ADVANCED VEIN & LASER CENTER
veinsbegone.com

Dear _____,

APPOINTMENT DATE AND TIME: _____

As a courtesy, we will notify you of your appointment time prior to your visit.

Welcome to our office, and thank you for selecting our practice for your vein and laser needs. This letter is to introduce you to our office and some of our practice policies.

We are located at 191 Leader Heights Road, York, PA 17402, which is on the corner of Security Drive and Leader Heights Road. If you require further directions to locate our office, please call (717) 741-2214, and a staff member will be happy to assist you.

Enclosed are patient information forms. **Please complete the forms and bring them with you to your appointment**. You will need to **arrive 15 minutes earlier than your scheduled appointment** so that we can review the forms. If you are unable to complete the enclosed forms, please bring them to your office visit, and a member of our staff will be happy to help you complete them. In this circumstance, you will need to arrive **30 minutes** prior to your scheduled appointment time.

Our staff works hard to stay on schedule by performing a thorough evaluation specific to each patient's needs. We apologize if this causes any delay in the appointment schedule. If you have questions prior to your scheduled visit, please call us, and we will be happy to assist you. Our office hours for phone calls and scheduling are Monday through Friday from 8:00 a.m. to 5:00 p.m. If you require medical assistance when the office is closed, you can reach Dr. Heird by calling (717) 741-2214 option 3.

Finally, we require 24-hour notice to cancel or reschedule an appointment. **Please call us as soon as possible if you will be unable to keep your upcoming appointment or would like to reschedule for another day. This will allow us to contact another patient who may wish to use your appointment time slot.**

Thank you, and we look forward to meeting you soon!

Dr. Heird and Staff at Advanced Vein & Laser Center

PLEASE ARRIVE 15 MINUTES PRIOR TO YOUR NEW PATIENT APPOINTMENT TIME

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Today's date: / /	Social Security #:	Gender:	Date of Birth: / /
Last Name: First Name: Middle Name:			Previous/Maiden Name:
Street Address:	City:	State:	Zip Code:
Home Phone #:	Cell Phone #:	Work Phone #:	
Employer:	Occupation:		
Family Doctor:	Email Address:		

Referred by: □ Physician □ Advertisement
Name of Physician: _____ Where: _____
□ Insurance Plan □ Website
□ Family/Friend □ Other: _____

Race: □ Caucasian □ Black/African American □ Native American
□ Asian □ Hispanic/Latino □ Unspecified

INSURANCE INFORMATION

Primary Insurance:			
Subscriber's Name:	Subscriber's Social Security #:	Subscriber's DOB: / /	
Subscriber's Employer:	Relationship to Subscriber:		
Co-payment: $	Insurance ID #:	Insurance Group #:	
Secondary Insurance:			
Subscriber Name:	Subscriber's Social Security #:	Subscriber's DOB: / /	
Subscriber's Employer:	Relationship to Subscriber:		
Co-payment: $	Insurance ID #:	Insurance Group #:	

IN CASE OF EMERGENCY

Name:	Relationship to patient:	
Home Phone #:	Cell Phone #:	Work Phone #:

I authorize that the above information is correct and true to the best of my knowledge. I am also responsible for letting AVLC know of any changes in my personal information. I hereby authorize AVLC to release any information required to (but not limited to) my insurance company.

Patient/Guardian Signature: _____ Date: _____

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Name: _____ ID#: _____

What is the reason for your visit today? _____
How long have you had your symptoms? _____
Where are the veins you are seeking a medical opinion for located? □ Leg(s) Right / Left / Both □ Face
□ Chest □ Other _____

Please check the box next to the symptoms that apply to you:

□ Aching Pain	□ Cramps	□ Burning	□ Other _____
□ Dull Pain	□ Restlessness	□ Itching	
□ Sharp Pain	□ Tiredness	□ Swelling	
□ Throbbing	□ Heaviness	□ Leg Ulcer(s)	

VEIN HISTORY

Are your symptoms getting worse?	Yes	No
Are your symptoms affecting daily living activities?	Yes	No

If yes, how have they altered your daily living? _____

_____

What factors precipitate symptoms? _____

_____

What factors relieve your symptoms? _____

_____

Have you ever worn any type of compression stockings?	Yes	No
If yes, for how long? _____ months / years		
Do you have a family history of varicose veins?	Yes	No
Do you have swelling after prolonged standing?	Yes	No
Have you ever tried over-the-counter medication for relief of you symptoms?	Yes	No
If yes, for how long? _____ months / years		

Do you have now or have you ever had any of the following?			**When?**
Phlebitis	Yes	No	_____
Deep Vein Thrombosis (DVT)	Yes	No	_____
Pulmonary Embolus (PE)	Yes	No	_____
Bleeding from veins	Yes	No	_____
Sclerotherapy	Yes	No	_____
Venogram	Yes	No	_____
Vein surgery	Yes	No	_____
Hemorrhoids	Yes	No	_____
IV drug use	Yes	No	_____
Clotting Disorder	Yes	No	_____
Cellulitis	Yes	No	_____

PAST SURGICAL HISTORY

Please list any operations you have had:

_____

_____

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PATIENT HEALTH ASSESSMENT QUESTIONNAIRE

Name: _____ ID#: _____

Please list any hearing, vision or reading issues: _____

Do you have an Advanced Directive? Yes No

Please bring all of your prescription medicines and over-the-counter vitamins and supplements to your appointment, OR list all prescription and over the counter medications, supplements and vitamins you take, including the dose or strength.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are you allergic to latex? Yes No

Allergies: _____

PAST MEDICAL HISTORY

Have you ever had any of the following?

Heart Disease	Yes	No	Hepatitis	Yes	No
High Blood Pressure	Yes	No	Eczema/Psoriasis	Yes	No
Chest Pain	Yes	No	Venereal Disease/STD	Yes	No
Glaucoma	Yes	No	Arthritis	Yes	No
Thyroid Disease	Yes	No	Depression	Yes	No
Lung Disease	Yes	No	Diabetes (Type)	Yes	No
Asthma	Yes	No	Stroke	Yes	No
Epilepsy	Yes	No	Blood Disease/Anemia	Yes	No
Cancer (Location)	Yes	No	Gallbladder Disease	Yes	No
Ulcers (Location)	Yes	No	Back Disorder	Yes	No
Colitis	Yes	No	Gastric Reflux	Yes	No
HIV/AIDS	Yes	No	History of Falls	Yes	No
Bruising Easily	Yes	No	Other: _____		

FAMILY/SOCIAL HISTORY

Do you have a family history of:			**Relationship**
Heart Disease	Yes	No	_____
High Blood Pressure	Yes	No	_____
Diabetes	Yes	No	_____
Stroke	Yes	No	_____
Cancer	Yes	No	_____
Thyroid Disease	Yes	No	_____
Clotting Disorder	Yes	No	_____
Dementia	Yes	No	_____
DVT/PE	Yes	No	_____
Other _____			_____

Your personal Habits:	**Do you?**	
Exercise regularly	Yes	No
How often? _____		
Smoke/Use tobacco	Yes	No
How much? _____		
Use tobacco in the past?	Yes	No
Drink alcohol?	Yes	No
How much? _____		

Females ONLY

How many pregnancies have you had? _____

How many deliveries have you had? _____

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Name: _____ ID#: _____

REVIEW OF SYSTEMS – CURRENT/ACTIVE PROBLEMS

CONSTITUTION			**WHEN?**
Appetite loss	Yes	No	_____
Fatigue	Yes	No	_____
Fevers	Yes	No	_____
EYES			
Retinal problems	Yes	No	_____
Blurred vision	Yes	No	_____
Diminished vision	Yes	No	_____
Double vision	Yes	No	_____
Vision loss	Yes	No	_____
ENT			
Discharge from ears	Yes	No	_____
Hearing loss	Yes	No	_____
Ringing in ears	Yes	No	_____
Sinus problems	Yes	No	_____
Hoarseness	Yes	No	_____
Sore throat	Yes	No	_____
CARDIAC			
Atrial fibrillation	Yes	No	_____
Chest pain	Yes	No	_____
Chest discomfort	Yes	No	_____
Congenital heart disease	Yes	No	_____
Dizziness	Yes	No	_____
Leg pain when walking	Yes	No	_____
Calf pain when walking	Yes	No	_____
Palpitations	Yes	No	_____
Swelling of ankles	Yes	No	_____
RESPIRATORY			
Bronchitis	Yes	No	_____
Breathing difficulty	Yes	No	_____
COPD	Yes	No	_____
Coughing blood	Yes	No	_____
Pneumonia	Yes	No	_____
Wheezing	Yes	No	_____
GASTRO			
Abdominal pain	Yes	No	_____
Gallbladder problems	Yes	No	_____
Gastritis	Yes	No	_____
Hemorrhoids	Yes	No	_____
Jaundice	Yes	No	_____
Liver disease	Yes	No	_____
Gastric reflux	Yes	No	_____
Change of stool color	Yes	No	_____
Bloody stools	Yes	No	_____
Painful swallowing	Yes	No	_____
Bloody vomit	Yes	No	_____

GU			**WHEN?**
Blood in urine	Yes	No	_____
Kidney disease	Yes	No	_____
Renal failure	Yes	No	_____
Excessive urination	Yes	No	_____
Decreased urination	Yes	No	_____
Painful urination	Yes	No	_____
MUSCLE/SKELETAL			
Bone/Joint deformity	Yes	No	_____
Limitations of movement	Yes	No	_____
Muscle aches	Yes	No	_____
Back pain	Yes	No	_____
SKIN			
Dryness	Yes	No	_____
Itchy skin	Yes	No	_____
Changes in moles	Yes	No	_____
Rash	Yes	No	_____
NEURO			
Ataxia	Yes	No	_____
Confusion	Yes	No	_____
Depression	Yes	No	_____
Fainting	Yes	No	_____
Headache	Yes	No	_____
Migraine	Yes	No	_____
Memory lapses	Yes	No	_____
Numbness	Yes	No	_____
Paralysis	Yes	No	_____
Seizures	Yes	No	_____
Unclear speech	Yes	No	_____
Stroke	Yes	No	_____
Weakness	Yes	No	_____
PSYCH			
Delusions	Yes	No	_____
ENDOCRINE			
Diabetes w/ Insulin	Yes	No	_____
Diabetes w/o Insulin	Yes	No	_____
Intolerance to cold	Yes	No	_____
Thyroid disease	Yes	No	_____
HEMA/LYMPH			
Anemia	Yes	No	_____
Bleeding/clotting disorder	Yes	No	_____
Bruising easily	Yes	No	_____
IMMUNIZATIONS			
Pneumonia vaccination	Yes	No	_____
SCREENINGS			
Colonoscopy	Yes	No	_____

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Name: _____ ID#: _____

In the past 12 months, . . .

☐ Y ☐ N Fell two or more times.

☐ Y ☐ N Was injured by a fall that limited my regular activities for at least one day.

☐ Y ☐ N Saw a doctor because I had a fall.

☐ Y ☐ N Found it hard to climb stairs or walk a short distance.

☐ Y ☐ N Had trouble getting up from a soft chair.

☐ Y ☐ N Have been unable to stand on one foot for 12 seconds without losing my balance.

☐ Y ☐ N Trouble with my eyesight.

☐ Y ☐ N Felt dizzy or light headed after a big meal.

☐ Y ☐ N Took medication that caused me to feel dizzy or light headed.

☐ Y ☐ N Took 9 or more different medications.

☐ Y ☐ N Stopped some of my regular activities.

☐ Y ☐ N Have been taking a calcium supplement regularly. If "Yes", how much per day:

☐ Y ☐ N Have not had my vitamin D level in my blood checked.

☐ Y ☐ N Danced, exercised, or practiced Tai Chi at least 3 times a week.

☐ Y ☐ N Has my home checked for any dangers and modified as needed.

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Patient Name-Please Print: _____ **DOB:**_____

Advanced Vein and Laser Center appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

If a payment is not received within 30 days from the first patient statement or a payment plan is not established, your account will be turned over to the Credit Bureau of York. You will also be responsible for the fees incurred from your account being turned over to collections in addition to the balance of your account.

I have read the above policy regarding my financial responsibility to **Advanced Vein and Laser Center**. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Advanced Vein and Laser Center. The full and entire amount of bill incurred is ultimately my responsibility.

Patient Signature _____ Date_____

Guarantor Signature _____ Date _____
(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature _____Date_____

Self-Pay

I do not have health insurance and will be responsible for services rendered here at **Advanced Vein and Laser Center**. I agree to pay **Advanced Vein and Laser Center**, the full and entire amount of treatment given to me at each visit.

Patient/Guarantor Signature _____ Date_____

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PHOTO CONSENT

Subject to the conditions herein, I, the undersigned, hereby give my permission for use of photographs taken during the course of my treatment provided reasonable measures are taken to protect my identity and provided these photographs are used solely for ethical purposes which may include:

1. The use and publication of the photographs in whole or in part, individually or in conjunction with other photographs, in any medium for any purpose including medical records, professional journals, medical textbook, art, illustration, promotion, advertising or trade.
2. It is understood that the use of the photographs is for illustrating cosmetic procedures and demonstration of benefits. It is also understood that the use of the photographs will in no way reveal my identity.
3. The aforementioned photographs may be modified at the discretion of the facility, its clients, or agents to be more desirable. This will include, but will not be limited to, masking of the photographs to prevent identification or to cover private parts of the body.

_____ _____

PATIENT SIGNATURE for PHOTO CONSENT **Date**

I, the undersigned hereby give my permission for photographs to be taken during the course of my treatment and be a part of my clinical medical record only to demonstrate the benefits of treatment and evaluate before and after pictures. My photographs will only be a part of my medical record and not used for any other purposes.

_____ _____

PATIENT SIGNATURE for PHOTO CONSENT **Date**

CANCELLATION POLICY

Cancelled, No Call/No Show Appointments less than 24-hour notice will incur a $50 FEE

_____ _____

PATIENT SIGNATURE FOR CANCELLATION POLICY **Date**

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We do not double-book patients — a practice which is common in most physicians' offices. Your booked appointment is dedicated to your time.

Your visit is reserved in advance so we can focus on your comprehensive care. Insurance companies expect physicians to double-book an average of 6 patients per hour, which would not allow us to provide our patients with the care we are known for. Since we do not overbook and schedule one patient at a time, your missed appointment represents a loss for our medical staff and to the center, therefore we require a 24-hour notice of cancellation for all appointments.

As a reminder, please provide 24-hour notice if you wish to make a change to your appointment time in order to avoid a $50 fee.