DALLAS
VEIN INSTITUTE
(972) 646-VEIN | dallasvi.com

3500 Oak Lawn Avenue
Suite 380
Dallas, TX 75219

Phone: (972) 646-8346
Fax: (972) 597-4880

Patient Information

Name (First): ____________________________ (MI) _____ (Last) ____

Address ____

City ____ State ___________ Zip Code ____________________

Home Phone _______________________ Cell Phone ________________________

Social Security # _____________________ DOB ____/____/____ Email Address: ___________________________

Sex ☐ Male ☐ Female Marital Status ☐ S ☐ M ☐ D ☐ W

Occupation _________________________________ Employer __________________________

In Case of Emergency, Contact ______________________________ **Phone** ________________________

Relation to patient: ______________________

How did you find out about us? ☐Referral from Physician ___________ ☐ Friend / Family _________________
☐ Internet (website) ☐Insurance Company ☐ Billboard If Yes, circle location: Greenville Ave Love Field
☐ Magazine ☐Other ________________

Physician That Referred You

Name ________________________ Specialty __________________ Phone _______________

Address ________________________________ City _______________ State_____ Zip ______

Conservative Therapy

Have you worn Compression Stockings in the past? **YES** How many months? _______ year: _____ **NO**

Insurance may require you to wear stockings before treatment.

Where can we leave messages? Please circle all that apply

Cell Voicemail **Work Voicemail** **Home Voicemail** **Text Message** **Email**
For Appointment Reminders Only

Other Person's authorized to receive messages on my behalf:

a. Name ________________________________@______________________________

b. Name ________________________________ @ _____________________________

Insurance Information

Policy Holder: ☐ Patient ☐ Spouse

If neither patient or spouse policy holder: Name_____________________ DOB_____________

Primary ____________________ **Secondary** ____________________

Primary Care Physician / Internal Medicine Physician (if other than referring physician)

Name _________________________ Specialty ___________________ Phone ________________

Address _________________________________ City ________________ State_____ Zip _______

Race

☐ American Indian or Alaska Native

☐ Asian

☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander

☐ White

Ethnicity

☐ Hispanic or Latino

☐ Not Hispanic or Latino

☐ Decline to State

Preferred Primary Language

☐ English ☐ Spanish ☐ Other : _______________

HIPAA Notice of Privacy Practices This Notice of Privacy Practices describes how your health information and other private information about you may be used and disclosed, and further, how you may request access to this information.
Please Review this notice carefully. You have privacy rights under Texas and Federal health insurance portability and Accountability Act of 1996 (**HIPAA**). These laws protect your privacy, but also permit us, as covered healthcare providers to use and disclose your information about your treatment, payment and healthcare operation purposes, and to disclose your information to others if the law requires it. This information is available to individuals with disabilities by calling our office.

Why do we use and disclose your personal information?
To decide what services you are eligible for, To distinguish you from other individuals with the same last name, To provide you with medical health, financial or social services that you may need, To determine if you can pay for your services, To undertake research, audits, and evaluations of our programs, To investigate reports of people who may lie about the help they may need, To collect payment from private or public insurance companies for your care. Your social security number is required in order to provide you with coverage and benefit information regarding your insurance company. At times it also allows us to submit claims and check on status of health insurance claims.

Photograph/Video and Personal Testimony Release Form
I understand the photographs that are taken of my legs become property of the Dallas Vein Institute and authorize the Dallas Vein Institute to edit, alter, copy, exhibit the photographs as before and after pictures for educational purposes. My name will not be associated with the photos and waive any right to royalties or other compensation arising or related to the use of the photographs. I hereby grant Dallas Vein Institute my permission to use my photograph and personal testimony or likeness in any and all of their media publications including but not limited to print, website entries, video, social media pictures, and any other considerations. In Addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my photographs and personal testimony or likeness appears. I hereby hold harmless and release and forever discharge Dallas Vein Institute or any future entities they create from all claims, demands, and cause of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate or may have reason of this authorization.

I authorize **Dallas Vein Institute** to execute any documents necessary, and release to my health insurance carrier, or other organization as required, any pertinent medical information about myself as may be required to process claims for reimbursement of fees charged to me for medical treatment at Dallas Vein Institute. I authorize **Dallas Vein Institute** to release my medical records to my referring physician to assist with coordination of care. This medical release is good for one year starting on today's date.

Signature ____ **Date** _________

DALLAS VEIN INSTITUTE

Patient History

Patient Name: ____________________ Date _________ Please list your weight: ________ lbs Height: ______ ft _____ inch

Symptoms: (please check if yes)

	R	L
Aching / pain in leg	☐	☐
Heaviness	☐	☐
Tiredness / Fatigue	☐	☐
Itching / burning / warmth	☐	☐
Leg Cramping	☐	☐
Leg Restlessness	☐	☐
Throbbing	☐	☐
Swelling	☐	☐

Conservative Measures Used Currently or Previously:

☐ Pain Medications ☐ Weight Loss
☐ Leg Elevation ☐ Job Change
☐ Exercise
☐ Compression Stockings or leg wraps?
Strength of stockings: _________ mmHg
How long? _____________
Date Range: _____________

Do your symptoms interfere with your sleep? ☐
Are your symptoms worse later in the day? ☐
Are your symptoms worse with or after activity? ☐ —— If yes, circle type of activities: Work Exercise Stairs Housekeeping Caregiving Walking Standing Other: _________
Do your symptoms keep you from doing anything? ☐

Employment

Are you currently employed? Yes No Occupation: _________________________________

Does your work require: Prolonged standing periods? Yes No How long? ______
Prolonged Sitting? Ye s No How long? ____
Heavy Lifting? Yes No

Tobacco Use History

☐ Never smoked or used tobacco
☐ Former smoker but quit
☐ Current Smoker Amount of cigarettes: ____ per day
☐ Use tobacco in other forms

Alcohol Use History

Did you have a drink containing alcohol in the past year? ☐ Y ☐ N
If Yes: ➔How Often?
____ drinks per day
____ drinks per week
____ drinks per month

List your Allergies & Allergic Response ☐ **No Known Allergies**

____________ ____________ ____________ ____________ ____________

Current Medications: ☐ NONE Include prescription drugs/ over-the-counter drugs, vitamins, minerals, herbals, supplements.

#	Medication Name	Dose	Frequency	Route		#	Medication Name	Dose	Frequency	Route
1				☐ Oral ☐		4				☐ Oral ☐
2				☐ Oral ☐		5				☐ Oral ☐
3				☐ Oral ☐		6				☐ Oral ☐

Patient Signature: ______________________________ Date: _______________

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Patient Financial Responsibility Release

Your signature below forms a binding agreement between Dallas Vein Institute and the Patient who is receiving medical services or the Responsible Party. The Responsible part is the individual who is financially responsible for payment of medical care.

- Dallas Vein Institute will assist you by billing to our contracted insurance providers. However, the patient is required to provide us with the most correct and updated information about their insurance and any changes in phone numbers or addresses, and will be responsible for any charges incurred if the information provided is not correct or updated in a timely manner.
- Patients are responsible for the payment of their **specialist** co-pays for each office visit, coinsurance, deductibles, and complete out of pocket expenses.
- Patients may incur, and are responsible for the payment of additional charges at the discretion of Dallas Vein Institute. These charges may include, but are not limited to:
    - Compression stockings
    - Charge for returned checks - **$25.00 fee**
    - Charge for missed appointments within 24 hours advance notice - **$50.00 fee**
    - Charge for release of medical records (copy/fax) - **$25.00 fee**
    - Any costs associated with collection of patient balances – **fee varies**

Patient Authorizations:

- By my signature below, I hereby authorize Dallas Vein Institute to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies and other third party payers, to obtain authorization for my treatment plan.
- I understand that it is ultimately my responsibility to ensure that proper authorization has been granted by my insurance company prior to my procedures. If I am treated and no authorization was obtained and the services are denied by my insurance company, I am then held financially responsible for that date of service and treatment cost.

Patient Collections:

A portion of your patient responsibility is due prior to your procedure.

A pretreatment breakdown will be given to you to assist you in planning for upcoming procedures. Deductibles and coinsurance questions can be verified by calling your member service department located on the back of your insurance card. Billed Patient balances are expected to be paid within 30 days. Should collection proceedings or other legal action become necessary to collect an overdue account, the Patient or the patient's Responsible Party, understands that Texas Vein and Wellness has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The Patient, or the patient's Responsible Party, understand that they are responsible for all costs of collections including, but not limited to, transfer fees.

For your convenience, we do accept cash, checks, MasterCard, Visa and Discover.

By signing below, you agree to accept full financial responsibility as a Patient who is receiving medical services or as a Responsible Party, and that it is your responsibility to know the terms of your insurance.

Patient name: ________________________________ Signature: ___________________________ Date: _____________

Witness name: _______________________________ Signature: ___________________________ Date: _____________