Vein Clinics of Hawaii

WELCOME TO OUR OFFICE

Patient Name: _____ Today's Date: _____
First Middle Last

Date of Birth: _____ Age: _____ Social Sec. No. _____

Billing Address: _____ _____ _____ _____
Street City State Zip

Home Address: _____ _____ _____ _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Email: _____

Marital Status: Single Married Divorced Widowed

Employer: _____ Work Phone Number: _____

Employer Address: _____ _____ _____ _____
Street City State Zip

Emergency Contact Name: _____ Relationship: _____

Home Address: _____ _____ _____ _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Who is your primary care physician: _____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party Name: _____ Relationship to Patient: _____

Date of Birth: _____ Social Security No.: _____

Home Address: _____ _____ _____ _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____

Employer Address: _____ _____ _____ _____
Street City State Zip

How did you learn about our practice? _____

INSURANCE INFORMATION

Patient Name: _____ Today's Date: _____
First Middle Last

Primary Insurance Co. Name: _____

Insured's Name: _____ Relationship to Patient: _____

Date of Birth: _____ Social Security Number: _____

ID Number: _____ Group Number: _____

Secondary Insurance Co. Name: _____

Insured's Name: _____ Relationship to Patient: _____

Date of Birth: _____ Social Security Number: _____

ID Number: _____ Group Number: _____

Tertiary Insurance Co. Name: _____

Insured's Name: _____ Relationship to Patient: _____

Date of Birth: _____ Social Security Number: _____

ID Number: _____ Group Number: _____

Signature of Patient or Responsible Party: _____ Date: _____

Please have insurance cards ready for receptionist to copy.

TREATMENT AUTHORIZATION

I hereby authorize Vein Clinics of Hawaii and/or any authorized persons employed by them to perform and/or initiate medical evaluation and treatment and authorize and/or order any related services on my behalf.

Signature: _____ Date: _____

Vein Clinics of Hawaii

Notice of Privacy Practices and Policies

This notice describes how medical information about you may be used and disclosed and your rights regarding access to this information.

Your rights as a patient related to your medical information are as follows: You have the right to request restrictions on the way we use your medical information. You have the right to request and receive information from us in a different way or manner. You have the right to review your medical information. You have the right to request that we amend your medical information. You have the right to know how we have used and to whom we have disclosed your medical information. We will not use or disclose your health information without your authorization except as otherwise described in this notice of privacy practice and policy.

It is our responsibility to protect your medical information, provide you with our notice of privacy policies and abide by these policies. We do reserve the right to change our privacy practices.

May we leave messages containing Private Health Information at your home or on your answering machine? Yes___ No___

May we send you appointment reminders or test results via mail? Yes___ No___

May we discuss Private Health Information with your spouse, significant other, parents, siblings or children? Yes___ No___
Please specify to whom we may leave information.

_____
_____
_____

May we leave a message at your place of employment? Yes___ No___ N/A___

If you believe your privacy rights have been violated, you may file a complaint with our practice, or with the Secretary of the Department of Health and Human Services; Office of Civil Rights, 200 Independence Avenue, SW, Washington, D.C., 20201, or phone (202) 619-0257 or toll free (877) 696-6775. To file a complaint with our practice, contact Leonette Meyer, 65-1158 Mamalahoa Hwy, Suite 16, Kamuela, HI, 96743, or phone (808) 885-4401. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
Updated: 5/16/2016

Signature _____ Date _____

PATIENT RESPONSIBILITY
FOR PAYMENT OF CHARGES

PATIENT: _____ DOB: _____

All patients are responsible for their insurance deductible and co-pay amounts. If your insurance company determines that the procedure is not covered for any reason, you will also be responsible for the remaining charges.

For those patients who do not have insurance, payment is due at the time of service, unless other arrangements have been agreed upon in writing.

If this was an emergency procedure at the hospital, payment arrangements or insurance information is due within 30 days.

I understand that I am responsible for the charges incurred. In the event that I fail to pay these charges, I will be responsible for reasonable collection costs and/or attorney fees associated with the cost of resolving my account.

Authorizations and notifications do not guarantee payment by the employee's medical plan. Payment is subject to the patient's eligibility and coverage limitations at the time services are delivered. Authorizations and notifications are not in any way intended to change the physician's primary responsibility for the patient's care.

I _____ understand and agree
(Print name)
to the aforementioned payment of my account.

SIGNATURE: _____

DATE: _____

Vein Clinics of Hawaii

Randall S. Juleff, M.D., F.A.C.S.

65-1158 Mamalahoa Hwy, Suite 16
Kamuela, HI 96743
Phone: 808-885-4401
Fax: 808-885-4412

1401 South Beretania St, Suite 340
Honolulu, HI 96814
Phone: 808-585-2955
Fax: 808-585-2958

ASSIGNMENT OF BENEFITS
AND
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I request that payment of authorized benefits (Medicaid, Medicare and/or Insurance Companies) be made either to me or on my behalf to Vein Clinics of Hawaii for any services furnished to me by their physicians. I authorize any holder of medical information about me to release it to the responsible agent needed to determine benefits for services provided.

Signature_____Date_____

Vein Clinics of Hawaii

Consent for Photography

I _____ agree to have both pre and postoperative photos taken for my records. I expect no compensation for these photographs and waive all right to any claims for payment or royalties.

Print Name_____

Signature_____Date_____

Witness_____

Confidential Health and History Form

TODAY'S DATE: _____

Patient Name: _____ Date of Birth: _____Age:_____

Sex: _____ Primary Care Physician_____

How did you hear about us?_____

Chief Complaint

WHAT IS THE REASON FOR YOUR VISIT:_____
_____

HPI

Please answer the following questions. Provide estimates for date of occurrence.

Past Venous History

Have you ever had vein stripping surgery ☐ Yes ☐ No
If yes, when and which leg? _____

Have you ever had vein injections? ☐ Yes ☐ No
If yes, which leg and where on the leg? _____

Have you ever had a blood clot? ☐ Yes ☐ No
If yes, where and when? _____

Have you ever had phlebitis? ☐ Yes ☐ No
If yes, which leg and when? _____

Have you ever had any test(s) done on your veins? ☐ Yes ☐ No
If yes, when and what type of test and where on the leg? _____
_____

Current Medication

Please List ALL medications include the dosages and how often you take them.
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Past Medical History

Do you have a history of?

___Anemia
___Atherosclerosis
___Ankle skin changes
___Bleeding/Blood disorder
___Cancer
___Chest pain or discomfort
___Crohn's disease/IBS
___Constipation
___Deep Vein Thrombosis/Clot
___Diabetes
___Easy bruising
___Hepatitis
___HIV
___Hypertension
___Kidney disease
___Leg ulcers
___Liver disease
___Lupus
___Migraine headaches
___Myocardial Infarction
___Mitral Valve Prolapse
___Pulmonary Embolus
___Rupture of a vein
___Superficial Thrombophlebitis
___Trauma to your legs
___Other_____

ALLERGIES:_____

LATEX ALLERGY: ___YES ___NO

Surgical History

Please list any surgeries or injuries you have had. _____
_____
_____
_____
_____

Hospitalizations

Please list any non-surgical hospitalizations. _____
_____
_____
_____
_____

Family History

Does anyone in your family have (or did have) varicose veins, spider veins, leg ulcers or swollen legs?

Father	☐ Yes	☐ No
Mother	☐ Yes	☐ No
Brother(s)	☐ Yes	☐ No
Sister(s)	☐ Yes	☐ No
Other _____		

Is there a history in your family of venous disease, deep venous thrombosis, stroke, clotting disorders or heart disease?

___Mom _____
___Dad _____
___Grandparents _____
___Siblings _____
___Aunt/Uncle _____
___Child _____

Social History

Do you smoke? ___yes ___no If yes, how much? _____ for how long? _____
If no, did you ever smoke? _____ When did you quit? _____
What do/did you do for a living? _____
How many hours a day do you think you are up on your feet at work?_____ At home?_____
Do you exercise? ☐ Yes ☐ No
If yes, what kind of exercise and how often? _____
Who do you live with?_____
Activity level? ____Very active ____ Some activity ____ Sedentary

Review of Systems

Are you currently experiencing or recently experienced any of the following? Please mark yes or no.

	Yes	No	
Cardiovascular:	☐	☐	Chest pain, pressure
	☐	☐	Tightness or heaviness in your chest
	☐	☐	Any of the above with exertion
	☐	☐	Irregular heart beat
	☐	☐	High cholesterol
Pulmonary:	☐	☐	Shortness of breath
	☐	☐	Coughing up blood
	☐	☐	Asthma or tuberculosis
	☐	☐	Pneumonia or pleurisy
	☐	☐	Cough

Vitals

Height_____ Weight_____

Patient Signature: _____Date:_____