BOSTON VEIN CARE
PATIENT PERSONAL INFORMATION

Name: _____ Date of Birth: _____

Address: _____ City, State, and Zip: _____

Home Phone: _____ Is it OK to leave a message? Y N

Cell Phone: _____ Is it OK to leave a message? Y N

Email: _____ Best number to reach you: ___Home ___Cell

Marital Status: ___Married ___Single ___Divorced ___Widowed

Ethnicity/Race: _____ Preferred Language: _____

Referring Physician: _____

Primary Care Physician_____ Address: _____

City, State Zip: _____Phone: _____Fax: _____

Do you want us to send your record to your referring or primary care doctor ☐ Y ☐ N

EMERGENCY CONTACT

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Relationship: _____

EMPLOYMENT INFORMATION

__Employed __Unemployed __Retired

__Self Employed

Employer Name: _____

Employer Phone: _____

Employer Address: _____

PRIMARY INSURANCE

Insurance Company: _____

ID Number: _____

Group/Policy Number: _____

SECONDARY INSURANCE

Insurance Company: _____

ID Number: _____

Group/Policy Number: _____

Fill section below only if you are not primary policy holder
Subscriber Name: _____ Subscriber Phone: _____

Subscriber Date of Birth: _____Address_____

PATIENT HISTORY SHEET

Name: _____ **Date:** _____

Date of Birth: _____ **Age:** _____

PRESENTING COMPLAINTS

1. ☐Leg Pain ☐ Leg/Ankle Swelling ☐Other_____
   If other explain_____
2. Affecting ☐ Right Leg ☐ Left leg
3. How long have you noticed these problems? _____
4. Pain is : ☐Aching ☐ Throbbing ☐ Resting cramps ☐ Night cramps,
5. Legs have : ☐Heaviness ☐ Burning ☐ Itching ☐Tender bruised areas
6. Severity of pain: On scale of 1 to 10_____ Pain is:☐ Continuous ☐ Periodic
7. Pain is made worse by; ☐ standing for prolonged period ☐ towards the end of day.
   ☐ Other_____
8. The pain are relieved by; ☐ sitting and stretching the legs, ☐ lying and elevating legs, ☐Elastic stockings, ☐Walking and/or exercising, ☐other_____
9. Leg Swelling made worse by; ☐ standing for prolonged period ☐ towards the end of the day, ☐ Others_____
10. Leg Swellings is relieved by; ☐ sitting and stretching the legs, ☐ lying down and elevating the legs ☐ others_____

Associated symptoms:

11. ☐ Skin discoloration ☐ Venous Bleeding ☐ Phlebitis
    ☐ Ulceration/wounds

OTHER COMPLAINTS

GENERAL: ☐ Feel sick, ☐ weight loss, ☐ weight gain, ☐ Other_____

SKIN: ☐ Rash ☐ Itching, ☐ Bruising ☐ Bleeding

CARDIAC: ☐ Chest Pain ☐ Palpitation ☐ Shortness of breath, on exertion/on rest ☐ Leg swelling

CIRCULATION: ☐ Pain calf or hips ☐ on walking/ ☐ on rest ☐ need to stop due to pain
☐ Blood clot in vein ☐ Blood clot in artery

CHEST: ☐ Cough ☐ Asthma ☐ Tuberculosis ☐ Bronchitis

GIT: ☐ Vomiting ☐ Constipation ☐ Diarrhea ☐ Blood in stools ☐ Jaundice ☐ Liver disease

NERVOUS SYSTEM: ☐ Headache ☐ Dizziness ☐ Numbness ☐ Falls ☐ Stroke/TIA ☐ Dementia

BLOOD: ☐ Anemia ☐ Sickle Cell ☐ Hemophilia ☐ Swollen glands

METABOLISM: ☐ Increased thirst ☐ Increased urine ☐ Diabetes ☐ Intolerance to heat or cold

MUSCULOSKELETAL: ☐ Weakness ☐ Stiffness ☐ Join pain ☐ Joint swelling ☐ Arthritis ☐ Gout

PSYCHAITRIC: ☐ Anxiety ☐ Depression ☐ Bipolar ☐ ADHD ☐ Addiction

PAST MEDICAL HISTORY

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Deep Vein Thrombosis (DVT) or pulmonary embolism
- ☐ Bleeding disorder.
- ☐ Diabetes

Controlled with: ☐ Insulin, How long: _____ ☐Pills ☐ Diet

Current Medications: (please list all prescriptions, non-prescription medications and nutritional supplements)

CURRENT MEDICATIONS	DOSE (Strength)	SCHEDULE (How many & times per day)	HOW LONG HAVE YOU TAKEN?

Previous Operations/Procedures	Year	Surgeon	Place (Hospital or City)	Complications/Problems

Drug/Food Allergies:

Do you have history of allergy: ☐ No, if yes please describe reaction in following lines?

- ☐ Medications:_____
- ☐ Food/Environmental:_____

Social History

Do you drink alcohol? ☐No ☐ Yes, if yes, how many drinks a week on average_____

Do you smoke any type of tobacco product?

- ☐ Never smoked ☐ X-Smoker Last Smoked:_____
- ☐ Current smoker, how many cigarettes a day:_____ How Many Years:_____

Family History: Family history of varicose veins, spider veins, leg ulcers or swollen legs? Y N

Relation (like mother, dad)	Conditions & age of onset

Yours risk factors for vein disorders are

☐ I am overweight, ☐ Prolonged standing (hours/day): At work ----------, At home----------

☐ Family history of varicose veins ☐ Past history of DVT ☐ Past history of vein Treatments

Your Height _____,Weight_____

FOR WOMEN ONLY

Number of times you have been pregnant_____, planning pregnancy in near future? ☐ Y ☐ N

Are you breast feeding? ☐ Y ☐ N

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature _____ Date _____

(Please do not write below this line, for office use only)

Blood Pressure _____ Temperature____ Pulse_____ Respirations____

I have reviewed patient's history and review of systems

_____	_____	_____
Physician signature	**Physician Name**	**Date**

Rt Lt

INSURANCE AUTHORIZATION AND ASSIGNMENT

(Please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor and/or Boston Vein Care, and authorize Boston Vein to furnish information regarding my illness to my insurance carrier. I have been informed of HIPPA Patient Privacy Rules. **I understand that I am financially responsible for any amount(s) not paid by my insurance company. I acknowledge receipt of the HIPPA Privacy Policy**.

_____ _____

Patient/Patient's Representative Signature Date

CONDITIONS OF SERVICE
FINANCIAL POLICY
HIPAA POLICY ACKNOWLEDGMENT

Thank you for choosing Boston Vein Care. This document represents our established *Conditions of Service* that will be used to resolve any issues or disputes pertaining to vein vascular or esthetic care services rendered by the practice. We ask you to read, sign, and return this agreement prior to any treatment.

CONSENT TO TREATMENT: The patient identified below consents to diagnostic and therapeutic evaluations and treatment, which may be performed or assisted by Dr. Muzzamal Habib, colleagues and staff. These evaluations and treatments may include, but are not limited to, initial evaluation or consultation, history and physical examination, and periodic follow up. Diagnostic assessments include but limited to arterial and venous ultrasounds, physiological tests and exercise testing and blood work. Therapeutic treatments include infiltration of tumescent and/or local anesthesia, radiofrequency or endovenous laser ablation, ultrasound-guided sclerotherapy, Veinlite sclerotherapy, and/or conservative vein therapy. Appropriate referrals will be facilitated as well to optimize patient care for services unavailable within the practice.

PAYMENTS: Boston Vein Care PC participates with many insurance plans as a convenience to our patients. Your insurance company determines your co-payment and/or deductibles. Our contracts require that all we collect these fees, to ensure the insurance policy is enforced. Please understand that payment of your bill is considered in part the responsibility of the patient. Payment, according to the policies below, is due at the time of service. We accept cash, checks, Care Credit, Visa, American Express, and Master Card. "Returned Checks" will be charged a $50.00 fee and if not paid within 10 days will be referred to Court for legal action. It is your responsibility to contact us as soon as you are aware that your check has been returned without payment. Also if you write a dishonored check you will be required to pay via cash or credit card.

PATIENTS WITH INSURANCE: In order for us to correctly bill your insurance company we will need a copy of your health plan ID card at the time of your visit. You are responsible for payment of these items not payable by your insurance plan including but not limited to: deductibles, co-pays, coinsurances and non-covered services. If your insurance requires prior authorization for treatment or procedures, we will be happy to assist you; however it is the patient's responsibility to insure authorization is obtained. For services deemed "not medically necessary" by your insurance plan you will be required to read and sign a Patient Responsibility Agreement with this Office each time you request those types of treatment. Co-payments are required to be paid at the time of your office visit according to our agreement with your health plan. Any "co-insurance" amount you owe for rendered services are due and payable upon receipt of our bill. Accounts not paid within thirty (30) days will be considered delinquent and must be paid prior to scheduling your next office visit.

PATIENTS WITHOUT INSURANCE: Payment in full is due at the time of service. If you are a vein patient and are unable to pay the entire balance at the time of service, we offer another payment option under our agreement with Care Credit, a patient payment finance company. We will not be able to perform any treatment or procedure without receipt of full payment at the time of your visit.

MEDICARE: Our office will submit your Medicare charges to Medicare and your secondary insurance if applicable. You are responsible for deductibles, co-pays and any non-covered services for which we have on file a signed Advanced Beneficiary Notice!""

MISSED APPOINTMENTS: Office Visits, Follow-ups and Ultrasound Testing: **Please notify this office at least 48 hours in advance of any cancellations.** If not notified you will be charged a $25.00 fee. Patients having any procedure (including, but not limited to vein ablation) a 48 hour notification are required for cancellation or to reschedule an appointment. If not notified a $100.00 fee will be charged. Cosmetic Procedures: (including but not limited to Sclerotherapy) will be charged a fee of $50.00 if not given at least 48 hour notice. Please help us serve you and all of our patients better by keeping scheduled appointments; 3 unapproved cancellations will result in dismissal from the practice.

PERSONAL VALUABLES: It is understood and agreed that Boston Vein Care PC shall not be held liable for the loss, theft or damage to any personal property left behind in any dressing room, exam or treatment room including but not limited to: cash, coin, checkbooks, jewelry, documents, eyeglasses, hearing aids or other personal property.

CONSENT TO PHOTOGRAPH/VIDEO TAPING/TEACHING: Boston Vein Care PC is permitted to take pictures of the medical or surgical progress involving vein care. The patient consents to photography and/or videotaping during medical or surgical procedures and the use of same for scientific, educational or medical research purposes. The patient further consents to routine photo documentation related to patient care. There may be other Physicians and Technicians observing your procedure (with your permission) in order to enhance their medical education and training as we are a teaching facility.
SEVERABILITY: If any terms or conditions of this agreement are held by a court of law to be invalid or Unenforceable, then this agreement, including all of the remaining terms and conditions, will remain in full force and effect as if such invalid or unenforceable term or condition had never been included. My signature below acknowledges that I have received a copy of this document and accept its terms.

DEFAULT: I understand that regardless of insurance coverage, that if after default my account is placed in the hands of an attorney or collection agency for collection, the undersigned agrees to pay for any unpaid balance and all attorney and/or collection fees.

Thank you for taking the time to read and understand our Financial Policy. Our practice believes good communications is essential in our relationship with our patients. Please let us know if you have any questions or concerns before signing below. Your signature indicates that you have read this policy and understand and agree to its terms.

_____ I have read and agree to the Financial Policy and Release Information paragraphs.
Initial

_____ I have been offered/given a copy of Boston Vein Care PC's HIPAA Policy and Patient's Initial Rights
Initial & Responsibilities and I have been given the opportunity to ask questions.

_____ _____ _____
Signature Print Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entitles that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include surgeries, follow-up care, administering medication, etc.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your medical health plan for your medical services.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities. Auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care who assist in taking care of you. We will use and disclose your protected health information when we are required to do so by federal, state or local law. We may disclose your protected health information to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your protected health information if requested by a law enforcement official for any circumstance required by law. We may release your protected health information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directions to perform their jobs. We may release protected health information to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your protected health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your protected health information if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your protected health information to federal officials for intelligence and national security activities authorized by law. We may disclose protected health information to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose protected health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official. Disclosure for these purposes would be necessary: (a) for the Institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your protected health information for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access inspect and copy your protected health information.
- The right to request and amendment to your protected health information.
- The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:
Name: Janixza Rosado or Office Manager at Boston Vein Care
Address: 1 Courthouse Ln #9, Chelmsford, MA 01824
Phone: (978) 666-4200

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)