Welcome to Illinois Vein Specialists!

Thank you for choosing Illinois Vein Specialists. We are very pleased to welcome you to our practice and look forward to providing you the most up to date technology in varicose vein treatment.

In order to make your initial visit efficient, we are enclosing the following for you to fill out prior to your appointment:

- Health History Form
- Patient Information Sheet
- HIPPAA Guidelines for you to sign

Please bring a picture ID, insurance cards, and the above paperwork with you on your first visit.

We look forward to meeting you and if you have any questions prior to your visit, please feel free to call us at any time.

Jack Perlmutter, M.D.

Director, Illinois Vein Specialists

A Center of Excellence
in the Diagnosis and Treatment of Vein Disease™

Illinois Vein Specialists, S. C | 22285 Pepper Rd Ste 105, Lake Barrington, IL 60010 | Tel: 847-277-9100 Fax: 847-277-9110

Illinois Vein Specialists

Illinois Vein Specialists, S. C 22285
Pepper Rd Ste 105
Lake Barrington, IL 60010
Tel: 847-277-9100 Fax: 847-277-9110

Patient Name: ______________________________
Nickname: ______________________________
Date of Birth: ______________________________
Sex: ______________________________
Soc. Sec.# ______________________________
Address: ______________________________
City: ______________________________
State: ______________________________
Zip Code ______________________________
Country ______________________________
Marital Status: ______________________________
Race: ______________________________
Ethnicity: Non-Hispanic or Latino
(please check) Hispanic or Latino
Decline to Answer
Language ________________________

Guardian: ______________________________
Home Phone: ______________________________
Work Phone: ______________________________
Cell Phone: ______________________________
License / ID# ______________________________
Contact Email: ______________________________
Emergency Contact: ______________________________
Emergency Phone: ______________________________
Primary Care MD: ______________________________
2nd Physician: ______________________________
Referring Physician: ______________________________
How did you hear about us? ______________________________
____
____
____
____

HIPAA Choices:

Did you receive a copy of the HIPAA Notice? Yes___ No___

Allow Voice Msg? Yes___ No___

Allow Postal Mail? Yes___ No___

Allow SMS (text message?) Yes___ No___

Allow eMail? Yes___ No___

With whom may we discuss clinical or financial information?

Allow Calls to Cell? Yes___ No___

____

Occupation: ________________________
Employer: ________________________
(If retired list your prior occupation)

Employer Address: ________________________
City: ________________________
State: ________________________
Zip Code: ________________________

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Insurance Provider: (Please provide a copy of your card)

Insurer:	______________________	Subscriber:	______________________
Plan Name:	______________________	(If self, do not complete the following lines)	
Effective Date:	______________________	Relationship:	______________________
Policy Number:	______________________	Date of Birth:	______________________
Group Number:	______________________	Soc. Sec. #	______________________
Co Pay:	______________________	Sex:	______________________
Subscriber Employer:	______________________	Subscriber Address:	______________________
Address:	______________________	City:	______________________
City:	______________________	State:	______________________
State:	______________________	Zip Code:	______________________
Zip Code:	______________________	Country:	______________________
Country:	______________________	Subscriber Tele #	______________________

Secondary Insurance Provider: (Please provide a copy of your card)

		Subscriber:	______________________
Insurer:	______________________	(If self, do not complete the following lines)	
Plan Name:	______________________	Relationship:	______________________
Effective Date:	______________________	Date of Birth:	______________________
Policy Number:	______________________	Soc. Sec. #	______________________
Group Number:	______________________	Sex:	______________________
Co Pay:	______________________	Subscriber Address:	______________________
Subscriber Employer:	______________________	City:	______________________
Address:	______________________	State:	______________________
City:	______________________	Zip Code:	______________________
State:	______________________	Country:	______________________
Zip Code:	______________________	Subscriber Tele #	______________________
Country:	______________________		

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PATIENT INFORMATION (PLEASE PRINT)
Medical Information Release and Assignment of Benefits:

I, ______________________________ have authorized medical services from **ILLINOIS VEIN SPECIALISTS, S.C.** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. **Illinois Vein Specialists S.C. is hereby authorized to furnish payments for medical services rendered to myself or my dependents. I understand that I am responsible for ANY and ALL amounts not reimbursed by insurance and further agree** to pay all such charges incurred in full immediately upon receipt of my billing statement.

1) **DEDUCTIBLE:** the amount of expenses that must be paid out of pocket by the insured patient before an insurer will cover any expenses.
2) **COPAY:** fixed amount defined in the insurance policy and paid by the insured patient each time a medical service or a particular medical service is billed.
3) **COINSURANCE:** is a percentage that the insured patient pays after the insurance policy's deductible and copay is exceeded.
4) **NON-COVERED SERVICES:** portion for which policy will not remit payment.

If the office must take any action to collect an outspending balance on my account, I will be responsible for payment and will reimburse **ILLINOIS VEIN SPECIALISTS, S.C.** for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees. If a check is returned for insufficient funds I understand I will be responsible for a $25 returned check fee due to Illinois Vein Specialists.

I certify that the information I have reported with regard to my insurance coverage is correct, current, and coordination of benefits is up to date. I permit a copy of this authorization to be used in place of the original. I have the right to revoke this authorization at any time in writing. I further certify that I have read and fully understand the above contract.

Patient Signature ______________________________ Date ______________________________

Parent or Guardian Signature ______________________________ Date ______________________________

MEDICAL APPOINTMENT NOTICE AND FEES

We understand that sometimes things can up or emergencies can arise, at Illinois Vein Specialists we make every effort to schedule your appointments according to your needs. We put aside our time for only you and we do not double book our appointments. Should you need to cancel or reschedule an appointment with us we require 48 hours notice. This allows us adequate time to refill the appointment and check to make sure you are following the appropriate scheduling needs to continue your care in a timely manner. A missed appointment is defined as failure to show up for an allotted appointment time, without a phone call or notice of at least 48 hours. The fee for a missed appointment is $50. This fee is not covered by insurance and is the patient's responsibility. The missed appointment fee must be paid prior to future office visits. This fee applies to both established and new patients.

By signing below I have read and understand the missed appointment policy:

Patient Signature ______________________________ Date ______________________________

Parent or Guardian Signature ______________________________ Date ______________________________

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PATIENT HISTORY

Patient Name: ____

Patient is here for: ____

____

Chief Complaint: *Please indicate which leg by writing RT=Right, LT=Left, B=Bilateral next to your symptom below

___Pain ___Inflammation ___Spider veins

___Swelling ___Skin rash or discoloration ___Reticular veins

___Varicose veins ___Bleeding ___Numbness or tingling in legs

___Ulceration ___Reddened/hard knot in vein ___Burning

___Restless leg Syndrome ___Leg cramps ___Heaviness

Other: ____

Which Leg: ___Right ____Left ___Bilateral

How Long: ____________________________

Previous Treatments: ____

____

____

Worse With:

___Sitting ___Walking ___Menstrual cycle

___Standing ___Working ___Lying down

___Beginning of day ___End of day ___Pregnancy

Improved By

___Elevation ___Compression Hose ___Fluid Pills

___Rest ___Tylenol/Motrin Equivalent ___Walking

___Beginning of day ___End of day

Social History: Other: ____

Alcohol: ___Never ___Rare ___Occasional/Social ___Daily

Smoking: ___Never ___Quit>10 yrs ___Quit 1-10 yrs ___Quit<1 yr ___Current Smoker

OB History: # of Pregnancies: ______ # of Children: ______

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PATIENT HISTORY (continued)

Past Surgeries:

___Coronary Artery Bypass

___Angioplasty / Stenting

___Vein Stripping

Other: ______________________________

____

____

Past Medical History:

___Coronary Artery Disease

___Blood Clots (DVT)

___High Blood Pressure

___Phlebitis

___Peripheral Vascular Disease

___Varicose Veins

Other: ______________________________

____

____

____

____

____

____

Allergies:

Please List: ______________________________

____

____

____

____

Family History:

___Coronary Artery Disease Details: ______________________________

___Varicose Veins Details: ______________________________

___Blood Clots (DVT) Details: ______________________________

___Peripheral Vascular Disease Details: ______________________________

Other: ______________________________

____

Current Medications:

Please List: ______________________________

____

____

____

____

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PATIENT HISTORY (continued)

Review of Systems: Please check all that apply.

Skin:
___Itching
___Hives
___Bruising
___Bleeding

Eyes:
___Vision changes or loss
___Double Vision

Ears:
___Hearing aids
___Hearing loss
___Pain
___Discharge
___Ringing
___Infections

Nose:
___Nosebleeds
___Discharge
___Infections
___Pain

Mouth/Throat:
___Cavities
___Dentures
___Bleeding Gums
___Sores / Lesions
___Hoarseness

Neck:
___Goiter
___Pain
___Thyroid Problems

Respiratory:
___Cough
___Blood
___Shortness of breath
___Asthma
___Emphysema
___Tuberculosis
___Pneumonia
___Bronchitis

Cardiovascular:
___Chest Pain
___Palpitations
___Shortness of breath
___when sleeping
___when walking
___Legs swelling
___Cramps
___Varicose veins
___Color changes
___Legs/feet

Gastrointestinal:
___Vomiting
___Constipation
___Diarrhea
___Heartburn
___Blood in stool
___Changes in stool
___Difficulty / pain
___in swallowing
___Jaundice
___Liver Disease
___Gallbladder disease

Genitourinary:
___Urine frequency
___Pain
___Bloody urine
___Incontinence

Hematology / Lymphatic:
___Anemia
___Sickle cell
___Hemophilia
___Swollen glands
___Night sweats
___Itching

Neurological:
___Headaches
___Dizziness
___Numbness
___Falls
___Tremors
___Stroke/TIA's
___Loss of memory
___Problems with gait

Psychiatric:
___Depression
___Anxiety
___Bipolar

Endocrine:
___Increased thirst
___Increased Urine
___Intolerance to heat
___Intolerance to cold
___Diabetes
___Hot flashes

Allergy / Immune:
___AIDS
___Hepatitis B
___Hepatitis C

Musculoskeletal:
___Weakness
___Paralysis
___Stiffness
___Joint pain
___Swelling
___Arthritis
___Gout

Patient Signature: ______________________________ **Date:** ____________________

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HIPAA NOTICE OF PRIVACY PRACTICES

In accordance with the Health Insurance Portability and Accountability Act of 1996, as of April 14, 2003 all health care providers are required to provide their patients with a “Notice of Privacy Practice” statement.
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

DISCLOSURE OF YOUR HEALTH CARE INFORMATION

TREATMENT

1. We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, or health care operations.
2. On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with the health care provider named above.
3. It is our policy to provide a substitute health care provider, authorized by the health care provider named above to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider’s absence due to vacation, sickness, or other emergency situation.

PAYMENT

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to us for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received.

Workers’ Compensation

We may disclose your health information as necessary to comply with State Workers’ Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Dug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

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HIPAA NOTICE OF PRIVACY PRACTICES

Marketing

We may contact you for marketing purposes or fundraising purposes as described below.

1. As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If your are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.
2. It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of health care provider sponsored fundraising events.

Change of Ownership

In the event that the health care provider named above is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

1. You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that the healthcare provider named above is not required to agree to the restriction that you requested.
2. You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery upon your request.
3. You have the right to inspect and copy your health information.
4. You have a right to request that the health care provider named above is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
5. You have a right to receive an accounting of disclosures of your protected health information made by the healthcare provider named above.
6. You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

1. The health care provider named above reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, the health care provider named above is required by law to comply with this Notice.
2. The health care provider named above is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please call the office number listed at the top of this page.

Complaints

Complaints about your Privacy rights, or how the healthcare provider named above has handled your health information should be directed to Practice Privacy Officer by calling this office at the number noted at the top of this page. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights, 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, DC 20201

I have read the privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide the healthcare provider named above with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice:

Patient's Name (print) ____

Patient's Signature ____ Date: _____________

Authorized Facility Signature ____ Date: _____________

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Physician and Referral Information

We are very interested to know how you heard about us and who your primary care physician is so that we can keep them updated on your progress. If you could take a moment to fill out the following information, we would appreciate it! This information will also help us to provide better overall care. Any information you can provide is helpful. Thank you!

Primary Care Physician (PCP)

___ I do not have one ___I do not wish to provide information

___I do not wish to share information with my PCP

NAME: ____

ADDRESS:____

SUITE #:______________CITY:______________________________STATE:________ZIP:______________

PHONE #:______________________________FAX#:______________________________

Referral Physician

___ Same as above ___I do not wish to provide information

___I do not wish to share information with my referral physician

NAME: ____

ADDRESS:____

SUITE #:______________CITY:______________________________STATE:________ZIP:______________

PHONE #:______________________________FAX#:______________________________

Referral Source

___ Suburban Woman ___ Quintessential Barrington Magazine
___ Internet ___IVS Website ___Google
___ Yahoo ___E-Mail Blast ___Another Patient (Name: ________________)
___ Other: ____