Vein Specialists

Joseph G. Magnant MD, FACS, RPVI Patrick A. Nero MD, FACS, RPVI

1500 Royal Palm Square Blvd. Ste.105
Fort Myers, FL 33919
(239) 694-8346

3359 Woods Edge Circle, Ste.102
Bonita Springs, FL 34134
(239) 694-8346

Patient Information (Please Print)

Name: _____
Last First Middle Initial

D.O.B.: _____ Soc. Sec # _____ Gender: M F Marital Status _____

Address: _____

Address: _____
If different from above (Visitor or non-permanent FL Resident)

Home Phone: (____) _____ Work Phone: (____) _____

Cell Phone: (____) _____ Email: _____

Primary Language: _____ Race: _____

Emergency Contact: _____ Emergency Phone: (____) _____

Primary Care MD: _____ Referring Physician: _____

Pharmacy: Name/location: _____

Occupation: _____ Employer: _____

Employer address: _____ Phone: _____

HOW DID YOU HEAR ABOUT VEIN SPECIALISTS? – Please circle one that most applies.

Physician Referral	Friend/Relative/ Other Patient	Billboard	Vein Van
Attended Health Fair	Attended Lecture	Newspaper	Magazine
Internet	Radio	Medical Directory	Charity/Sponsorship

Other/ Please Specify: _____

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Patient Information (Please Print)

Primary Insurance Provider:

Insurer: _____ Subscriber: _____

Complete below if you are not subscriber

Relationship: _____ D.O.B.: _____ Soc Sec #_____ Gender: M F

Plan Name: _____ Effective Date: _____

Policy Number: _____ Group Number: _____

Co Pay For Specialist: _____

Subscriber (Patient/Spouse/Parents)

Subscriber Address: _____ City: _____ State: _____ Zip: _____

Employer: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Subscriber Phone # Home: (____) _____ Cell: (____) _____

Secondary Insurance Provider:

Insurer: _____ Subscriber: _____

Complete below if you are not subscriber

Relationship: _____ D.O.B.: _____ Soc Sec #_____ Gender: M F

Plan Name: _____ Effective Date: _____

Policy Number: _____ Group Number: _____

Co Pay For Specialist: _____

Subscriber (Patient/Spouse/Parents)

Subscriber Address: _____ City: _____ State: _____ Zip: _____

Employer: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Subscriber Phone # Home: (____) _____ Cell: (____) _____

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Medical Information Release & Assignment of Benefits:

Vein Specialists is hereby authorized to furnish information to insurance carriers concerning my illness and treatments, and to collect all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered or paid by insurance. I am also responsible for any Deductible, Co- pay and/or Co-Insurance at the time of services rendered. I certify that the information I have reported with regard to insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. I have the right to revoke this authorization at any time in writing.

Patient signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

MEDICAL INFORMATION

Reason for Today's Visit (please circle)? ☐ Right leg ☐ Left Leg ☐ Both Legs ☐ Pelvic Pain

☐ Pain in Legs	☐ Swelling in Legs	☐ Achy/Heavy legs	☐ Varicose Veins	☐ Blue/Spider veins
☐ Leg cramps	☐ Inflammation	☐ Skin Discoloration/rash	☐ Bleeding from Veins	☐ Superficial Blood clot
☐ Night time Urination	☐ Ulceration	☐ Thigh/Leg Swelling	☐ Restless Leg	☐ History of DVT
☐ Buttock or Hip Pain (May be one sided)	☐ Pain During or After Intercourse	☐ Pelvic Pain/ Heaviness	☐ Gluteal, Groin, Labial or Vulvar Varicosities	☐ Dull achiness in back of thigh or knee aggravated by standing, sitting or worse by menstruation

How Long Have you Had the Above?
# of Days:_____ # of Weeks:_____ # of Months:_____ # of Years:_____

Number of Full Term Pregnancies: _____

Family Medical History:

□ High Blood Pressure	□ High Cholesterol	□ Stroke
□ Heart Disease	□ Diabetes	□ None

Has anyone in your family been diagnosed with Varicose Veins or Venous Disease?
□ Mother □ Father □ Sister/Brother □ Aunt/Uncle □ Grandparent

Continued on reverse side

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MEDICAL INFORMATION (Regarding your Legs) Please circle all that apply

My legs feel worse:

Working	Standing	Walking	Sitting
Lying down	In the morning	At the end of day	Driving or riding in a car
During or After Menstrual Cycle	Pregnancy	During or After Intercourse	None

Other: _____

My legs feel better with:

Elevation	Rest	Compression Hose	Tylenol/Motrin
Water Pill	In the morning	At the end of day	Walking
Swimming	None		

Other:_____

Previous Treatments:

Elevation	Compression Hose	Tylenol/Motrin	Water Pill
Sclerotherapy	Microphlebectomy	Vein Stripping	Endovenous Closure

Other: _____

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Allergies:

□ N/A □ Latex □ Iodine or Dye □ Lidocaine □ Adhesive Tape

Please List other Allergies: _____

Current Medications: (please list name and dosage)

_____

_____

Past Medical History:

□ High Blood Pressure □ Stroke □ High Cholesterol
□ Heart Disease □ Diabetes □ None

List other Medical History: _____

_____

Do you currently smoke? _____

Have you smoked more than 100 cigarettes in your lifetime? _____

Alcohol Consumption: None Rarely Daily

Past Surgeries: Please check all that apply

□ Appendectomy □ Hysterectomy □ Endovenous Closure

□ Arthroscopy □ Tubal Ligation □ Injection Sclerotherapy

□ Back Surgery □ Hip Replacement □ Laser Sclerotherapy

□ Stent Placement □ Knee Replacement □ Vein Excision

□ Heart Bypass □ Gall Bladder □ Vein Stripping

Please List All Other : _____

MEDICAL INFORMATION (continued)

Have you had ANY of the following? – *Please Circle All That Apply*

SKIN

Itching

Hives

Rash

Ulcers

EYES

Vision changes or loss

Double Vision

EARS

Ringing

Hearing Loss

NOSE

Nosebleeds

Discharge

MOUTH/THROAT

Sore Throat

Hoarseness

RESPIRATORY

Shortness of Breath

Cough

Wheezing

PSYCHIATRIC

Anxiety

Depression

CARDIOVASCULAR

Palpitations

Chest Pain

Cardiac murmurs

Irregular heartbeat

High Blood Pressure

High Cholesterol

GASTROINTESTINAL

Nausea

Vomiting

Diarrhea

Constipation

Blood in Stool

Heartburn

Jaundice

GENITOURINARY

Frequent urination

Painful urination

Blood in Urine

Nighttime urination

LYMPHATIC/ Blood

Swollen Glands Night

Sweats

Easy Bleeding

Easy Bruising

NEUROLOGICAL

Tingling/numbness

Seizures

Headaches

Dizziness

Falls

Tremors

Memory Loss

MUSCULOSKELETAL

Bone Pain

Joint Pain

Back Pain

Swelling

Calf Cramps

ALLERGY/IMMUNE

Aids/HIV

Hepatitis B or C

ENDOCRINE

Cold Intolerance

Heat Intolerance

Weight gain/loss

Diabetes

Hot flashes

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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name/Address: _____

_____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice:

Signature: _____ Date: _____

FOR OFFICE USE ONLY

We were unable to obtain written acknowledgement of receipt of the Notice of Privacy Practices because:

☐ An emergency existed and signature was not possible at the time.

☐ The individual refused to sign.

☐ A copy was mailed with a request for signature by mail.

Unable to communicate with patient for following reason: _____

_____

_____

_____

Practice Representative: _____ Date: _____

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Vein Specialists Release of Information

In order to allow Vein Specialists' Physicians and employees to discuss patient information with others (spouse, child, relative, friend, neighbor, care taker, etc.) involved in your treatment or the arrangements of services rendered, please provide the following information:

Patient Representative Information:

1. Name: _____ Phone Number: _____

Relationship to Patient: _____

2. Name: _____ Phone Number: _____

Relationship to Patient: _____

3. Name: _____ Phone Number: _____

Relationship to Patient: _____

4. Name: _____ Phone Number: _____

Relationship to Patient: _____

My signature below indicates I understand the following:

I may change the names of the individuals listed above at any time. Changes must be made in writing.

This information applies to all departments of Vein Specialists.

Signature: _____ Date: _____

Print Name of Patient: _____

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EXPLINATION FINANCIAL RESPONSIBILITY & INSURANCE INFORMATION

Thank you for choosing Vein Specialists as your medical care provider. We are committed to providing you with quality, ethical, and affordable health care. Please read the following information regarding your financial responsibility and insurance coverage for services rendered. Health insurance is a contract between you and your insurance company. We will inform you whether we are a participating provider with your insurance company and plan. As a courtesy to our patients we will be happy to file your insurance claims. You are responsible for timely payment of your account. If a balance remains after 30 days, Vein Specialists reserves the right to recover the unpaid balance as soon as possible.

Insurance: We participate with most insurance plans including Medicare. Always bring your insurance card (s) with you at the time of your visit. If you are not insured by a plan that we participate with, payment will be required at each visit. If you are insured by a provider that we do participate with, but do not have an up-to-date insurance card, payment in full will be expected at each visit until a valid card and/or verification of coverage is provided.

Co-payments & Deductibles: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contractual agreement with your insurance company.

Acceptable forms of payment: We accept cash, check, money order, Visa, MasterCard, American Express and Discover. If a personal check is returned as insufficient funds, a $40 fee will be incurred in addition to the original balance owed.

Referrals: It is the patient's responsibility to know whether or not their insurance requires a referral from their primary care physician, in order to cover your visit with specialist, such as Dr. Magnant or Dr. Nero.

Non-covered Services: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by your insurance company. If you elect to have the non-covered service, you must pay at the time of the visit or procedure.

Medicare Patients: If we believe you are receiving a service that Medicare considers not reasonable or necessary for your condition, you will be notified in writing on a form called an Advanced Beneficiary Notice (ABN). This will provide you with the opportunity to decide if you wish to proceed with the services ordered. This process is required by Medicare and preserves your right to appeal their decision.

Claims Submission: Vein Specialists will submit your claims and assist you in getting them paid. Your insurance company may reques information directly from you and it is your responsibility to supply that information in a timely manner. Please be aware that the balance o your claim is your responsibility whether or not your insurance company pays your claim.

Coverage Changes: If your insurance coverage changes, please notify us immediately or before your next visit. This will ensure your correct submission of claims and maximize your insurance benefits.

Non-Payment: Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you will be assessed at 30% surcharge to cover agency fees. Partial payments will not be accepted unless otherwise arranged with Vein Specialists billing office. Extended payment arrangements must be discussed with the billing office at (239) 208-2585.

Missed Appointments: Vein Specialists reserves the right to charge for unexcused no-show appointments and those that are not cancelled within 48 hours of the appointment date without legitimate cause.

Patient Initial: _____ Date: _____

Continued on reverse side

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RELEASE OF INFORMATION WITH REGARD TO SERVICES FURNISHED TO A BENEFICIARY

I hereby authorize my insurance carrier to furnish Vein Specialists any information obtained in the adjudication of any claim in regard to services furnished by Vein Specialists. This authorization is valid until rescinded by the patient in writing. I further authorize Vein Specialists to furnish information requested by my insurance carrier or its intermediaries regarding services rendered.

PRIVACY ACT STATEMENT: I understand that as part of my health care, Vein Specialists originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning care and treatment.
- A means of communication among 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 payers can verify that services billed were actually provided or performed.
- A tool for routine healthcare operations such as assessing quality of care and outcome and reviewing competence of healthcare professionals.

Patient Signature: _____ Date: _____

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Photography Consent

I agree to have Vein Specialists and staff take photographs of my legs for the purpose of medical records and future comparison or reference for any treatments I may have. These photographs will be held in confidentiality according to HIPAA regulations. I also consent to the future use of my leg photographs, without reference to my name or other personal identifying information for the purpose of insurance authorization, patient and physician education, and presentations and clinical photo galleries. The primary reason for taking these photographs is to demonstrate the comparison of pre and post treatment photos.

_____ _____

Patient Signature Date

_____

Print