Albuquerque Vein & Laser Institute New Patient Intake Form

Patient Information

Name: ______________________________ Date of Birth: ______________ Gender: ☐ F ☐ M

Social Security #: ______________________ Driver's License #: ___________________ State: ____

Home Address: ______________________________ City/State/Zip: ________________________

Email address: ____

Contact Numbers- Home: (___)_____________ Work: (___)_____________ Cell: (___)_____________

Employer: ______________________ Employer's address: ______________________________

Spouse Name: ____

Spouse Employer: ____

Referring Physician: ____

Primary Care Physician: ____

Person to Contact in Case of Emergency: ____

Relation to Patient: ______________________________ Telephone #: ____________________

Do you have an advance medical directive document? ☐ Yes ☐ No

How did you hear of our practice? ☐ Referring Doctor ☐ Friend/Family Member ☐ Internet

☐ Yellow Pages ☐Print Ad (where) ______________________ ☐ Other ______________________

Health Insurance Information

Primary Insurance: ___________________________ Policy Holder's Name: __________________

Address: ____ Date of birth: _____________

Secondary Insurance: ___________________________ Policy holder's name: __________________

Address: ____ Date of birth: _____________

Other Insurance: ______________________________ Policy holder's name: __________________

Address: ____ Date of birth: _____________

Authorization: I hereby authorize my insurance carriers to pay benefits directly to Albuquerque Vein & Laser Institute. I understand that I am responsible to pay for any services not covered by my insurance. I also authorize release of pertinent medical information to my insurance carriers and the above-named physicians. I understand that photographs or other digital images may be recorded to document my care. I agree to have photographs taken for my records, and understand they may be required by my insurance company to obtain approval for treatment and for web and social media marketing.

____ ________________________

Signature Date

Albuquerque Vein & Laser Institute Patient Financial Information

Patient Financial Information

Billing Information:

Patients treated in this practice are responsible for the fees associated with their tests, treatments and office visits. Patients seek medical attention for a variety of venous conditions and problems. Medicare and health insurance plans consider some conditions and treatments to be 'medically necessary' and others to be 'cosmetic' or 'elective'.

Cosmetic or elective procedures are usually not covered by insurance plans. Fees for initial office visits and cosmetic services must be paid at the time service is provided. Fees for office consultations may vary, depending on the complexity of the consultation required.

Medically necessary procedures are often covered in part by insurance plans. Albuquerque Vein & Laser Institute bills insurance for medically necessary procedures performed on patients covered by through Aetna, Amerigroup, Blue Cross Blue Shield, Champ VA, Cigna, Coventry, Evercare, GEHA, Healthscope, Humana, Medicaid, Medicare, Molina Health Care, MultiPlan/PHCS, Presbyterian Health Plan, Rock Mountain Health Plan, Tricare, True Health New Mexico, UMR, United Health Care, and Western Sky Community Care. Patients covered by other insurance plans must pay at time of service and will be provided the information needed to submit their claim directly to their insurance carrier.

Payment for Services

All patients except those insured through Aetna, Amerigroup, Blue Cross Blue Shield, Champ VA, Cigna, Coventry, Evercare, GEHA, Healthscope, Humana, Medicaid, Medicare, Molina Health Care, MultiPlan/PHCS, Presbyterian Health Plan, Rock Mountain Health Plan, Tricare, True Health New Mexico, UMR, United Health Care, and Western Sky Community Care, are responsible for full payment. If you have another form of medical insurance, you will be furnished with an itemized statement for professional services rendered for the operative or interventional procedure, and you may submit the charges to your insurance company for reimbursement

Payment of professional fees for elective procedures is due at the time of the procedure.

Patients are encouraged to consult their insurance company to determine or confirm specific coverage.

By using a check for payment, you agree to the following terms: In the event your check is dishonored or returned for any reason, you authorize us to electronically (or by paper draft) re-present the check to your bank account for collection of the amount plus any applicable fees as permitted by state law.

My signature below confirms: I have received a copy and understand Albuquerque Vein & Laser Institute patient financial information.

I understand that it is my responsibility to know what the terms of my insurance coverage are, and in compliance with those terms, agree to pay all applicable co-pays and outstanding patient balances as described in the provided document.

________________________________ ________________

Patient/Guarantor Signature | Today's date

Albuquerque Vein & Laser Institute Notice of Privacy Practices

Notice of Privacy Practices

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.

This notice applies to all of the records of your care generated by the practice, whether made by the practice or an associated facility. This notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA).

HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION
We will routinely use your medical information inside our office for these purposes without any special permission:

Treatment - Our practice may use and disclose your medical information to treat you.
Payment - We may use and disclose your medical information in order to bill and collect payment for services.
Health care operations - Our practice may use and disclose your medical information to operate our business.

In addition, we may use or disclose your medical information for the following reasons:

Appointment reminders- Our practice may use and disclose your medical information to contact you and remind you of an appointment.
Treatment options and health-related benefits - To inform you of potential treatment options or services that may be of interest to you.
Disclosures required by law - Our practice may use and disclose your medical information when we are required to do so by federal, state, or local law.
Health oversight activities - Oversight activities can include investigations, inspections, audits, surveys, licensure and disciplinary actions, civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
Lawsuits and similar proceedings - If you are involved in a lawsuit or similar proceeding, we may use and disclose your medical information in response to a court or administrative order or to defend the office.
Serious threat to health/safety - We may use or disclose your medical information when it is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.
Involvement in individual's care - We may disclose your medical information about you to a family member, close personal friend or other person identified by you if directly relevant to that person's involvement with your care or payment related to your health care.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

Your rights include but are not limited to the following:
- Confidential communications. You have the right to request that we communicate with you in certain ways. Albuquerque Vein & Laser Institute will accommodate reasonable requests.
- Inspection and copies of records. With limited exceptions, you may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. This request must be made in writing and you may be charged a fee for the costs of copying, mailing, and other costs incurred by us in complying with your request.
- The right to request amendments to your information. You may request an amendment of protected health information about you as long as we maintain this information. Requests must be made in writing and must be directed to the office manager.
- Disclosures. You have the right to a detailed list of all disclosures our practice has made of your medical records.
- Paper copy or complaints. You have the right to a paper copy of this notice and the right to file a complaint with the office manager if you feel that your privacy rights have been violated at any time.

I have received a copy of Albuquerque Vein & Laser Institute's Notice of Privacy Practices.

____________________________ ____________________
Signature Date

Albuquerque Vein
& LASER INSTITUTE

Authorization of Release of Information to Family and/or Friends

Name of Patient: ______________________________ Date of Birth: ______________

I authorize Albuquerque Vein & Laser Institute to release protected health information to the entities named below:

Give information to spouse/partner: ___ Yes ___ No ___N/A

Name of spouse/partner: ____

Give information to a family member or friend, please list: ______________________________

Primary Contact Number: ______________________

Contact me at work: ___Yes ___No ___N/A

Leave a message at work: ___Yes ___No ___N/A

Leave message at home: ___Yes ___No ___N/A

Contact me by email/text: ___Yes ___No ___N/A

Description of Information to be released to family or friend:

Financial/Billing: ___Yes ___No

Medical Information: ___Yes ___No

Rights of the patient:

I understand that I have the right to revoke this authorization at any time and I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Albuquerque Vein & Laser Institute. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective immediately upon receipt of notification by Albuquerque Vein & Laser Institute.

I understand that information used or disclosed as a result of this authorization and that my treatment will not be conditional on signing this authorization.

I understand that the information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

This authorization shall be in force and effect until revoked by the patient or representatives signing the authorization.

____ Date: ____________________

Signature of Patient or Personal Representative

Albuquerque Vein & Laser Institute New Patient Intake Form

Name: ______________________________ Date of Birth: ________________

Vein History

Please ☑ next to the symptoms that apply to you: ☐ Aching leg ☐ Burning ☐ Tiredness ☐ Dull Pain ☐ Heaviness ☐ Itching ☐ Leg Ulcers ☐ Restless Legs ☐ Sharp Pain ☐ Swelling ☐ Throbbing ☐ Other: ________

Do you have (now or in the past): ☐ Varicose veins ☐ Spider veins ☐ Skin ulcer

When did you first notice enlarged or discolored veins, or begin experiencing leg discomfort? ________________

Is the problem getting worse? ☐ Yes ☐ No

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

Is the leg discomfort aggravated by: ☐ Standing ☐ Walking ☐ Exercise ☐ Other ____________

Is the leg discomfort relieved by: ☐ Walking ☐ Leg Elevation ☐ Medication ☐ Other ____________

Have you ever worn prescription grade compression stockings? ☐ No ☐ Yes, When and for how long? ________

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

Is there a family history of blood clots in the legs or lungs? ☐ No ☐ Yes, What family member? ____________

Do you take any medications for pain in your legs? ☐ No ☐ Yes, Which? ________________________

Have you ever had any of the following:

Skin ulcer on your leg?	☐ No	☐ Yes, When ________________
Previous vein surgery?	☐ No	☐ Yes, When ________________
Bleeding from varicose veins?	☐ No	☐ Yes, When ________________
Clotting disorder?	☐ No	☐ Yes, When ________________
Deep vein blood clot (DVT)?	☐ No	☐ Yes, When ________________
Pulmonary embolus (blood clot to lungs)?	☐ No	☐ Yes, When ________________
Phlebitis (clot in surface vein of leg)?	☐ No	☐ Yes, When ________________
Sclerotherapy?	☐ No	☐ Yes, When ________________
Trauma/injury to your legs?	☐ No	☐ Yes, When ________________
HIV/Hepatitis?	☐ No	☐ Yes, When ________________
IV drug use?	☐ No	☐ Yes, When ________________

Habits

Do you drink alcoholic beverages? ☐ No ☐ Yes *(#/week __________)*

Do you now or have you ever used tobacco? ☐ No ☐ Yes *(Packs/week ______)*

Quit Date, if applicable __________

Do you exercise regularly? ☐ No ☐ Yes *(#of days / week __________)*

Albuquerque Vein & Laser Institute New Patient Intake Form

Medications (please list all prescriptions, over-the-counter medications, and herbs/supplements)

Allergies (please list any allergies to medications, latex, etc...)

Past Medical History

Condition	YES	NO
Thyroid abnormalities	☐	☐
Asthma	☐	☐
COPD	☐	☐
Atrial fibrillation	☐	☐
Murmur	☐	☐
Diabetes	☐	☐
Cancer	☐	☐
High cholesterol	☐	☐
Glaucoma	☐	☐
Migraine headaches	☐	☐
Depression	☐	☐

	YES	NO
Anemia	☐	☐
Angina (chest pain)	☐	☐
Arthritis	☐	☐
Heart attack	☐	☐
High blood pressure	☐	☐
Acid reflux (GERD)	☐	☐
Spinal stenosis	☐	☐
Stroke/seizures/TIA	☐	☐
Osteoporosis/Osteopenia	☐	☐

Other:

Past Surgical History (Please list surgeries & dates):

Albuquerque Vein & Laser Institute New Patient Intake Form

Females only:

Are you pregnant? ☐No ☐Yes Number of Pregnancies _____ Number of Deliveries _____ Miscarriages_____

Height: _____ft _____ inches **Weight**: _________ lbs

Review of Systems: Have you recently had any of the following symptoms?

General:

Weight changes ☐ No ☐ Yes
Fatigue ☐ No ☐ Yes

Eye:

Decreased vision ☐ No ☐ Yes
Blurred vision ☐ No ☐ Yes

Neurological:

Weakness ☐ No ☐ Yes
Seizure ☐ No ☐ Yes
Headache ☐ No ☐ Yes

Cardiac:

Chest pain ☐ No ☐ Yes
Palpitations ☐ No ☐ Yes
Swelling ☐ No ☐ Yes
Shortness of breath ☐ No ☐ Yes

Urinary:

Painful urination ☐ No ☐ Yes
Blood in urine ☐ No ☐ Yes
Prostate problems ☐ No ☐ Yes

Mental:

Anxiety ☐ No ☐ Yes
Depression ☐ No ☐ Yes
Confusion ☐ No ☐ Yes

Hematologic:

Easy bruising ☐ No ☐ Yes
Abnormal blood clotting ☐ No ☐ Yes

Skin:

Rash ☐ No ☐ Yes
Dry skin ☐ No ☐ Yes

Ears/Nose/Throat:

Sore throat ☐ No ☐ Yes
Nosebleeds ☐ No ☐ Yes
Ringing in ears ☐ No ☐ Yes

GI:

Indigestion ☐ No ☐ Yes
Vomiting blood ☐ No ☐ Yes
Bloody stools ☐ No ☐ Yes
Abdominal pain ☐ No ☐ Yes

Respiratory:

Cough ☐ No ☐ Yes
Wheezing ☐ No ☐ Yes
Coughing blood ☐ No ☐ Yes

Musculoskeletal:

Bone/joint deformity ☐ No ☐ Yes
Joint swelling ☐ No ☐ Yes
Back pain ☐ No ☐ Yes

Endocrine:

Excessive thirst ☐ No ☐ Yes
Thyroid problems ☐ No ☐ Yes

Gynecologic (females only):

Irregular periods ☐ No ☐ Yes
Breast problems ☐ No ☐ Yes