COMPLEX VASCULAR

New Patient Registration

Patient Name: _____ **Date of Birth:** _____

Address: _____**City:** _____ **State:** _____ **Zip Code:** _____

Phone Number (Cell) : _____ **Phone Number (Home) :** _____

Email Address: _____ **Preferred Name:** _____

Contact me by (check all that apply): ☐ Phone ☐ SMS Text ☐ E-mail

I acknowledge by choosing any of the above options, I give Complex Vein and Vascular authorization to contact me via the selected method(s).

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other

Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Primary Insurance Information

Name of Policy Holder: _____

Date of Birth: _____ **Relationship to Patient:** _____

Insurance Company: _____

ID Number: _____ **Group Number:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Secondary Insurance Information

Name of Policy Holder: _____

Date of Birth: _____ **Relationship to Patient:** _____

Insurance Company: _____

ID Number: _____ **Group Number:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

A copy is available upon request.

Continued on next page.

Responsible Person (if patient is under 18)

Name: _____ **Date of Birth:** _____

Relationship to Patient: _____

Address: _____**City:** _____ **State:** _____ **Zip Code:** _____

Phone Number: _____

Employment Information

Employer: _____ **Occupation:** _____

Address: _____**City:** _____ **State:** _____ **Zip Code:** _____

Employment Status: ☐ Employed ☐ Student ☐ Other

Emergency Contact

Name: _____ **Phone Number:** _____

Address: _____**City:** _____ **State:** _____ **Zip Code:** _____

Relationship to Patient: _____

Pharmacy

Name: _____ **Phone Number:** _____

Address: _____**City:** _____ **State:** _____ **Zip Code:** _____

How Did You Hear About Us?

☐ Searched Online
☐ Social Media
☐ Flyer
☐ Advertisement
☐ Online Reviews
☐ Event
☐ Other: _____
☐ Insurance Company Website
☐ HR Department
☐ Drove by and saw location
☐ Existing Patient Referral: _____
☐ Provider/Physician/Employee Referral: _____
☐ Complex Vein and Vascular Employee: _____

Patient Medical History

Name: _____ **Date:** _____

Please circle any illness or condition you have been formally diagnosed with:

Anemia	Arthritis	Arterial Aneurysm	Cancer
Diabetes Type 1	Diabetes Type II	Back pain, chronic	DVT
Gastroesophageal Reflux	High Cholesterol	Diverticular disease	Kidney disease
Heart disease	Osteoporosis	High blood pressure	Peripheral Arterial Desease
Thyroid Dysfunction	Rheumatoid arthritis	Osteopenia	Stroke
Tobacco use	Varicose veins	Seizure disorder	
		Venous insufficiency	

Please list any operations performed below:

Name of Operation	Location of Operation	Year Performed

Please list any and all hospitalizations below:

Reason for Hospitalization	Location of Hospitalization	Year of Admission

Family History:

Is there a history in your family of:	**Yes**	**No**	**Affected relative(s)**
High Blood Pressure?			
Diabetes?			
Kidney disease?			
Vascular disease?			
Other? Cancer, etc.			

Social History:

Tobacco Use: Current ☐ Former ☐ Never Smoker ☐

Alcohol Use: None ☐ Daily ☐ Weekly ☐ Monthly ☐

Drug Use: Have you ever used any intravenous drugs?

Yes ☐ No ☐

Medications: Please include over the counter meds.

Name and Strength	**How Often**

Allergies: Are you allergic to any medications?

Yes ☐ No ☐

If yes, what are you allergic to? _____

_____

_____

COMPLEX VASCULAR

Review of Systems

Please circle any and all symptoms you or your loved one are currently experiencing in the last 3 months:

General / Constitutional: change in appetite, fatigue, fever, weight loss.

Respiratory: cough, hemoptysis, shortness of breath with exertion, wheezing.

Cardiovascular: chest pain, pain in legs with walking, difficulty laying flat, dizziness, dyspnea on exertion, fluid accumulation in the legs, high blood pressure, irregular heartbeat, difficulty breathing at night, palpitations, shortness of breath, swelling in hands / feet.

Gastrointestinal: abdominal pain, blood in stool, change in bowel habits, decreased appetite, diarrhea, nausea, vomiting.

Hematology: easy bruising, history of cancer.

Genitourinary: blood in the urine, frequent urination, painful urination, incontinence

Musculoskeletal: arthritis / arthralgia, muscle aches, painful joints, swollen joints, weakness, back problems

Peripheral Vascular: blanching of skin, cold extremities, decreased sensation in extremities

Podiatric: foot pain, sole pain, leg pain

Skin: change in pigmentation, foot ulcers, rash

Neurologic: balance difficulty, difficulty speaking, fainting, gait abnormality, loss of use of extremity, transient loss of vision, stroke.

COMPLEX VASCULAR

HIPAA Consent and Consent to Treat

I voluntarily consent to receive medical and health care services that may include diagnostic procedures examinations and treatment.

Consent to Obtain Prescription History

This consent form authorizes Complex Vein and Vascular to obtain and review my prescription history. Detailed prescription history provides your physician with information about medications being prescribed by other providers involved in your medical care. This information will improve the accuracy of our medication list in your medical chart and decrease any adverse drug reactions or inaccurate medication information such as medication names or dosages.

By signing this consent form, you agree that Complex Vein and Vascular can request and use your prescription medication history from other healthcare providers, pharmacies, and benefit payers (such as your insurance company) for treatment purposes.

Understanding the above, I hereby provide informed consent to Complex Vein and Vascular to request, view, and use my external prescription history for treatment purposes.

HIPAA

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I can request a copy of this notice at any time. I have the right to review the notice prior to signing this consent. I have had the opportunity to receive and review the Notice of Privacy Practices of Complex Vein and Vascular.

Approved HIPAA Contacts – Disclosure of Health Information

Keeping information private is important to us and by default we will only disclose information related to the patient's Billing Account and Medical Conditions to the patient or legal guardian. Please note, in order to share protected health information with your spouse they must be listed as an approved contact.

The following names are people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Complex Vein and Vascular to share my protected health information with:

Name: _____ **Date of Birth:** _____

Phone: _____ **Relationship:** _____

Consent and Agreement

I have carefully reviewed this document and agree to fully comply with guidelines defined herein related to the Assignment of Benefits, Financial Policy, HIPAA Policy and Approved HIPAA contacts. The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any personal health information.

Patient's Name: _____ **Patient's DOB:** _____

Signature of Patient, Parent, or Legal Guardian: _____

Date: _____

COMPLEX VEIN AND VASCULAR SPECIALISTS

12740 HILLCREST ROAD, SUITE 272
DALLAS, TX 75230
475 ELM STREET, SUITE 201
LEWISVILLE, TX 75075
PHONE: 469-780-2300 FAX: 469-780-2301

PATIENT CONSENT FOR PHYSICIAN TO USE OR DISCLOSE HEALTH CARE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE.

PATIENT'S NAME:_____

DATE OF BIRTH:_____ **SOCIAL SECURITY NUMBER:**_____

TO GIVE CONSENT TO DISCLOSE HEALTH CARE INFORMATION TO SOMEONE OTHER THAN THE PATIENT, PLEASE WRITE THEIR NAME BELOW: (E.G. FAMILY MEMBER, CARETAKER)

NAME:_____

I UNDERSTAND THAT MY HEALTH INFORMATION IS PRIVATE AND CONFIDENTIAL. I UNDERSTAND THAT **COMPLEX VEIN AND VASCULAR SPECIALISTS** WORKS VERY HARD TO PROTECT MY PRIVACY AND PRESERVE THE CONFIDENTIALITY OF MY PERSONAL HEALTH INFORMATION.

I UNDERSTAND THAT SIGNING THIS DOCUMENT MEANS THAT **COMPLEX VEIN AND VASCULAR SPECIALISTS** MAY USE AND DISCLOSE MY PERSONAL HEALTH INFORMATION TO HELP PROVIDE HEALTH CARE TO ME, TO HANDLE BILLING AND PAYMENT, AND TO TAKE CARE OF OTHER HEALTH CARE OPERATIONS. FAILURE TO SIGN THIS CONSENT MAY RESULT IN THE PHYSICIAN DECLINING TO TREAT ME.

UNDER THE TERMS OF THIS CONSENT, I CAN ASK **COMPLEX VEIN AND VASCULAR SPECIALISTS** TO RESTRICT HOW MY PERSONAL HEALTH INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. I UNDERSTAND THAT **COMPLEX VEIN AND VASCULAR SPECIALISTS** DOES NOT HAVE TO AGREE TO MY REQUEST. IF HE DOES AGREE TO MY REQUEST, I UNDERSTAND THAT HE WOULD FOLLOW THE AGREED LIMITS.

I UNDERSTAND THAT I HAVE THE RIGHT TO CANCEL THIS CONSENT IN WRITING AT ANY TIME. IF I DO CANCEL THE CONSENT, I UNDERSTAND THAT **COMPLEX VEIN AND VASCULAR SPECIALISTS** MAY HAVE ALREADY USED OR DISCLOSED INFORMATION ABOUT ME AND CANCELING THIS CONSENT WOULD NOT AFFECT THE INFORMATION ALREADY USED OR DISCLOSED.

I MAY CANCEL THIS CONSENT AT ANY TIME BY DOING THE FOLLOWING:

WRTING, SIGNING, AND DATING A LETTER TO **COMPLEX VEIN AND VASCULAR SPECIALISTS** THAT SAYS I WANT TO REVOKE MY CONSENT TO AUTHORIZE THE USE AND DISCLOSURE OF MY PERSONAL HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPTIONS.

I UNDERSTAND IF I CANCEL THIS CONSENT, **COMPLEX VEIN AND VASCULAR SPECIALISTS** IS NOT OBLIGATED TO PROVIDE FURTHER HEALTH CARE SERVICES TO ME.

MY SIGNATURE BELOW INDICATES THAT I AGREE TO THE POLICIES OUTLINED BY THIS DOCUMENT AND ALL STATEMENTS THEREIN.

_____ _____

PATIENT OR LEGALLY AUTHORIZED INDIVIDUAL'S SIGNATURE **DATE**

_____

RELATIONSHIP TO THE PATIENT IF SIGNED BY ANYONE OTHER THAN HIM/HER (PARENT, LEGAL GUARDIAN, PERSONAL REPRESENTATIVE, ETC.)

Financial and Office Policies

The following are our Financial and Office Policies. Please read, initial on the left, sign at the bottom and return to the front office representative. Please ask us any questions that you may have.

Initial Below

_____ **Patient Responsibility:** We participate in many insurance plans. We recommend you become familiar with your insurance benefits and confirm our participation with your plan. Most misunderstandings about insurance can be avoided if you understand what your policy covers. Please contact your insurance company with any questions you may have regarding your coverage. We will submit your claims and assist you in any way we reasonably can to help get your claims paid.

_____ **Insurance Carriers Requiring Referral:** If you are referred to another specialist and your insurance carrier requires a referral number, our office must have at least a 48-hour notice in order to complete that referral.

_____ **Proof of Insurance:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your valid government issued identification and a current, valid insurance card. Please bring these items with you to each visit. Payment in full is required if we are unable to verify your current insurance information.

_____ **Payments due at the time of service:** Co-pay, deductible, co-insurance

_____ **Nonpayment & Returned Checks:** Unpaid accounts will be referred to an outside collection agency and could result in dismissal from the practice. There will be a $30 fee for all returned checks.

_____ **Late Arrivals:** Please arrive 15 minutes before your appointment. If you arrive late to your appointment, our office may have to reschedule your appointment to a new time or date.

No Shows: Please notify us 24 hours in advance by phone or secure portal if you must cancel or change your appointment time. **Failure to do so will result in a no show fee that is not covered by your insurance. A third no show may result in dismissal from the practice.**

_____
- Please notify us 48 hours in advance by phone if you must cancel or change your appointment time. **Failure to do so will result in a no show fee that is not covered by your insurance.**
- **No Show Fees:** Office Visit = $35 Vein Procedure = $100 Vascular Testing = $100 Surgery = $200

_____ **Referrals:** The providers of Complex Vein and Vascular would advise you that at some point, you the patient may be referred to providers in which a physician or physicians of this practice would receive renumeration for healthcare and services provided. It is the option of the patient to receive ancillary healthcare services from any ancillary healthcare provider or facility of their choice.

_____ **Form Completion:** All forms requiring medical review and physician signature – including prior authorizations, FMLA, disability or other paperwork – may be subject to an administrative fee of $25. Administrative fees may be waived if the patient has a scheduled appointment in conjunction with forms completion.

_____ **Policy:** I have read and understand the Financial and Office Policies of Complex Vein and Vascular and agree to abide by its guidelines.

Signature: _____ **Date:** _____

COMPLEX VASCULAR

Authorization for Release and/or Disclosure of Medical Information

Please **REQUEST** medical information **FROM**:	Please **SEND** medical information **TO**:
Clinic/Physician: _____	Complex Vein and Vascular:
Address: _____	12740 Hillcrest Rd. Ste. 272
City:_____ State:_____ Zip:_____	Dallas, TX 75230
Phone: _____	Phone: 469-780-2300
Fax: _____	Fax: 469-780-2301

I hereby authorize the above-mentioned provider to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above. I also understand this information may contain information relating to Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV), mental health, and alcohol and /or drug abuse.

Release and/or disclose records and information regarding:

_____	_____-_____-_____	_____/_____/_____
Name of Patient	Social Security Number	Date of Birth

_____	_____	_____	_____
Address	City	State	Zip Code

_____	_____	_____
Home Phone Number	Work Phone Number	Cell Phone Number

Duration: This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for ninety days from the date of signature if no date entered.

Revocation: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

Redisclosure: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

Please specify records to be released and/or disclosed:

☐ Entire medical records ☐ History and Physical ☐ Chart Summary ☐ Labs ☐ Radiology ☐ Pathology

☐Other (please specify) _____

I request that the health information release and/or disclosed pursuant to this authorization be used for the following purposes only:
☐ Physician or Health Care Facility ☐ Legal ☐ Personal ☐ Other (please specify) _____

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization. The copy is for me to keep. I understand that there may be a fee for preparing and furnishing this information.

_____	_____	_____
Signature of patient or legal representative	Date	Relationship