

DALLAS VEIN SPECIALISTS

LONNIE L. WHIDDON, M.D.

PATIENT INFORMATION

Patient Name: <i>(First, Middle, Last)</i>		Age:	Date of Birth: ____/____/____	Sex: M F
SSN: ____-____-____		Drivers License #:		Marital Status:
Street Address:				
City:	State:	Zip Code:	E-Mail:	
Home #:	Work #:		Cell #:	
Employer Name:			Occupation/Title:	
Employer Address:			Phone #:	
City:	State:	Zip:		

SPOUSE INFORMATION (FOR INSURANCE PURPOSES)

Name:	Date of Birth: ____/____/____	SSN: ____-____-____
Home #:	Cell #:	
Employer Name:		Phone #:

REFERRING PHYSICIAN (OR SOURCE) INFORMATION:

Name:	Specialty:		
Address:		Phone #:	Fax#:
City:	State:	Zip:	
Other referring source:			

EMERGENCY CONTACT INFORMATION:

Name:	Relationship:	Phone#:
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INSURANCE INFORMATION:

Name: Primary
Name: Secondary

Authorization to Release Information: I hereby authorize Dallas Vein Specialists to release any medical information to process a medical claim. I understand that I am financially responsible for any and all charges rendered at the time of the office visit and that fees collected on the days of procedures. If for any reason it becomes necessary to initiate collections proceedings, I understand that I am responsible for the cost off all treatments received, as well as any and all legal or collection fees Dallas Vein Specialists incurs. **I agree to inform DVS if any changes in my insurance policy.**

Sign: _____ Date: ____/____/____

HEALTH INFORMATION:

Patient Name:	Height:	Weight:	Sex:	Age:
Referring Doctor (or source):		Primary Care Physician:		
Chief Complaint: <i>(Regarding Veins/Leg)</i>				
Have you had previous vein treatment? If yes, when and by whom?				

PHYSICAL FINDINGS:

			Describe how long these symptoms have been present.
Ache/Hurt:	Left	Right	
Swell:	Left	Right	
Cramp:	Left	Right	
Restlessness:	Left	Right	
Fatigue:	Left	Right	
Itch:	Left	Right	
Other:	Left	Right	

Skin Discoloration	L	R		Flat, Blue/Green Veins	L	R	
Purple/Red Veins	L	R		Leg Ulcers	L	R	
Vein Network	L	R		Bulging veins	L	R	
Abdominal Veins	L	R		Bleeding/ Vein Rupture	L	R	

CONSERVATIVE THERAPY:

Please check any methods you have used to relieve your symptoms.			
No Discomfort		Warm Soaks	
Leg Elevation		Cold Packs	
Exercise		Pain Meds	
Flexion/Extension		Aspirin	
Walking		Tylenol	
Support Hose (please note amount of time worn) # _____ Months/Years/Days		Ibuprofen	
Wraps		Other:	

PAST MEDICAL HISTORY:

Have you had any previous vein treatment? Please list the treatment and the doctor?

_____	_____
_____	_____
_____	_____

Are you currently being treated for an illness? If so list:

_____	_____
_____	_____

Please list any operations or procedures you have previously had and when these have occurred.

_____	_____
_____	_____
_____	_____

Are you pregnant or could you possibly be pregnant?

Do YOU have a history of the following?

Check those that apply:	X	When were you diagnosed:
Migraine Headaches		
Diabetes (list type)		
Anemia		
Skin Changes		
Vein Rupture		
Blood Disorder		
Clotting Disease		
DVT (Deep Vein Thrombosis)		
Heart Disease		
Hypertension		
Mitral Valve Prolapse		
Bleeding Disorder		
Pulmonary Embolus		
Superficial Thrombophlebitis		
Leg Ulcers		
Trauma to the leg		
Hepatitis (list type)		
HIV		
Other:		

Do you smoke cigarettes?	Yes	No	<i>Frequency & Amount:</i>
Do you drink?	Yes	No	<i>Frequency & Amount:</i>

FAMILY HISTORY:

Has anyone in your family been treated for or currently being treated for any of the following?

	X	Relationship and Treatment
Varicose Veins		
Spider Veins		
Venous Ulcers		
Clotting Disorders		
Bleeding Disorders		
Stroke		

MEDICATIONS:

Please list any current medications with doses you have been prescribed or over the counter medications you take regularly.

_____	_____
_____	_____
_____	_____
_____	_____

Do you have any sensitivity/allergies to medicines or tape? List all:

HIPAA AUTHORIZATION

I understand that I am giving authorization to Dallas Vein Specialists (and/or its designated record/database custodian) to release and disclose my protected health information. This information may relate to my past, present, or future payment for the provision of health care to me.

I may revoke this authorization at any time by notifying in writing of my intent to revoke this authorization. However, I also understand that such a revocation will not have any effect on any information already used or disclosed by Dallas Vein Specialists before receipt my written notice of revocation. And, I also understand that my revocation may not be honored if Dallas Vein Specialists have taken action in reliance upon my signed Authorization Form.

I understand that I may inspect and receive a copy of the protected health information to be released and disclosed pursuant to this Authorization Form. By signing this form below, I acknowledge that my signature is voluntary and I understand that I am not required to sign this form in exchange for receiving health care treatment.

A photocopy or facsimile copy of this authorization shall be considered as effective and valid as the original. If the patient is a minor, is incapacitated, or is deceased, then the signature of the guardian or representative shall be considered as effective and valid.

Signature of Patient (or Guardian/Representative)

Date

Printed Name of Patient (or Guardian/Representative)

Date

Dallas Vein Specialists
Lonnie Whiddon, MD

TO OUR PATIENTS:

Our foremost goal is to provide you with excellent medical care. Our staff hold that as our highest priority. We also want to excel in providing you with clear information about the financial concerns and responsibilities you have as a patient and we have as a medical practice. To that end, we hope you will carefully read the following summary about insurance and cash reimbursement. If you have any questions please ask our office for further explanation.

Managed Care Contracts

We have chosen to contract with a number of insurance companies or networks to provide medical care to their insured members at a negotiated discount. If you are insured by one of these companies or through one of the networks, we are considered **In-Network** providers for you. We abide by the terms of our contract with them *which includes the collection of Co-Pays, Co-Insurance, and Deductable amounts. By contract, we collect these amounts at time of service for office visits and in advance for surgeries and may not waive them.*

We make every effort to obtain reliable information from the insurance companies/networks and obtain the benefits with the company. Based on that information, we collect your portion of the fee. If the information proves to be incorrect when the claim is filed, you may owe additional money or we may refund money to you. *You receive an Explanation of Benefits (EOB) at the same time as we receive payment. The EOB states the contracted amount, the amount of Patient Responsibility, and the discount for which the practice cannot bill a patient.* If the EOB is incorrect, we will file an appeal. Otherwise, the amount due from you stands as per the contract. If, in spite of our best effort, we have collected an incorrect amount from you, we will either refund any overpayment to you promptly or collect any underpayment from you promptly.

Prompt Pay Discount

We welcome patients to our practice who are not covered by insurance plans/payors with whom we are contracted. Some patients are covered by Medicare; we are NOT Medicare providers and cannot file claims with Medicare or receive payment from them. Some patients are covered by insurance plans/payors with whom we are NOT contracted and are considered Out-of-Network with our practice. Some patients are not insured at all. We believe our fee schedule reflects a usual and customary fee for the medical services provided. However, we do offer a discount for prompt payment at the time of visits and diagnostic testing. Payment for surgery is due on or before the day of surgery. We extend a discount for this timely payment. Our office manager will be pleased to discuss this policy with you.

Financial Policy for Sclerotherapy (cosmetic treatment)

Sclerotherapy for spider veins is considered a cosmetic procedure and is not covered as a medical benefit. This is true even if the spider veins cause symptoms such as aching and burning. Payment will be expected at the time of service. Treatment of spider veins involves time and injection agents, both of which are expenses covered in the treatment charge. Each treatment session is a separate charge. The response to the treatment is variable with some patients having an excellent result and some less than hoped for results. The charge for the service is the same regardless of the outcome of treatment.

Written Estimate

You may request a written estimate of your out-of-pocket expenses. We are glad to comply with this request as we want our patients to be informed about the financial implications of their medical care. Please ask our billing manager if you want such an estimate.

If you have any questions about the above information or any uncertainty regarding payment for services, PLEASE do not hesitate to ask us.

Signature

Date