ Rt__	__Laser Catheter Ablation	Lt__ Rt__
__Ligation	Lt__ Rt__	__Laser for Spider Veins	Lt__ Rt __
__Other_____			

What have your results been?

_____

_____

_____

_____

_____

MEDICAL HISTORY:

Is there a history in your FAMILY of spider or varicose veins?
WHO? _____

Is there a history in your FAMILY of deep venous thrombosis, stroke or clotting disorders?
WHO?_____

Do YOU have a history of:

__Anemia
__Ankle Skin changes
__Atherosclerosis
__Bleeding/Blood disorder
__Chest pain discomfort
__Constipation
__Crohn's disease, IBS
__Deep Vein Thrombosis/clot
__Diabetes; Insulin dependent
__Easy bruising
__Erectile difficulty/dysfunction
__Heart disease
__Hepatitis
__HIV
__Hypertension
__Kidney disease
__Leg ulcers
__Liver Disease
__Lupus
__Migraine Headaches
__Mitral valve prolapse
__Pulmonary embolus
__Rupture of a vein
__Superficial Thrombophlebitis
__Trauma to your legs
__Other_____
_____
_____

CURRENT MEDICAL INFORMATION:

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

_____

Are you being treated for any illnesses or conditions?_____If so, what illness:

_____

_____

Please list all medicines that you take (Prescription, Non-Prescription, Vitamins and Herbal):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you smoke? _____

What operations have you had?

_____ _____

_____ _____

_____ _____

Any complications from your surgery?

_____

Acknowledgment Form

I acknowledge receipt of this Notice of Privacy Rights, which I have reviewed and give my permission to **Reeder Vein Institute** to use and disclose my health information in accordance with it.

_____	_____
Signature of Patient	Signature of Patient's Representative
_____	_____
Name of Patient (Print or Type)	Relationship of Representative to patient
_____	_____
Date	Date

TO OUR PATIENTS:

Our foremost goal is to provide you with excellent medical care. We and our staff hold that as our highest priority. We also want to excel in providing you with clear information about the financial concerns and responsibilities you have as a patient and we have as a medical practice. To that end, we hope you will carefully read the following summary about insurance and cash reimbursement. If you have any questions please ask our office manager for further explanation.

Managed Care Contracts

We have chosen to contract with a number of insurance companies or networks to provide medical care to their insured members at a negotiated discount. If you are insured by one of these companies or through one of the networks, we are considered **In-Network** providers for you. We abide by the terms of our contract with them *which includes the collection of Co-Pays, Co-Insurance, and Deductable amounts. By contract, we collect these amounts at time of service for office visits and in advance for surgeries and may not waive them.*

We make every effort to obtain reliable information from the insurance companies/networks and obtain the benefits with the company. Based on that information, we collect your portion of the fee. If the information proves to be incorrect when the claim is filed, you may owe additional money or we may refund money to you. *You receive an Explanation of Benefits (EOB) at the same time as we receive payment. The EOB states the contracted amount, the amount of Patient Responsibility, and the discount for which the practice cannot bill a patient.* If the EOB is incorrect, we will file an appeal. Otherwise, the amount due from you stands as per the contract. If, in spite of our best effort, we have collected an incorrect amount from you, we will either refund any overpayment to you promptly or collect any underpayment from you promptly.

Prompt Pay Discount

We welcome patients to our practice who are not covered by insurance plans/payors with whom we are contracted. Some patients are covered by insurance plans/payors with whom we are NOT contracted and are considered Out-of-Network with our practice. Some patients are not insured at all. We believe our fee schedule reflects a usual and customary fee for the medical services provided. However, we do offer a discount for prompt payment at the time of visits and diagnostic testing. Payment for surgery is due on or before the day of surgery. We extend a discount for this timely payment. Our office manager will be pleased to discuss this policy with you.

Financial Policy for Sclerotherapy (cosmetic treatment)

Sclerotherapy for spider veins is considered a cosmetic procedure and is not covered as a medical benefit. This is true even if the spider veins cause symptoms such as aching and burning. Payment will be expected at the time of service. Treatment of spider veins involves time and injection agents, both of which are expenses covered in the treatment charge. Each treatment session is a separate charge. The response to the treatment is variable with some patients having an excellent result and some less than hoped for results. The charge for the service is the same regardless of the outcome of treatment.

Written Estimate

You may request a written estimate of your out-of-pocket expenses. We are glad to comply with this request as we want our patients to be informed about the financial implications of their medical care. Please ask our office manager if you want such an estimate.

If you have any questions about the above information or any uncertainty regarding payment for services, PLEASE do not hesitate to ask us.

_____ _____

Signature Date

_____

Printed name