RED SANDS VEIN & LASER INSTITUTE

PATIENT INFORMATION (please print)

Today's Date_____

Name_____
Last First MI

Mailing Address_____

Home Phone( )_____Work Phone( )_____Cell Phone( )_____

Date of Birth_____/_____/_____ SSN_____ Age____ Sex____ Marital Status_____
Language_____ Employer_____

Email Address_____

How did you hear about RSVL? Physician Family/Friend Radio Magazine Other_____

INSURANCE POLICY HOLDER(if different from patient)

Name_____
Last First MI

Mailing Address_____

Home Phone( )_____Work Phone( )_____Cell Phone( )_____

Date of Birth_____/_____/_____ SSN_____ Age____ Sex____ Marital Status_____

INSURANCE INFORMATION (Please present insurance card at time of check in)

Primary Insurance_____ Secondary Insurance_____

Name of Insured_____ Name of Insured_____

Date of Birth of Insured_____/_____/_____ Date of Birth of Insured_____/_____/_____

Insured's ID#_____ Insured's ID#_____

Relationship to Patient_____ Relationship to Patient_____

Pharmacy of Choice_____ Phone #( )_____

In case of an Emergency, who should be notified?_____

Relationship to Patient_____ Phone #( )_____

Primary Care Physician_____ Phone #( )_____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

Patient Signature_____ Date_____/_____/_____
Name_____ Date_____/_____/_____

Jeremy Hopkin, MD
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Daniel Adams, MD
Ivo Hanza, NP-C
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PATIENT INFORMATION (please print)

Date of Birth ____/_____/_____ Age _____ Sex: M F

Symptoms:	Right	Left
Unsightly veins	☐	☐
Ankle edema	☐	☐
Bleeding from vein	☐	☐
Leg pain while standing	☐	☐
Itching	☐	☐
Ulcer_____ (Location)		

	Right	Left
Aches/Pains	☐	☐
Heavy/Tired legs	☐	☐
Restless legs	☐	☐
Leg pain while resting	☐	☐
Night cramps	☐	☐

Duration of symptoms: _____Multiple Years _____Less than 1 year

History:	Right	Left
SVT (Superficial vein blood clot)_____ (# of episodes)	☐	☐
DVT (Deep vein blood clot)_____(# of episodes)	☐	☐
PE(Blood clot in lung)	☐	☐
Spider Vein treatment	☐	☐
Sclerotherapy	☐	☐
Ligation/Stripping	☐	☐
Thermal Ablation	☐	☐

Worn prescription compression stockings? Y N

____Longer than 3 months _____Longer than 6 months _____Longer than 12 months

Taking any medication for pain from veins, etc.? Y N _____ Does it help? Y N

Do you have an intolerance to anti-inflammatories? Y N

Female Patients ONLY:

Labial Varices? Y N

Pelvic Pain? Y N (If yes, please continue to questions below)

Please answer the following questions on a scale from 0 to 10, 10 being the highest level of pain.

How intense is your overall pelvic pain? 0 1 2 3 4 5 6 7 8 9 10

How intense is your pelvic pain while lying down? 0 1 2 3 4 5 6 7 8 9 10

How intense is your pelvic pain while standing? 0 1 2 3 4 5 6 7 8 9 10

How intense is pain in your leg(s) while lying down? 0 1 2 3 4 5 6 7 8 9 10

How intense is the pain in your leg(s) while standing? 0 1 2 3 4 5 6 7 8 9 10

How intense is your pain during menstruation? 0 1 2 3 4 5 6 7 8 9 10

How intense is your pain during or after intercourse? 0 1 2 3 4 5 6 7 8 9 10

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PATIENT INFORMATION (please print)

Personal Health History Today's Date _____/_____/_____

Patient Name_____

SURGERIES

YEAR	Surgery	If Hospitalized, name of hospital

MEDICAL HISTORY _____
_____
_____
_____

MEDICATIONS

List all medications you are currently taking including dose.
(i.e. Ibuprofen 800 mg)

Medication	**Dose**	**Allergies to Medications**
_____	_____	List all allergies and reaction
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

HEALTH HABITS (Check substances you use and how often you use them)

____ Caffeine _____ Do you Smoke? Y N Current use # packs per day _____

____Tobacco_____ Use to smoke but quit? Y N Year you quit _____

____ Alcohol _____ **OFFICE USE ONLY**: BP:_____ P:_____

____ Drugs _____ Respiratory Rate:_____ HT:_____ WT:_____
(Non-prescription)

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PATIENT INFORMATION (please print)

PLEASE READY THE FOLLOWING INFORMATION CAREFULLY. We would like to share the following office policies with you so that you understand our process, the billing procedures, and your responsibility regarding the charges for the services rendered to you by this office and notifying the office if you are unable to make your scheduled appointment.

FINANCIAL POLICY

1. Insurance Patient: As a courtesy to you, we will file a claim with your primary and secondary plans. When each has paid their portion of the charge, the remainder becomes your balance and is indicated on the statement you will receive from the office. While our billing professionals will do all they can to help you in communicating/negotiating with your insurance plan, we must remind you that you are responsible for all charges until they are paid in full. Keep in mind, we are unaware of your copay, plan deductible and what has been met at the time of service. It is your responsibility to check your insurance benefits. You will be asked to sign an Advance Beneficiary Notice (ABN) for each service provided to you by our office.
   Should a surgical procedure be necessary, we will help you communicate with your insurance for pre-notification or pre-authorization.
   If we do not have a contractual relationship with your insurance carrier, we will bill your primary and secondary insurance for services rendered. If we do not receive payment from either insurance, you will be billed for the entire amount. Please understand that since we do not have a contract with your plan, we are not obligated to adjust our charges based on your plans coverage or benefits. The entire balance remaining after your primary carrier has paid will be billed to you. Payment or payment arrangements must be made 10 days after receipt of statement.

2. Self-pay Patients: We expect payment at the time of treatment for patients who have no insurance coverage. We will do our best to give you an estimate of the charges prior to your visit. If a surgical procedure is necessary, we will collect 50% of the cost prior to the procedure being done. Prior to the procedure, or on the date of the procedure, you will be asked to guarantee payment for the remaining balance by providing RSVL with a credit card number. If financial arrangements are needed, you will need to arrange this with our billing office.

3. Medicare Patients: We are a Medicare participating provider. We will bill Medicare carriers. You will be responsible at the time of service for payment of co-payments and charges for non-covered or cosmetic services. You will be asked to sign an Advance Beneficiary Notice (ABN) for each service provided to you by our office.
   If you have Medicare as well as secondary coverage with a commercial plan that we do not have contractual coverage with, we will file a claim to your secondary/supplemental carrier. If no payment is received from your secondary/supplemental carrier within 45 days after we file a claim, you will be sent a bill and will be responsible for the balance.

4. All follow ups and office visits are a separate charge and will be billed accordingly.

CANCELLATION POLICY

1. Late Patients: Patients are required to be on time to their appointment. If possible patients should arrive a few minutes early to check in and fill out any required paperwork. If a patient is more than 20 minutes late for an appointment, the appointment may be cancelled. It will be at the discretion of the provider and the office staff to determine if there will be enough time to see the patient without making other patients wait. A cancellation fee may be charged if your appointment has to be cancelled.
2. Cancellation/No Shows:
   a. Prior to an appointment our office will attempt to contact you the day before as a reminder of the appointment. If the patient is unable to make the consultation/ultrasound or follow-up/ultrasound, they are requested to give a 24-hr notice. Our time is valuable and it is difficult to fill the cancelled appointment slot on such short notice. If this notice is not given in time, or not at all, then the patient will be charged $50.00
   b. Prior to procedure our office will attempt to contact you as a reminder of the procedure. If the patient is unable to make the procedure appointment, they are requested to give a 48-hr notice. If this notice is not given in time, or not at all, then the patient will be charged $200.00 for cancelled/missed procedure.

Your signature below signifies that you understand and agree to our financial policy, our cancellation policy, and your responsibility regarding charges incurred in this office.

Signature_____ Date_____/_____/_____

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