PATIENT INFORMATION

PATIENT NAME_____PHONE_____

PATIENT ADDRESS_____CITY_____STATE_____ZIP_____

STATUS (PLEASE CIRCLE): Single Married

ETHNICITY (PLEASE CIRCLE): Caucasian Afro-American Native American Hispanic Asian Middle Eastern

How did you hear about our office? Doctor ___ Another patient ____ Relative ____Friend____Other_____

PRIMARY CARE PHYSICIAN:_____PHONE:_____

PHARMACY:_____PHONE:_____

EMERGENCY CONTACT:_____ RELATIONSHIP:_____ PHONE:_____

ALL FINACIAL ARRANGMENTS FOR PAYMENT SHOULD BE MADE PRIOR TO YOUR TREATMENT.
INSURANCE: PLEASE PRESENT YOUR INSURANCE CARD ALONG WITH IDENTIFICATION TO THE RECEPIONIST. THANK YOU!

Primary Insurance Co. Claims Address

_____ _____

Insured's Name Group # or Name

_____ _____

Primary Insurance Co. Claims Address

_____ _____

Insured's Name Group # or Name

_____ _____

I hereby authorize my insurance benefits to be paid directly to the physician, realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Patient/Guarantor Signature _____Date_____

Patient Name_____ DOB_____ Age_____

ALLERGIES: _____

Pharmacy: _____

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING, BELOW IN CHART:

Medications

Date	Medication	Dosage	Qty	Freq	Refills Date & Initial				Stop Date

Mark any of the following conditions you or a family member has EVER experienced?

Condition	No	Self	Family	Please Explain
Sinusitis	☐	☐	☐	_____
Hypothyroidism	☐	☐	☐	_____
Skin cancer	☐	☐	☐	_____
Abnormal moles	☐	☐	☐	_____
Psoriasis	☐	☐	☐	_____
Eczema	☐	☐	☐	_____
Hives	☐	☐	☐	_____
Asthma	☐	☐	☐	_____
COPD	☐	☐	☐	_____
Lung cancer	☐	☐	☐	_____
Pneumonia	☐	☐	☐	_____
Atrial fibrillation	☐	☐	☐	_____
Murmur	☐	☐	☐	_____
Angina (chest pain)	☐	☐	☐	_____
Ankle swelling	☐	☐	☐	_____
Heart attack	☐	☐	☐	_____
High blood pressure	☐	☐	☐	_____
Rheumatic/Scarlet fever	☐	☐	☐	_____
Gastric reflux (GERD)	☐	☐	☐	_____
Gastric bleeding	☐	☐	☐	_____
Colon cancer	☐	☐	☐	_____
Prostate/cancer enlargement	☐	☐	☐	_____
Testicular cancer	☐	☐	☐	_____
Pinched nerve	☐	☐	☐	_____
Spinal stenosis	☐	☐	☐	_____
Stroke/seizures/TIA	☐	☐	☐	_____
Diabetes (type)	☐	☐	☐	_____
Breast cancer	☐	☐	☐	_____
Anemia	☐	☐	☐	_____

Surgeries & Dates:

_____

Are you pregnant? ____Yes_____No Number of pregnancies_____ Number of Births_____

Please ☑ next to the symptoms that apply to you:

Decreased appetite	☐ No ☐ Yes
Change in weight	☐ No ☐ Yes
High blood pressure	☐ No ☐ Yes
High cholesterol	☐ No ☐ Yes
Fatigue	☐ No ☐ Yes
Fevers	☐ No ☐ Yes
Cancer	☐ No ☐ Yes
Decreased vision	☐ No ☐ Yes
Double vision	☐ No ☐ Yes
Temporary blindness	☐ No ☐ Yes
Blurred vision	☐ No ☐ Yes
Detached retina	☐ No ☐ Yes
Temporal arteritis	☐ No ☐ Yes
Paralysis	☐ No ☐ Yes
Weakness	☐ No ☐ Yes
Seizure	☐ No ☐ Yes
Fainting	☐ No ☐ Yes
Headache	☐ No ☐ Yes
Migraine	☐ No ☐ Yes
Stroke	☐ No ☐ Yes
Numbness in limbs	☐ No ☐ Yes
Slurred speech	☐ No ☐ Yes
Decreased memory	☐ No ☐ Yes
Ankle swelling	☐ No ☐ Yes
Atrial fibrillation	☐ No ☐ Yes
Labored breathing	☐ No ☐ Yes
Dizziness	☐ No ☐ Yes
Congenital heart dis.	☐ No ☐ Yes
Rheumatic heart dis.	☐ No ☐ Yes
Murmur	☐ No ☐ Yes
Loss of consciousness	☐ No ☐ Yes
Palpitations	☐ No ☐ Yes
Chest pain	☐ No ☐ Yes
Chest discomfort	☐ No ☐ Yes
Unable to urinate	☐ No ☐ Yes
Painful urination	☐ No ☐ Yes
Prostate problems	☐ No ☐ Yes
Kidney/bladder dis.	☐ No ☐ Yes
Decr. urine stream	☐ No ☐ Yes
Kidney failure	☐ No ☐ Yes
Blood in urine	☐ No ☐ Yes
Excessive urination	☐ No ☐ Yes

Anxiety	☐ No ☐ Yes
Confusion	☐ No ☐ Yes
Depression	☐ No ☐ Yes
Delusions	☐ No ☐ Yes
Easy bruising	☐ No ☐ Yes
Anemia	☐ No ☐ Yes
Clotting disorder	☐ No ☐ Yes
Bleeding disorder	☐ No ☐ Yes
Pain in leg at rest	☐ No ☐ Yes
Leg pain when walking	☐ No ☐ Yes
Slow healing leg wound	☐ No ☐ Yes
Sensitivity to cold	☐ No ☐ Yes
Arterial disease	☐ No ☐ Yes
History of gangrene	☐ No ☐ Yes
Change in moles	☐ No ☐ Yes
Itching	☐ No ☐ Yes
Rash	☐ No ☐ Yes
Dry skin	☐ No ☐ Yes
Chronic skin problems	☐ No ☐ Yes
Sore throat	☐ No ☐ Yes
Sinus drainage	☐ No ☐ Yes
Hoarseness	☐ No ☐ Yes
Discharge from ears	☐ No ☐ Yes
Nose bleeds	☐ No ☐ Yes
Hearing loss	☐ No ☐ Yes
Ringing in ears	☐ No ☐ Yes
Painful swallowing	☐ No ☐ Yes
Indigestion	☐ No ☐ Yes
Vomiting	☐ No ☐ Yes
Vomiting blood	☐ No ☐ Yes
Gall bladder problems	☐ No ☐ Yes
Liver disease	☐ No ☐ Yes
Hemorrhoids	☐ No ☐ Yes
Diarrhea	☐ No ☐ Yes
Jaundice	☐ No ☐ Yes
Constipation	☐ No ☐ Yes
Abdominal pain	☐ No ☐ Yes
Bloody stools	☐ No ☐ Yes
Change in stool color	☐ No ☐ Yes
Change in bowel habits	☐ No ☐ Yes

Cough	☐ No ☐ Yes
Respiratory pain	☐ No ☐ Yes
COPD	☐ No ☐ Yes
Prod. of sputum	☐ No ☐ Yes
Coughing blood	☐ No ☐ Yes
Apnea	☐ No ☐ Yes
Wheezing	☐ No ☐ Yes
Bronchitis	☐ No ☐ Yes
Pneumonia	☐ No ☐
Bone/joint deformity	☐ No ☐ Yes
Joint swelling	☐ No ☐ Yes
Back pain	☐ No ☐ Yes
Muscle aches	☐ No ☐ Yes
Limited motion	☐ No ☐ Yes
Knee replacement	☐ No ☐ Yes
Hip replacement	☐ No ☐ Yes
Spinal problems	☐ No ☐ Yes
Thyroid disorder	☐ No ☐ Yes
Diabetes w/ insulin	☐ No ☐ Yes
Diabetes -no insulin	☐ No ☐ Yes
Extreme appetite	☐ No ☐ Yes
Extreme thirst	☐ No ☐ Yes
Lupus	☐ No ☐ Yes
Rheumatoid arthritis	☐ No ☐ Yes

FEMALE ONLY

Irregular periods	☐ No ☐ Yes
Breast problems	☐ No ☐ Yes
Menopause	☐ No ☐ Yes
Last pelvic exam	_____ mo / year
Last period	_____ year

OFFICE USE ONLY

VEIN HISTORY

When did you **first** notice your enlarged or discolored vein? _____

Where are the veins you are seeking a medical opinion for located? ☐ Face ☐ Leg (s),
(*Circle*) Right Leg / Left Leg / Both

Do you have a family history of vein problems? ☐ No ☐ Yes, What family member? _____

Please ☑ next to the symptoms that apply to you: (Circle) R = right, L = left, B = both legs

☐ Swelling L R B	☐ Restless Legs L R B	☐ Intense pain L R B	☐ Sharp Pain L R B
☐ Itching L R B	☐ Tenderness L R B	☐ Severe pain L R B	☐ Throbbing L R B
☐ Burning L R B	☐ Tiredness L R B	☐ Dull pain L R B	☐ Numbness / tingling L R B
☐ Heaviness L R B		☐ Aching leg(s) L R B	☐ Discoloration L R B
	Other_____	☐ Cramps L R B	☐ Bleeding of varicosities L R B

What factors bring on your symptoms? _____
How much relief do you experience with sitting after long periods of standing? _____
How much swelling do you have after prolonged standing? _____
Due to leg discomfort, what degree of relief do you find with sitting? _____

Describe how these symptoms have affected your lifestyle activities:
_____
_____

CONSERVATIVE THERAPY:

What is your average daily walking distance? _____
With leg elevation, do symptoms subside? Or worsen? _____
What medications have you taken for your symptoms for more than 2 weeks?
☐ Ibuprofen ☐ Tylenol ☐ Aleve ☐ Advil ☐ Motrin ☐ Aspirin Any relief? _____
What compression grade stockings have you worn? _____ How long? _____
What type of stockings and when? _____
What intervention and/or treatment have you had on your varicose veins? _____

Have you had:

Phlebitis (clot in surface veins in legs?) ☐ No ☐ Yes, When_____
Deep Vein Thrombosis (clot in deep veins?) ☐ No ☐ Yes, When _____
Pulmonary Embolus (blood clot in lungs?) ☐ No ☐ Yes, When _____
Bleeding from vein? ☐ No ☐ Yes, When _____
Have you had sclerotherapy before? ☐ No ☐ Yes, When_____
Venogram (Vein X-Ray?) ☐ No ☐ Yes, When _____
Have you ever had vein surgery? ☐ No ☐ Yes, When _____
Hemorrhoids? ☐ No ☐ Yes, When _____
IV drug use? ☐ No ☐ Yes, When _____
AIDS/HIV/Hepatitis? ☐ No ☐ Yes, When _____
Trauma/injury to your legs? ☐ No ☐ Yes, When _____
Clotting disorder? ☐ No ☐ Yes, When_____

Habits

Do you drink alcoholic beverages? ☐No ☐Yes (*#/week* _____) Exercise? ☐No ☐Yes (*#of days / week* _____)

Do you now or have you ever used tobacco? ☐No ☐Yes (*Packs/week* _____) Quit Date, if applicable _____

ACKNOWLEDGEMENT: The following services may require 3 or more treatments: Aura Laser, Lyra Laser, Sclerotherapy injections. Depending on your individual needs, the length of time in which you will see results can vary. Please discuss the possible number of treatments and costs when scheduling your treatments.

I, _____, verify that the above is true.

Patient Signature:_____ Date:_____

Print Name:_____

NOTICE OF PRIVACY PRACTICES

This notice defines Florida Vein Center Privacy Policy. It describes how healthcare information about you may be used and disclosed and how you can get access to this information.

Please review it carefully:

This office uses and discloses your protected healthcare information (PHI) for the following reasons:

- To share with other treating healthcare providers regarding your health care.
- To submit to insurance companies, Workers' Compensation, or other Third Party Administrators claim information to verify treatment has been rendered.
- To determine patient's benefits in a healthcare plan.
- Releasing information required by State of Federal Public Health Law.
- To assist in overcoming a language barrier when caring for a patient.
- Business associates providing written assurances for your privacy have been attained.
- Emergency situations.
- Abuse, neglect, or domestic violence.
- Appointment reminders to household members or answering machines.
- Sign-in logs may be disclosed to verify office visits.
- *Any other uses or disclosures will only be made with your specific written prior authorization.*

You have the right to:

- Revoke authorization, in writing, at any time by specifying what you want restricted and to whom you want it restricted.
- Speak to our privacy office manager, who can be reached at (941) 907-3400 regarding privacy issues.
- Inspect, copy, and amend your protected health information and amend it as allowed by law.
- Obtain an accounting of disclosures of your protected health information.
- To render a complaint to our privacy officer or the Secretary of Health & Human Services.

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy of our policy, upon request, at any time simply by requesting it from a staff member.

I acknowledge that I have received and reviewed this notice with full understanding.

_____ _____ _____

Patient/Guardian Name (Print) Patient/Guardian Signature Date

NOTICE OF ULTRASOUND LABORATORIES

Federico Richter, MD has a vascular ultrasound lab located at Florida Vein Center. We are required by law to inform you there is other vascular ultrasound testing labs, such as: *Manatee Diagnostic Center (300 Riverside Dr. E, Bradenton, FL 34208) & Manatee Memorial Hospital (206 2nd St. E, Bradenton, FL 34208).*

However, these centers' tests are not as complete as the ones performed by Florida Vein Center' Registered Vascular Technologist. Vital information can be left out which is needed for an accurate evaluation for your plan of care.

Medicare, or any other insurance company will only pay for services deemed to be "reasonable and necessary" under section 1862(a)(1) of Medicare law. Medicare or any other insurance company will deny payment for services that are considered cosmetic procedures. Cosmetic procedures performed at Florida Vein Center are not considered to be medically necessary by your insurance company. They consider these services to be strictly cosmetic. As a provider of these services, we are informing you these will not be filed with your insurance. Only services that are medically necessary will be billed to your insurance company.

_____ _____ _____

Patient /Guardian Name (Print) Patient/Guardian Signature Date

_____ _____ _____

Witness Name(Print) Witness Date

ASSIGNMENT OF BENEFITS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INSURANCE INFORMATION

In consideration of services rendered or to be rendered, I hereby assign to the provider Federico Richter, MD of such services my major medical insurance benefits and rights attendant thereto as shall equal the full amount of the bill for such services, and the provider or his assigns may secure same in my name.

I further understand if said sum is not collected, I will remain liable therefore.

Kindly furnish my insurance company or its representatives all information you may have regarding my condition while under your treatment or observation. You are authorized to provide this information in accordance with applicable laws.

Kindly furnish the provider, or his representatives, all information relating to the status or extent of my applicable insurance benefits.

A photocopy of this assignment and authorization shall be valid and accepted as the original.

DATE: _____

_____
SIGNATURE (IF MINOR PARENT OR GUARDIAN)

PRINT NAME:_____