Rejuvenation
THE VEIN RESTORATION GROUP

PATIENT REGISTRATION FORM

Patient ID:_____

PATIENT INFORMATION

Patient name: _____ Date of Birth: _____ Social Security #:_____

Address: _____ City: _____ State: _____ Zip: _____

Gender: ☐ Female ☐ Male Home Phone: _____ Cell phone: _____

Consent to send appointment reminders via text: ☐ Yes ☐ No

Email: _____ Request Portal Access: ☐ Yes ☐ No

Prefer method of contact: ☐Home Phone ☐Cell Phone ☐ Online Portal ☐Other _____

Marital status: ☐ Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Partner

Primary Language: _____ Race: _____ Ethnicity: _____

Were you referred by a Physician? ☐Yes ☐ No **If yes, please indicate below.**

Referred by: _____ Phone: _____

If No, how did you hear about us? ***(Check all that apply)***

☐ Patient in Practice ☐Internet Search ☐ Facebook ☐ Vein Screening

☐ Other _____

Primary Care Physician: _____ Phone: _____
Pharmacy: _____ Phone: _____

Would you like a summary of your visit to be sent to your Primary Care Physician in addition to your Referring Physician? ☐Yes ☐No

EMERGENCY CONTACTS

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

INSURANCE INFORMATION

Guarantor (insurance policy holder)

Name: _____ Relationship: _____ Date Of Birth: _____

Primary Insurance Name: _____ Policy / ID #: _____

Secondary Insurance Name: _____ Policy / ID #: _____

Patient ID:_____

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Financial Agreement

We would like to thank you for choosing RejuVeination. We make every effort to keep you informed of your financial responsibilities and available options. Please review our Financial Policy outlined below regarding your obligations as a RejuVeination patient.

No Insurance: Payment will be due at the time of service.

Insurance: While your insurance policy is a contract between you, your employer and the insurance company, we will gladly file your claims on your behalf. In exchange for this service we request that you assign insurance benefits to be paid directly to the healthcare provider for all services rendered at RejuVeination.

Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely your responsibility. Although we may estimate your insurance benefits, we are not responsible for their accuracy. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate. All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all the services we provide are covered benefits. **Fees for non-covered services, along with deductibles and copayments, are due at the time of treatment.**

Patients may incur, and are responsible for the payment of additional charges at the discretion of RejuVeination. These charges may include, but are not limited to:

- Compression Stockings Small-Large (Short/Long) $40; Extra Large (Short/Long) $65
- Charge for returned checks $30.
- Charge for missed *Procedures* that are not rescheduled will be billed a $100.00 fee.
- Charge for any procedure that is rescheduled within 72 hours of the original date of service will be billed a $100.00 fee.
- Any costs associated with collection of patient balances

For questions regarding your out of pocket responsibilities, your insurance company can provide you an Explanation of Benefits outlining payments and patients balances, and can give you very detailed information regarding your benefits. Some questions to ask are:

- What is my deductible amount and how much has been met?
- What is my coinsurance percent?
- What is my yearly out of pocket, does that include my deductible and how much of that has been met?

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services or as the responsible party for minor patients, and that it is my responsibility to know the terms of my insurance.

_____ _____

PATIENT SIGNATURE DATE

Patient ID:_____

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PATIENT PRIVACY NOTICE / AUTHORIZATION TO DISCLOSE

In accordance with Ohio State Law and the 1996 HIPPA Privacy Act, we are not permitted to disclose, copy transfer, email, fax, mail, etc. any protected health information to anyone without your written consent. We make every effort to keep your records safe and secure.

By signing below, you authorize us to receive and disclose information regarding your medical records to:

1. Primary Care Physician on file
2. Insurance Company on file
3. SureScripts Prescription Medication History
4. Family member as listed below:

Name _____ Relationship _____

Name _____ Relationship _____

I wish to be contacted by any of the following methods: (PLEASE CHECK ALL THAT APPLY)

☐ Online Patient Portal

☐ Home telephone. If unavailable, please leave a message with

☐ detailed information ☐ call back number only ☐ no message

☐ Work telephone. If unavailable, please leave a message with

☐ detailed information ☐ call back number only ☐ no message

☐ Mobile telephone, If unavailable, please leave a message with

☐ detailed information ☐ call back number only ☐ no message ☐

Other: _____

I acknowledge that I have received a copy of our Notice of Privacy Practices related to your treatment at RejuVeination. In the event that you would like your medical records sent on your behalf to a third party, you will be required to sign a Medical Records Release. If you have elected to authorize a family member to receive your records above, RejuVeination cannot be held responsible under the HIPPA Privacy Act for re-disclosure of this information to a third party. You have the right to revoke or change this authorization at any time as long as it is done via a written request to the office manager of RejuVeination.

_____ _____

PATIENT SIGNATURE DATE

Rejuveination
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Patient ID:_____

PATIENT PHOTOGRAPH RELEASE FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to the privacy regarding my protected health information (PHI). The term "photograph" includes video or still photography, in digital or any other format, and any other means of recording or reproducing images. I hereby acknowledge that photographs will be taken by one of the designated staff member(s) of Rejuveination, LLC.

This release is to give permission to Rejuveination, LLC to use my digital patient photos solely for the purpose of my medical care and will be kept confidential within my personal medical history file at Rejuveination.

I have been provided the opportunity to ask questions concerning my medical photography and understand that refusal to consent will not affect my medical care.

I have a right to receive a copy of this Authorization.

I certify that I have read the above authorization and release and fully understand its terms, intending to be legally bound hereby.

By signing this form, I acknowledge my consent and I further recognize that this consent may be revoked at any time by written request or by completion of a new form.

Patient Name: _____Date of Birth of Patient: _____

_____

Patient Signature Date

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Comprehensive Patient History Form

Patient ID:_____

Reason for your visit today:

- ☐ Varicose (Bulging) Veins _____ Right _____ Left _____ bilateral
- ☐ Leg pain/swelling _____ Right _____ Left _____ bilateral
- ☐ Cosmetic (spider veins) _____ Right _____ Left _____ bilateral

VENOUS HISTORY

*Do you have **family history** of any of the following concerns? **Please check all that apply.***

- ☐ Spider or Bulging Veins
- ☐ Deep Vein Thrombosis
- ☐ Stroke
- ☐ Clotting disorders

Please check any of the symptoms below you have experienced in your legs or ankles:
If any are checked below, **please note, how often the symptoms occur and circle the level of severity of each symptom & indicate length of time (yrs. /months) you have been experiencing each symptom.**

- ☐ Ache/Hurt: _____ Mild, Moderate, Severe _____ Length of Time _____
- ☐ Swell: _____ Mild, Moderate, Severe _____ Length of Time _____
- ☐ Cramp: _____ Mild, Moderate, Severe _____ Length of Time _____
- ☐ tired/heavy: _____ Mild, Moderate, Severe _____ Length of Time _____
- ☐ Itch: _____ Mild, Moderate, Severe _____ Length of Time _____
- ☐ Restless leg: _____ Mild, Moderate, Severe _____ Length of Time _____

If you have experienced any of the following, please check all that apply:

- ☐ Bulging Veins
- ☐ Leg Ulcers
- ☐ Spider Veins
- ☐ Ruptured Vein
- ☐ Pulmonary Embolism
- ☐ Deep Venous Thrombosis
- ☐ Bleeding Disorder
- ☐ Abdominal Veins
- ☐ Diagnosis of vein disease
- ☐ Superficial blood clots
- ☐ Skin discoloration below knee

Please check any methods you have used to relieve your leg discomfort:

- ☐ Warm socks
- ☐ Cold Packs
- ☐ Wraps
- ☐ Rx Pain Meds
- ☐ Ibuprofen
- ☐ Tylenol
- ☐ Aspirin
- ☐ Flex/extension of your feet
- ☐ Other_____ (ex: leg elevation)
- ☐ No method alleviates pain

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Have you ever had any of the following treatments for your veins?

☐ Stripping	☐ Laser Catheter Ablation	☐ Ambulatory Phlebectomy
☐ Ligation	☐ Laser for Spider Veins	☐ Ultrasound-guided injections
☐ Cosmetic injections	☐ Radiofrequency Ablation	☐ Other: _____

If so, by whom? _____ When? _____Was it successful? _____

MEDICAL HISTORY

Please indicate any of the following that apply to you currently or in the past:

☐ Anemia	☐ Dizzy Spells	☐ Paralysis / Numbness
☐ Anxiety/Depression	☐ Gall Bladder Disease	☐ Rashes/skin irritations
☐ Arthritis	☐ Herpes	☐ Seizures
☐ Asthma	☐ High Blood Pressure	☐ Shortness of breath
☐ Autoimmune Disease	☐ Kidney Disease	☐ Sleep apnea
☐ Bleeding Disorder	☐ Liver Disease	☐ Stomach Ulcers
☐ Bruise easily	☐ Low Blood Pressure	☐ Stroke/TIA
☐ Chest Pains	☐ Lung Disease	☐ Thyroid Disease
☐ Decreased Circulation	☐ Migraine Headaches	☐ Yellow Jaundice
☐ Diabetes	☐ Mitral Valve Prolapse	☐ Vision loss
☐ Diarrhea	☐ Nausea	

When was your last physical exam? _____

Please list any medications you are <u>currently</u> taking: ☐ No Medications

_____ _____
_____ _____
_____ _____
_____ _____

Please list any allergies you have: ☐ No Known Allergies

_____ _____
_____ _____
_____ _____

Do you have a reaction to sulfites? (Red wine/sauerkraut/pickled foods)? Yes_____ No_____

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Do you have any allergies or sensitivities to medication or tape? ☐ Yes ☐ No

If yes, please describe the reaction: _____

FAMILY HISTORY

Has anyone in your immediate family (parent, brother, sister) been treated with the following?

☐ Bleeding Disorder	☐ Deep Venous Thrombosis	☐ Kidney Disease
☐ Cancer	☐ Heart Disease	☐ MI/ Heart Attack
☐ Coronary Artery Disease	☐ High Blood Pressure	☐ Pulmonary Embolism
☐ Diabetes	☐ High Cholesterol	☐ Stroke

SOCIAL HISTORY

Do you smoke cigarettes, marijuana, or use any nicotine products? ☐ Yes ☐ No

If so, how many often do you use each day? _____

Do you normally have more than 2 drinks of alcohol per day? ☐ Yes ☐ No

Have you ever been told you have MRSA or are a carrier of MRSA? ☐ Yes ☐ No

Have you ever had TB, Hepatitis, VRE or any other communicable disease? ☐ Yes ☐ No

WOMEN:

Are you currently pregnant? ☐ Yes ☐ No

Do you plan to become pregnant? ☐ Yes ☐ No

SURGICAL HISTORY: ***Please list any type of surgical procedure you have had.***

Type of Surgery _____ Date _____
Type of Surgery _____ Date _____
Type of Surgery _____ Date _____

Did you experience any difficulties or complication with these surgeries? ☐ Yes ☐ No

If yes, please specify: _____

Have you had local anesthesia (i.e. Novocaine) by a dentist or doctor? ☐ Yes ☐ No

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Have you ever experienced an adverse reaction to anesthesia? ☐ Yes ☐ No

If yes, please describe the reaction: _____

Quality of Life Questionnaire:

What is your occupation? _____.

Are you on your feet for long periods of time? ☐ Y ☐ N If so, how long? _____

Have you worn Compression Hose? ☐ Y ☐ N If so, for how long? ___ year's__ months

Date(s) when compression hose was worn _____.

Does walking or exercise relieve your discomfort? ☐ Y ☐ N

Are your symptoms relieved with rest or elevation of leg(s)? ☐ Y ☐ N

Do you need to stop to elevate your legs throughout the day? ☐ Y ☐ N

Do your symptoms require you to make accommodations at work? ☐ Y ☐ N

Do you feel the need to sit after standing for a short period of time? ☐ Y ☐ N

Are your symptoms worse at end of day? ☐ Y ☐ N

What daily living activities do your symptoms restrict you from doing? (Example: housework, working)

_____

_____

_____

_____