Health History Form

Name: _____ Date: _____

Date of Birth: _____

Have you experienced any of the following problems with your legs? **Circle your answer please**.

Aching/pain in your legs?	Yes	No	Heaviness?	Yes	No
Tiredness/fatigue?	Yes	No	Itching/burning?	Yes	No
Swollen ankles?	Yes	No	Leg cramps?	Yes	No
Restless legs?	Yes	No	Throbbing?	Yes	No

Do you experience these problems in just one leg, or both? **Right** **Left** **Both**

How long have you had these symptoms: _____ Have your veins gotten worse in recent months? Yes No

Most insurance companies require that compression hose, leg elevation, and over the counter pain medications have been used. Please check your policy for specific requirements.

a.. What brand of compression hose have you worn? _____

b. How long have you worn the compression hose? years:_____ months:_____

c. Do the hose provide relief? Yes No

d. Do you elevate your legs to relieve discomfort? Yes No

Please circle two or more activities which are affected by your leg symptoms: Shopping Housework Job requirements

Exercise Walking the dog Other activities not listed: _____

Please answer the following questions. Provide the best estimate for dates of occurrence.

1. Have you ever had vein stripping surgery? Yes No
   If yes, which leg? right leg both when? _____

2. Have you ever had vein injections? (sclerotherapy) ? Yes No
   If yes, which leg? right leg both when? _____

3. Have you ever had a blood clot (deep vein thrombosis)? Yes No
   If yes, which leg? right leg both when? _____

4. Have you ever had phlebitis? Yes No
   If yes, which leg? right leg both when? _____

5. Have you had a previous vein study Yes No
   If yes, where and when? _____

Does anyone in your family have a history of varicose veins, spider veins, leg ulcers, or swollen legs? **Circle your answer please.**

Father	Yes	No	Brother(s)	Yes	No
Mother	Yes	No	Sister(s)	Yes	No
Other relatives	Yes	No			

Health History Form (continued)

Name: _____ Date: _____

Date of Birth: _____

Do you have asthma or a history of asthma? Yes No

Do you have migraine headaches? Yes No

Do you use aspirin or blood thinners? Yes No

List your Drug Allergies: _____

Circle all Pain Medication you use for your leg symptoms: Advil Aspirin Aleve Ibuprofen Motrin Tylenol Other: _____

List all prescription medication, Vitamins, and supplements you take: _____

_____

_____

List previous Surgery and/or Hospitalizations and when they occurred:

_____

_____

Alcohol consumption: Daily Occasionally Rarely Never

Exercise: Daily Occasionally Rarely Never

Tobacco Use Daily Occasionally Rarely Never

Female patients: Number of pregnancies: _____ Number of live births: _____

Please circle yes or no:

Recent weight loss/gain	Y	N	Unexplained Fever	Y	N
Fatigue	Y	N	Skin problems	Y	N
Neurological problem	Y	N	Gastrointestinal problem	Y	N
Cardiac	Y	N	Respiratory	Y	N
Genitourinary	Y	N	Musculoskeletal	Y	N
Mental	Y	N	Endocrine	Y	N
Hematological (blood)	Y	N	Immune System	Y	N
Arterial/Vascular	Y	N	OB/Gyn	Y	N
Diabetes	Y	N	Bleeding disorder	Y	N

Patient Registration Form

First name: _____ Last name: _____ Middle Initial: _____

Preferred name: _____ email address: _____

SSN # _____ _____ _____ Date of birth: _____ Age: _____ Marital status: _____

Address:_____ Apt. # or P.O. Box: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Name of spouse: _____ Spouse's date of birth: _____

Emergency Contact name and phone number: _____ _____
name and relationship to patient phone #

Employer: _____ Retired: Yes No Full-time student: Yes No

Spouse's Employer: _____ Retired: Yes No Full-time student: Yes No

Name of primary insurance company: _____

Name of secondary insurance company: _____

Name of primary care physician: _____

How did you hear about The Vein Center?
for example: referring physician's name, friend, relative, another patient, or the name of publication you saw our ad

_____

I authorize Dr. Thomas R. Wieters to request medical information necessary for my treatment. If I am covered under Blue Cross and Blue Shield, and/or Medicare, I authorize these entities to pay insurance benefits to be made on my behalf to Dr. Thomas R. Wieters for any services. I authorize any holder of medical information necessary to process a claim to release to the Health Care Financing Administration, its agents, or my insurance company, any information needed to determine benefits payable for related services. I permit a copy of this authorization to be used in place of the original. **We ask you to please check with your insurance company for deductible, co-insurance and co-pay information.**

I understand that I am financially responsible for all charges rendered. If, for any reason, it becomes necessary to initiate collection proceedings, I understand I am responsible for the costs of all treatment received, as well as any and all legal and collection fees that The Vein Center incurs.

Signature: _____ Date: _____

Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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 healthcare providers who may be involved in that treatment directly or indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a copy of the current Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I give permission for the staff at The Vein Center to discuss my account information with the following people:

_____

Patient name:_____ **Date**:_____

Signature:_____**Relationship to Patient:**_____

Please indicate below the methods that this office may use to contact you:

You may contact me at my home telephone number	**yes**	**no**
You may leave a message on my home answering machine	**yes**	**no**
You may contact me on my cell phone	**yes**	**no**
You may leave a message on my cell phone voicemail	**yes**	**no**
You may contact me at my work telephone number	**yes**	**no**
You may leave a message on my work voicemail	**yes**	**no**
You may leave a message with another person at the home telephone number	**yes**	**no**
You may leave a message with a co-worker	**yes**	**no**
You may contact my emergency telephone number and leave a message	**yes**	**no**

Please sign box 12 + 13

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M F					4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other					7. INSURED'S ADDRESS (No., Street)
CITY	STATE	8. PATIENT STATUS Single Married Other					CITY STATE
ZIP CODE	TELEPHONE (Include Area Code)	Employed Full-Time Student Part-Time Student					ZIP CODE TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) YES NO					a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F		b. AUTO ACCIDENT? PLACE (State) YES NO					b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? YES NO					c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 3. 2. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.		

THE VEIN CENTER

Thomas R. Wieters, M.D.
3070 Highway 17 North Suite 202
Mount Pleasant, South Carolina 29466

Telephone (843) 881-8346
Fax (843) 284-4093

Phlebology
General & Vascular Surgery

Our goal at The Vein Center is to serve you and all our patients in a prompt time frame with the most current appointment possible, so please consider us when re-scheduling. Procedures require the coordination of numerous staff, including Registered Nurses, Ultrasound Technologists, and the Physician.

- 48 business hours are required to re-schedule or cancel procedures (VNUS Closure or ultrasound guided endovenous chemical ablation).

- 24 business hours are required to re-schedule or cancel initial appointments and ultrasounds.

- No shows or cancellations less than 24 hours will require credit card information **before** rescheduling and the office visit and ultrasound charge will be processed to the credit card. This excludes unforeseen extreme emergencies.

Please sign and date:

_____ date: _____

The Vein Center
3070 Hwy 17 North Suite 202
Mt Pleasant, SC 29466
843-881-8346 (VEIN)

From Mt. Pleasant

Take Hwy 17 North. Go past I-526, past Towne Center, past the Isle of Palms connector. Stay on Hwy 17 North past Hwy 41. Just past the Hwy 41 intersection, watch for the left hand turn into the Ivy Hall subdivision. Turn left into Ivy Hall subdivision and take an immediate left into the parking lot. **The Vein Center** is on your right.

From Downtown Charleston

Take Hwy 17 North to Mt. Pleasant. Continue north on Hwy 17 North (Johnnie Dodds Blvd), past I-526, past the Isle of Palms connector. Two stop lights past the Hwy 41 intersection, watch for the left hand turn into the Ivy Hall subdivision. Turn left into Ivy Hall subdivision and take an immediate left into the parking lot. **The Vein Center** is on your right.

From West Ashley

Take I-526 East to Hwy 17 North. Turn Left onto Hwy 17 North. Go past the Isle of Palms connector. Go past the Hwy 41 intersection. Just past the Hwy 41 intersection, watch for the left hand turn into the Ivy Hall subdivision. Turn left into Ivy Hall subdivision and take an immediate left into the parking lot. **The Vein Center** is on your right.

From North Charleston

Take I-26 to I-526 East toward Mt. Pleasant. Take the Hwy 17 North (towards Georgetown) exit. Take Hwy 17 North past the Isle of Palms connector, and past the Hwy 41 connector. Just past the Hwy 41 intersection, watch for the left hand turn into the Ivy Hall subdivision. Turn left into Ivy Hall subdivision and take an immediate left into the parking lot. **The Vein Center** is on your right.

From Isle of Palms and Sullivan's Island

Take the Isle of Palms connector to Hwy 17 North. Turn right onto Hwy 17 North. Just past the Hwy 41 intersection, watch for the left hand turn into the Ivy Hall subdivision. Turn left into Ivy Hall subdivision and take an immediate left into the parking lot. **The Vein Center** is on your right.

From Georgetown

Take Hwy 17 South. Just past the Park West subdivision entrance on the right, watch for the Ivy Hall subdivision on your right. Turn right into the Ivy Hall subdivision, and take an immediate left into the parking lot. **The Vein Center** is on your right.