Joseph G. Magnant MD, FACS, RPVI

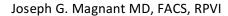
Patrick A. Nero MD, FACS, RPVI

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

Patient Information (Please Print)

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

Name:			_
	Last First	Middle Initial	
D.O.B.:	_ Soc. Sec #Ge	nder: M F Marital Status_	
Address:			
Address:			
	If different from above (Visito	or or non-permanent FL Resident)	
Home Phone: ()		Work Phone: ()	
Cell Phone: <u>(</u>)		Email:	
Primary Language:		Race:	
Emergency Contact:		Emergency Phone: ()	
Primary Care MD:	Referring Physician:		
Pharmacy: Name/location	on:		
Occupation:		Employer:	
Employer address:			_ Phone:
HOW DID YOU HEAR AE	SOUT VEIN SPECIALISTS? – Plea	ase circle one that most applies.	
Physician Referral	Friend/Relative/	Billboard	Vein Van
Filysiciali Nelellai	Other Patient	Biliboard	veiii vaii
Attended Health Fair	Attended Lecture	Newspaper	Magazine
, teensea ricatii ruii	Accorded Lecture	, te wspaper	MAGAZITIC
Internet	Radio	Medical Directory	Charity/Sponsorship
Other Discussion			
Other/ Please Specify: _			



Patrick A. Nero MD, FACS, RPVI

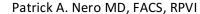


1500 Royal Palm Square Blvd. Ste.105 Fort Myers, FL 33919 (239) 694-8346 3359 Woods Edge Circle, Ste.102 Bonita Springs, FL 34134 (239) 694-8346

Patient Information (Please Print)

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: <u>(</u>)
Secondary Insurance Provider:	
Insurer:	
	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:	
	City: State:Zip:
Subscriber Phone # Home: _()	Cell: <u>(</u>)





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

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.

ratient signature			Da	ie	
Parent/Guardian Signature:			Date:		
MEDICAL INFOR	<u>MATION</u>				
Reason for Toda	y's Visit (please circle	e)? 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		Groin, r Vulvar ities	Dull achiness in back of thigh or knee aggravated by standing, sitting or worse by menstruation
How Long Have you					
# of Days:	_ # of Weeks:#	of Months:	# of Years:		
Number of Full Terr	n Pregnancies:				
Family Medical His	tory:				
□ High Blood Pressu		holesterol		roke	
□ Heart Disease	□ Diabet	es	□ N	one	
•	family been diagnosed v her □ Sister/Brothe				

Sitting



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

Working

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

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

Standing

My legs feel worse:

Walking

Lying down	In the morning	At the end of day	Driving or riding in a car	
During or After Menstrual Cyc	•	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:				



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

Allergies:					
□ N/A □ Latex □	lodine or Dye 🗆 Lidoca	ne 🗆 Adhesive Tape			
Please List other Allergie	Please List other Allergies:				
Current Medications: (p	Current Medications: (please list name and dosage)				
Past Medical Hist					
☐ High Blood Pressure	□ Stroke	☐ High Cholesterol			
☐ Heart Disease	□ Diabetes	□ None			
List other Medical Histo	ory:				
Do you currently smoke? Have you smoked more than 100 cigarettes in your lifetime? Alcohol Consumption: None Rarely Daily					
Past Surgeries: Please of	check all that apply				
□ Appendectomy	□ Hysterectomy	□ Endovenous Closure			
□ Arthroscopy	□ Tubal Ligation	□ Injection			
		Sclerotherapy			
□ Back Surgery	□ Hip Replaceme	ent 🗆 Laser Sclerotherapy			
□ Stent Placemen	t □ Knee Replacer	nent 🗆 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

<u>SKIN</u>	CARDIOVASCULAR	<u>NEUROLOGICAL</u>
Itching	Palpitations	Tingling/numbness
Hives	Chest Pain	Seizures
Rash	Cardiac murmurs	Headaches
Ulcers	Irregular heartbeat	Dizziness
EYES	High Blood Pressure	Falls
Vision changes or loss	High Cholesterol	Tremors
Double Vision	GASTROINTESTINAL	Memory Loss
<u>EARS</u>	Nausea	MUSCULOSKELETAL
Ringing	Vomiting	Bone Pain
Hearing Loss	Diarrhea	Joint Pain
NOSE	Constipation	Back Pain
Nosebleeds	Blood in Stool	Swelling
Discharge	Heartburn	Calf Cramps
MOUTH/THROAT	Jaundice	ALLERGY/IMMUNE
Sore Throat	<u>GENITOURINARY</u>	Aids/HIV
Hoarseness	Frequent urination	Hepatitis B or C
RESPIRATORY	Painful urination	ENDOCRINE
Shortness of Breath	Blood in Urine	Cold Intolerance
Cough	Nighttime urination	Heat Intolerance
Wheezing	LYMPHATIC/ Blood	Weight gain/loss
<u>PSYCHIATRIC</u>	Swollen Glands Night	Diabetes
Anxiety	Sweats	Hot flashes
Depression	Easy Bleeding	
	Easy Bruising	



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

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:				



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

Vein Specialists Release of Information

Patient Representative 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:

•		
1. Name:	Phone Number:	
Relationship to Patient:		
	Phone Number:	
	Phone Number:	
	Phone Number:	
Relationship to Patient:		
My signature below indicates I understand th	ne following:	
I may change the names of the individuals lis	ted above at any time. Changes must be made in writing.	
This information applies to all departments o	f Vein Specialists.	
Signature:	Date:	
Print Name of Patient		





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

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 or 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 cancelle	d
within 48 hours of the appointment date without legitimate cause.	

Patient Initial:		Pate:
·	_	



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

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:	Da	te:
		•



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

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	