



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
- HIPPA 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





Illinois Vein Specialists, S. C
22285 Pepper Rd Ste 211
Lake Barrington, IL 60010
Tel: 847-277-9100 Fax: 847-277-9110

Patient Name:	_____	Guardian:	_____
Nickname:	_____	Home Phone:	_____
Date of Birth:	_____	Work Phone:	_____
Sex:	_____	Cell Phone:	_____
Soc. Sec.#	_____	License / ID#	_____
Address:	_____	Contact Email:	_____
City:	_____	Emergency Contact:	_____
State:	_____	Emergency Phone:	_____
Zip Code	_____	Primary Care MD:	_____
Country	_____	2nd Physician:	_____
Marital Status:	_____	Referring Physician:	_____
Race:	_____	How did you hear about us?	_____
Ethnicity:	Non-Hispanic or Latino ☐		_____
(please check)	Hispanic or Latino ☐		_____
	Decline to Answer ☐		_____
Language	_____		_____

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	_____
Employer:	_____	Address:	_____
(If retired list your prior occupation)		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 outstanding 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 _____

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: _____

PATIENT HISTORY (continued)

Past Surgeries:

☐

Coronary Artery Bypass

Other: _____

☐

Angioplasty / Stenting

☐

Vein Stripping

Past Medical History:

☐

Coronary Artery Disease

Other: _____

☐

Blood Clots (DVT)

☐

High Blood Pressure

☐

Phlebitis

☐

Peripheral Vascular Disease

☐

Varicose Veins

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: _____

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 Drug 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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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 you 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: _____

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: _____ ☐ ☐ ☐ ☐

☐ ☐ ☐

☐