PATIENT REGISTRATION FORM

PATIENT INFORMATION (Please Print)

Name:_____Today's Date:___/___/____
Last First MI

Preferred Name:_____ Driver's License #:_____

Date of Birth:____/____/_____ Social Security #_____-____-_____

Gender: Male or Female Marital Status: Single / Married / Divorced / Separated / Widow

Address:_____
Street City State Zip Code

Home Phone: (____)_____ Cell Phone: (_____)_____Work Phone: (____)_____

Preferred Method of Contact (Please circle one):

Home Phone Cell Phone Work Phone Email

Is it OK to leave a detailed message on your voice mail? Yes or No

Personal Email Address:_____

Race (Please circle one):

American Indian/Alaskan Native Asian Black/African American

Native Hawaiian/Pacific Islander White/Caucasian Unknown

Ethnicity (Please circle one): Hispanic of Latino Not Hispanic or Latino Decline to specify

Patient Employment Information

Employment Status: Employed Student Self-employed Retired

Employer's Name:_____ Occupation:_____

Emergency Contact Information

Emergency Contact:_____Relationship:_____Phone #(____)_____

Would you like your medical information released to any family member? Yes No

If yes, whom?_____Relationship to you:_____Phone #(____)_____

Pharmacy

Name:_____

Address:_____

Phone Number:_____

How Did You Hear About Us?

Newspaper Ad / Yellow Pages / Insurance Carrier / Internet / Exterior Signage /

Friend or Family / Physician_____ / Other:_____

Physician

PCP Name:_____ OBGYN Name:_____

Phone # (_____)_____ Phone# (____)_____

Insurance Information:

(Please present your current insurance card at time of check in).

Primary Insurance:_____ Policy ID#_____

Group #_____ Insurance Phone #_____

Policy Holder (If not patient): _____

Policy Holder's SSN:_____ Policy Holder's Date of Birth: _____

Secondary Insurance:_____ Policy ID#_____

Group #_____ Insurance Phone #_____

Policy Holder (If not patient): _____

Policy Holder's SSN:_____ Policy Holder's Date of Birth: _____

I understand that I am responsible for all fees regardless of insurance coverage, and that charges are due at time of service unless other arrangements have been made in advance of treatment. If Goldman Vein Institute does bill my insurance, I authorize them to release any or all of my medical records to my insurance companies for assigned payment of medical benefits. Consent is hereby given to the treating physician to administer treatment and to perform such medical and/or surgical procedures that are deemed necessary for treatment.

Patient (Print Name):_____

Patient (Signature):_____Date:_____

OFFICE POLICIES

Insurance Financial Policy:

It is advised that as a patient, you should understand your insurance plan benefits and your responsibility for any deductibles, co-insurance or copayments amounts prior to any visit. As courtesy, Goldman Vein Institute will submit your claim to your insurance carrier; however, this is not a guarantee that your carrier will make the payment. Your insurance identification care is required at each visit, and is the patient responsibility to verify with your insurance company prior to your visit that your particular plan is considered in network with our office. Some insurance policies require that prior to your office visit you must obtain a referral from your primary care physician. If this is not acquired prior to your visit, you may be asked to reschedule your appointment or pay for your visit in full. Payment is required for all services at the time they are rendered unless you are covered under an insurance policy in which we participate. For these patients, applicable copayments, deductibles and/or coinsurance will be collected at the time of service. The patient is responsible for any and all charges not paid for by their insurance company. I have read and understand the financial policy statement. I agree to make prompt payment in full to Goldman Vein Institute when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered. Any unpaid balances will result in collection actions. Further, I authorize payment directly to Goldman Vein Institute for medical insurance benefits payable to me under the terms of my policy but not to exceed the balance due for serviced performed for my treatments. This authorization is valid until revoked in writing.

Disclosure for Medicare Patients

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. This authorization is valid until revoked in writing.

Appointment Policy

In order to provide timely appointments without excessive wait time, we ask that patients arrive to their appointments on time. Please be advised that we reserve the right to cancel an appointment if a patient is more than 15 minutes late.

After Hours Urgent Medical Need

If you required emergency medical services and it is not our offices normal business hours, please call 911 immediately. If this is an urgent medical need and you need to speak with our physician, please call 561-790-4550 or 561-625-9853. Your call will be returned promptly

No Show/Cancellation Policy

If you are unable to make your appointment, Goldman Vein Institute requires a **48 hour** notice prior to your appointment for cancellations. If you do not cancel your appointment within this time period, you are subject to a **$50.00** cancellation/no show fee. This fee will be the responsibility of the patient and is not covered by insurance. An excessive amount of missed appointments could result in being discharged from our practice.

Payment and Financing Options

Our office accepts payment types: Cash, Check, Debit, Mastercard, Visa, American Express. There is a $50.00 fee for any returned checks.

Return Policy

As a convenience, Goldman Vein Institute offers multiple products for sale in the office. It is our policy that open products cannot be returned. **Sales are Final.**

Consent for Photography

It is customary to have photos taken to help in the guidance and care of your medical records. These photos are for in office use only. If photos are needed for any other purpose, additional permission will be obtained. Therefore, I consent for before/after photos to be taken.

Consent to Treatment

As part of the course of the diagnosis and treatment of my medical condition, I voluntarily consent to the provision of all diagnostic tests, physical examinations, medications and other items and services that Dr. Alexander Goldman and/or Dr. Saluja Varghese (My Doctor) deem appropriate to diagnosis and treat conditions that I discuss with my doctor or care providers. I acknowledge that no guarantees have been made to me about the outcome of any services provided by my doctor or care providers.

I acknowledge that I have received and have read and understand the stated Office Policies of Goldman Vein Institute.

Patient Name (Print): _____

Patient Signature: _____

Patient History

NAME: _____ AGE: _____ DATE: _____

Symptoms: *(Please check if yes)*	R	L
Aching/pain in legs	☐	☐
Heaviness	☐	☐
Tiredness/fatigue	☐	☐
Itching/Burning	☐	☐
Leg cramping	☐	☐
Leg restlessness	☐	☐
Throbbing	☐	☐
Swelling	☐	☐

Do your symptoms interfere with your sleep? ☐
Do your symptoms interfere with walking? ☐
Do your symptoms worsen with or after activity? ☐

(Check if you've had any of the following)

Heart disease ☐
Contagious Disease ☐
Hepatitis ☐
High blood pressure ☐
Diabetes ☐
Cancer ☐
Leg Trauma/Surgery ☐
Major Surgery/Hospitalizations ☐
(Please list on back, if needed)

On a scale of 1 to 10, with 10 being the worst, I consider my vein disease to be:

Slightly bothersome 1 2 3 4 5 6 7 8 9 10 Severely affecting my life

Conservative Measures Used *Currently* or *Previously*: *(Please check those measures that you have tried)*

Pain medications or herbal supplements: ☐ Leg elevation: ☐ Exercise: ☐ Job Change: ☐
Compression stockings or leg wraps: ☐ *If so, how long?* _____ Weight loss: ☐

RLS: *(Please check box if yes)*

Do you find the need to move your legs to relieve an uncomfortable feeling? ☐
Do your legs feel better when moving them or walking? ☐
Are your leg symptoms worse when sitting or resting, without elevating legs? ☐
Are your leg symptoms worse later in the day or night? ☐

Women Only: *(Please check box if yes)*

Are you pregnant or considering a pregnancy sometime in the future? ☐
Are you breast-feeding? ☐ Are your legs more painful associated with menstruation? ☐
Have you been diagnosed with Pelvic Congestion Syndrome? ☐
Number of pregnancies? _____ Number of deliveries? _____ Ages of Children? _____

Please list *prescription* and *OTC* medications: *(Use back if needed)*

_____ _____ _____

_____ _____ _____

Please list Medical Allergies:

_____

_____

Please check box if you have, or have had, any of the following:

A prior evaluation for your veins? ☐
Previous vein surgery or laser treatment? ☐
Previous vein injections? ☐
Bleeding from a vein? ☐
A leg ulceration? ☐
Phlebitis? ☐
Any type of blood clot/clotting disorder? ☐
If so, were you treated with blood thinners? ☐

A family history of vein disease? ☐
A family history of leg ulceration? ☐
A family history of blood clots? ☐

Name:

Original Date:	
Dates Revised:	

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	If yes, what kind?		
	How many drinks per week?		
Cigarettes	☐ Cigarettes – pks./day ☐ Chew - #/day ☐ Pipe - #/day ☐ Cigars - #/day		
	☐ # of years ☐ Or year quit		
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother					
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

HIPAA PATIENT CONSENT FORM

The federal government required all medical offices to make patients aware that they have rights regarding the use of their personal health information. A copy of our Notice of Privacy Practices is available for your review at the front desk.

By signing this form, you consent to our use and disclosure of protected health information according to the Notice of Privacy Practices available to you at our front desk. You have the right to revoke this consent at any time, in writing; however, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. Goldman Vein Institute provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operation. This request must be done in writing. Whenever possible we will honor your request.

The patient understands that:

We will not release information to any future doctor, attorney, life insurance company, workman's comp company without your written consent. Protected health information may be sued for treatment through one of your current doctors, payment with your insurance company, or healthcare operations within our office. Goldman Vein Institute has a Notice of Privacy Practices that is available for review. Goldman Vein Institute reserves the right to change the Notice of Privacy Practices. The patient has the right to restrict the use of their information, but Goldman Vein Institute does not have to agree to these restrictions if, for example it interferes with payment, daily operations or providing quality health care.

The patient may revoke this consent in writing at any time and all future disclosures will then cease:

Goldman Vein Institute may condition treatment upon the execution of this consent. You have the right to be notified of protected health information breach. Goldman Vein Institute cannot sell your health information without your permission. Certain uses of your medical data, such as use of patient information in marketing, require prior disclosure and your authorization. Uses and disclosures not described in the Notice of Privacy Practice will only be made with your authorization.

I acknowledge that I was provided with a copy of the Notice of Privacy Practices.

Patient name:_____ Date:_____

(Print Name)

Signature:_____ Relationship to Patient:_____

FOR OFFICE USE ONLY

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review if carefully**.

The Joint notice of Privacy Practices is being provided to you on behalf of Goldman Vein Institute, with the respect to vein disorders medical service provided at Goldman Vein Institute facilities (collectively referred to herein as "We" or "Our"). We understand that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "protected health information includes any individually identifiable information that we obtain from you or others that relates to your past, present, or future physical or mental health, the health care you have received, or payment for your health care.

HIPPA NOTICE OF PRIVACY PRACTICES

Your Rights

You have the right to:

Get a copy of your health and claims records. Correct your health and claims records. Request confidential communication. Ask us to limit the information we share. Get a list of those with whom we've shared your information. Get a copy of this privacy notice. Choose someone to act for you. File a complaint if you believe your privacy rights have been violated.

Your Choices

You have some choices in the way that we use and share information as we:

Answer coverage questions from your family and friends. Provide disaster relief. Market our services and sell your information.

Our Uses and Disclosures

We may use and share your information as we:

Help manage the health care treatment you receive. Run our organization. Pay for your health services. Help with public health and safety issues. Do research. Comply with the law. Respond to organ and tissue donation requests and work with a medical examiner or funeral director. Address workers' compensation, law enforcement, and other government requests. Respond to lawsuit and legal actions. Business Associates. Appointments. Notification. Communication with Spouse/Family.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your health and claims records

You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

You can ask us to contact you in a specific way (for example, home or office phone) or send mail to a different address. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Your Information. Your Rights. Our Responsibilities.

Ask us to limit what we use or share

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

Share information with your family, close friends, or others involved in payment for your care. Share information in a disaster relief situation. *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we **never** share your information unless you give us written permission:

Marketing purposes. Sale of your information.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you. Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

Your Information. Your Rights. Our Responsibilities.

We can use and disclose your information to run our organization and contact you when necessary. Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services. Example: We share information about you with your medical plan to coordinate payment for your medical work.

How else can we use or share your health information?

We are allowed or required to share your information in other ways-usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding /consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

Preventing disease. Helping with product recalls. Reporting adverse reactions too medications. Reporting suspected abuse, neglect, or domestic violence. Preventing or reducing a serious threat to anyone's health or safety.

Do research

We can use or share your information for health research

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director.

We can share health information about you with organ procurement organizations. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

For workers' compensation claims. For law enforcement purposes or with a law enforcement official. With health oversight agencies for activities authorized by law. For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Business Associates

There are some services provided as Goldman Vein Institute, through contacts with business associates. Example: The management services of Goldman Vein Institute, certain laboratory, tests and collection services. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do and bill you or your third party payer for services rendered. So that your health information is protected; however, we require the business associate to appropriately safeguard your information.

Appointments

We may use or disclose your health information to contact you to remind you of an appointment.

Your Information. Your Rights. Our Responsibilities.

Notification

We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with Spouse/Family

Health professionals, using their best judgement, may disclose to your spouse, family member, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. If you are not at home, we may leave this information on your answering machine or in a message left with the person answering the telephone. We will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request

This is to acknowledge that I have received a copy of the Notice of Privacy Practices of Goldman Vein Institute.

Name:_____

(Please Print)

Signature:_____Date:_____

Disposition: File this Acknowledgement Form in the Patient's medical record.