760 W. Eisenhower Pkwy, STE.200
Ann Arbor, MI 48103
Office: 734.213.3700
Fax: 734.213.3706
www.michiganveincare.com

Patient Health History Form

First Name: ______________________________MI: ____________Last Name:_______________________________________

I prefer to be called: ____

Date of Birth: ____ Age: ____

Primary Care Physician Name: ____

Do you want us to send a report of our findings to him/her? ■ Yes ■ No

How did you hear about Vein Care Specialists? Check all that apply.

■ Referred by Primary Care Physician ■ Friend or Family

■ Online Ad ■ Internet Search

■ Other (please specify): ____

Current Occupation: ____

# of hours per workday you are required to stand: ____ hours

If you are retired, what kind of work did you do before you retired? _______________________________________

- -

History of Present Venous Condition (Check one.)

■ This is a new condition

■ This is a chronic condition. How long has this been bothering you? ____

Leg Signs and Symptoms: please check all that you have experienced in the past six months.

■ Enlarged veins that are visible on your skin ■ Itching or Burning

■ Fatigue/Heavy Feeling ■ Swelling of leg or ankle

■ Throbbing or Cramping ■ Leg ulcer / sores

■ Pain or tenderness. Please rate the severity of your pain by circling the number below.

1 (very mild) – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (severe)

What have you tried to relieve your pain ____

____

In the past year have you: (please check all that apply)

- ■ Tried support stockings for at least 3 months to relieve your leg vein condition without success?
- ■ Had to take pain medication because of your vein condition?
- ■ Needed to take time off work because of your leg condition?
- ■ Needed to limit your activities and/or lifestyle because of your leg condition?

Have you ever had any of the following conditions to your legs?

Check all that apply and identify which leg was affected.

Condition	**Affected Leg(s)**		
■ Injury that required surgery or casting	Right	Left	Both
■ Deep vein thrombosis (DVT) / blood clot	Right	Left	Both
■ Phlebitis (inflammation of leg veins)	Right	Left	Both
■ Venous stasis ulcer (leg sores due to poor circulation)	Right	Left	Both
■ Bleeding from a varicose vein	Right	Left	Both
■ Vein stripping	Right	Left	Both
■ Sclerotherapy (vein injections)	Right	Left	Both
■ Vein Ablation	Right	Left	Both

If you answered "yes" to any of these conditions, please provide details, treatment provided and the year it occurred in the space below.

- -

Past and Current Medical History

List any medications you take (drug name, dosage, frequency)

Include prescription, over-the-counter, herbal or dietary supplements.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

List any allergies you have (include medication, food, environmental, tape, Latex, other)

_____ _____

_____ _____

Are you pregnant or breastfeeding? ■ Yes ■ No

Do you have any blood borne diseases (Hepatitis, AIDS, other)? ■ Yes ■ No

Please list any surgeries you have had starting with the most recent. Please include the year.

____

____

____

____

- -

HEIGHT __________________ **WEIGHT** ______________________

Review of Systems

Do you have or have you experienced any of the following conditions? Please circle **yes** or **no** for each line.

Circulatory Problems

Yes	No	Chest Pain
Yes	No	Congestive Heart Failure
Yes	No	Irregular Heart Rhythm
Yes	No	High Blood Pressure
Yes	No	History of a heart attack
Yes	No	Other heart problems
Yes	No	Fainting
Yes	No	General Fatigue
Yes	No	Blood Clots

Respiratory Problems

Yes	No	Shortness of breath
Yes	No	Wake up breathless
Yes	No	Productive cough (sputum or blood)
Yes	No	Pain with breathing
Yes	No	Asthma
Yes	No	Emphysema
Yes	No	Smoker: _________ packs per day
Yes	No	Use of smokeless tobacco / chew
Yes	No	Bleeding disorder

Gastrointestinal Problems

Yes	No	Change in bowel habits
Yes	No	Nausea or vomiting
Yes	No	Abdominal pain
Yes	No	Ulcers
Yes	No	Liver Disease

Diabetes

Yes	No	Insulin dependent
Yes	No	Oral medications
Yes	No	Controlled with diet and exercise
Yes	No	Inflammatory Bowel Disease

Genitourinary

Yes	No	Kidney disease
Yes	No	Prostate disorder
Yes	No	Incontinence
Yes	No	Painful urination
Yes	No	Frequent urination

Musculoskeletal

Yes	No	Changes in walking ability
Yes	No	Change in strength
Yes	No	Painful joints
Yes	No	Arthritis
Yes	No	Spinal disorder

Neurological

Yes No Loss of memory or movement
Yes No Unexplained numbness
Yes No Tingling

Vision Problems

Yes No Vision loss or recent changes
Yes No Double vision
Yes No Excessive tearing
Yes No Glaucoma
Yes No Blindness

Other Medical Conditions

Yes No Thyroid Disorder
Yes No Cancer: Type_____ Yes

Ear, Nose and Throat

Yes No Change in hearing
Yes No Nasal discharge
Yes No Sore

Skin

Yes No Rashes or change in skin color
Yes No Sores that won't heal
Yes No Itching

Other

Yes No Anxiety
No Depression
Yes No Recent weight loss or gain (unintentional)
Yes No Recent loss of or increased appetite
Yes No General fatigue
Yes No Alcohol Use
_____ alcoholic beverages per week
Yes No Recreational Drug Use
Yes No Smoking
Current _____ packs/per day
Former _____ packs/per day
Years Smoked _____

Do any of your blood relatives have a history of: (please check all that apply)

■ Diabetes ■ Heart Disease ■ Cancer
■ High Blood Pressure ■ Kidney Disease ■ Liver Disease
■ Varicose Veins ■ Blood Clots ■ Vein Surgeries
■ Venous Ulcers (leg sores due to circulatory problems)

I have provided true and accurate information to all of the above questions to the best of my knowledge and ability.

_____ _____

Patient Signature Date

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Statement of Patient Responsibilities and Practice Policies

Patient Name:_____

DOB:_____

Michigan Vein Care Specialists appreciates the confidence you have shown in choosing us to provide for your health care needs. The appointment reservation and service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier for you. However, you are ultimately responsible for knowing your insurance benefits and for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at each visit. Thank you for your cooperation in this matter.

If you do not have health insurance, you will be responsible for all services rendered by Michigan Vein Care Specialists. You agree to pay Michigan Vein Care Specialists the full and entire amount of treatment given to you or to the above named patient at each visit.

Consent for Treatment and Authorization to Release Information

With your signature on this document, you are authorizing Michigan Vein Care Specialists to perform or have performed upon you, or the above named patient, appropriate assessment and treatment. You further authorize Michigan Vein Care Specialists to release to appropriate agencies any information acquired in the course of your or the above named patient's examination and treatment.

Cancelation/No Show Policy

We strive to schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. It is very important that
you keep your scheduled appointment with us, and arrive on time.

As a courtesy, and to help you remember you scheduled appointments, MICHIGAN VEIN CARE sends reminders by text messages, email, and/or phone in advance of your appointment time.

In the event of unforeseen circumstances causing you to cancel or reschedule your appointment, please give us at least 24 hours notice. This is a courtesy to our office as well as to those patients who are waiting to schedule with the physician.

If you do not cancel or reschedule your appointment with at least 24 hours notice, you will incur a "NO-SHOW CHARGE" that must be paid prior to rescheduling. This is not payable by your insurance company and will be billed directly to you as follows:

$25 "no show" for office visit
$75 "no show" for treatment/procedure visit

After three no-shows, our practice may decide to terminate its relationship with you.

Patient-Centered Medical Home

The goal at MVCS is to provide patient centered care to all of its patients. Patient centered care is a means where the physician and patient work together to provide quality health care. This will be achieved through patient and practice interaction whereby the needs and preferences of the patient are communicated honestly to our practice, the patient is compliant in following through with agreed upon treatment plans, consistently keeps their appointments. Our staff and physician will in turn listen to those needs and focus their education and training to ensure better health care results.

Affirmation/Signature

I have read the above policy regarding my financial responsibility to Michigan Vein Care Specialists for providing medical services to me or the above named patient. I certify that the information I have provided to the practice is to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Michigan Vein Care Specialists, the full and entire amount of bill incurred by me or the above named patient; or, if applicable, any amount due after payment has been made by my insurance carrier.

I have read and agree to the terms above, including but not limited to authorizations and consents, financial responsibility and no-show policy.

Patient or Guarantor Signature: _____

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on it's web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at:

(734) 274-5624

We will not retaliate against you for filing a complaint.

Effective Date 6/1/2018 Publication Date 6/1/2018

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that under the HIPAA (Health Insurance Portability and Account and Ability Act of 1996), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple health-care providers who may be involved in that treatment directly and indirectly.
Obtain payment from third-party payers.
Conduct normal healthcare operations such as quality assessments and physician certifications.

By signing below, I acknowledge that I have read or have been given an opportunity to read (if I so choose) a copy of the privacy practices of Michigan Vein Care Specialists, PLLC.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

Documentation of Failure to Obtain Signed Acknowledgement

On_____, I, _____ employee of Michigan Vein Care Specialists, PLLC presented this Acknowledgement of Receipt of Notice of Privacy Practices form to patient _____. The patient refused to provide a signature when requested.