



Steven F. Reeder, M.D., F.A.C.S.

Board Certified in Phlebology

Name: _____ Age: _____ Birth Date: _____ Sex: _____

Address: _____ City: _____ Zip: _____

Employer: _____ Occupation: _____

Address: _____ Work Phone: _____

Home Phone: _____ Cell Phone: _____

Social Security no.: _____ Driver's License no.: _____

Email Address: _____

Best way to contact you. Please Check from 1 to 4 (1 is best)

Home Phone: _____ Wk. Phone: _____ Cell Phone: _____ Email _____

Spouse: _____ Birth Date: _____

Employer: _____ Occupation: _____

Address: _____ Work Phone: _____

Cell Phone: _____ Social Security no.: _____

Next of Kin or Friend _____ Relationship _____

Address: _____ Telephone no.: _____

Referring doctor: _____

Insurance 1st: _____

Insurance 2nd: _____

Authorization to Release Information: I hereby authorize the Reeder Vein Institute to release any medical information to process a medical claim. I understand that I am financially responsible for any and all charges rendered at the time of office visit and that fees are collected on the day of the procedure. If for any reason it becomes necessary to initiate collections proceedings, I understand I am responsible for the cost of all treatments received, as well as any and all legal or collection fees Reeder Vein Institute (RVI) incurs. **I agree to inform RVI of any changes in my insurance policy.**

Sign: _____ Date: _____

CONFIDENTIAL HEALTH & VASCULAR HISTORY

PATIENT INFORMATION:

Name: _____ Date: _____

Age: _____ sex: _____ height: _____ weight: _____ Years with varicose/spider vein? _____

HOW DID YOU HEAR ABOUT US?

Referring Doctor: _____

PRIMARY CARE INFORMATION:

Primary Care Physician: _____ Phone: _____

VASCULAR SYMPTOMS AND HISTORY:

Please check if you have:

<input type="checkbox"/> Red spider veins	Lt__ Rt__	<input type="checkbox"/> Bulging veins	Lt__ Rt__
<input type="checkbox"/> Skin discoloration below your knee	Lt__ Rt__	<input type="checkbox"/> Flat bluish-green veins	Lt__ Rt__
<input type="checkbox"/> Purple veins	Lt__ Rt__	<input type="checkbox"/> Diagnosis of vein disease	Lt__ Rt__
<input type="checkbox"/> Purple vein network	Lt__ Rt__	<input type="checkbox"/> Leg ulcer	Lt__ Rt__
<input type="checkbox"/> Abdominal veins		<input type="checkbox"/> Other: _____	

Do your legs or ankles:

<input type="checkbox"/> Ache or hurt?	Lt__ Rt__	_____
<input type="checkbox"/> Swell?	Lt__ Rt__	_____
<input type="checkbox"/> Cramp?	Lt__ Rt__	_____
<input type="checkbox"/> Become restless?	Lt__ Rt__	_____
<input type="checkbox"/> Become tired/heavy?	Lt__ Rt__	_____
<input type="checkbox"/> Itch?	Lt__ Rt__	_____
<input type="checkbox"/> other?	Lt__ Rt__	_____

Please describe:

Please check any methods you have used to relieve your leg discomfort:

<input type="checkbox"/> No Discomfort	<input type="checkbox"/> Warm Soaks
<input type="checkbox"/> Leg Elevation	<input type="checkbox"/> Cold Packs
<input type="checkbox"/> Exercise	<input type="checkbox"/> Pain Meds
<input type="checkbox"/> Flexion/Extension of your feet	<input type="checkbox"/> Aspirin
<input type="checkbox"/> Walking	<input type="checkbox"/> Tylenol
<input type="checkbox"/> Support Hose	<input type="checkbox"/> Ibuprofen
<input type="checkbox"/> Wraps	<input type="checkbox"/> Other Method: _____

Are you on your feet for long periods? _____ In what capacity? _____

Does walking/exercise relieve your discomfort or make it worse? _____

Have you been treated for your veins before? _____

By whom? _____ When? _____

What method?

- | | | | |
|---|-----------|---|-----------|
| <input type="checkbox"/> Injections | Lt__ Rt__ | <input type="checkbox"/> Ultrasound-Guided Injections | Lt__ Rt__ |
| <input type="checkbox"/> Stripping | Lt__ Rt__ | <input type="checkbox"/> Radiofrequency Closure | Lt__ Rt__ |
| <input type="checkbox"/> Ambulatory Phlebectomy | Lt__ Rt__ | <input type="checkbox"/> Laser Catheter Ablation | Lt__ Rt__ |
| <input type="checkbox"/> Ligation | Lt__ Rt__ | <input type="checkbox"/> Laser for Spider Veins | Lt__ Rt__ |
| <input type="checkbox"/> Other _____ | | | |

What have your results been?

MEDICAL HISTORY:

Is there a history in your FAMILY of spider or varicose veins?

WHO? _____

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

WHO? _____

Do YOU have a history of:

- | | |
|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Ankle Skin changes | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Atherosclerosis | <input type="checkbox"/> Leg ulcers |
| <input type="checkbox"/> Bleeding/Blood disorder | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Chest pain discomfort | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Crohn's disease, IBS | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Deep Vein Thrombosis/clot | <input type="checkbox"/> Pulmonary embolus |
| <input type="checkbox"/> Diabetes; Insulin dependent | <input type="checkbox"/> Rupture of a vein |
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Superficial Thrombophlebitis |
| <input type="checkbox"/> Erectile difficulty/dysfunction | <input type="checkbox"/> Trauma to your legs |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hepatitis | _____ |
| <input type="checkbox"/> HIV | _____ |

CURRENT MEDICAL INFORMATION:

Do you have allergies or sensitivities to medicines or tape? List all:

Are you being treated for any illnesses or conditions? _____ If so, what illness:

Please list all medicines that you take (Prescription, Non-Prescription, Vitamins and Herbal):

Do you smoke? _____

What operations have you had?

Any complications from your surgery?

Acknowledgment Form

I acknowledge receipt of this Notice of Privacy Rights, which I have reviewed and give my permission to **Reeder Vein Institute** to use and disclose my health information in accordance with it.

Signature of Patient

Signature of Patient's Representative

Name of Patient (Print or Type)

Relationship of Representative to patient

Date

Date

TO OUR PATIENTS:

Our foremost goal is to provide you with excellent medical care. We and our staff hold that as our highest priority. We also want to excel in providing you with clear information about the financial concerns and responsibilities you have as a patient and we have as a medical practice. To that end, we hope you will carefully read the following summary about insurance and cash reimbursement. If you have any questions please ask our office manager, Mary Ellen Faber, for further explanation.

Managed Care Contracts

We have chosen to contract with a number of insurance companies or networks to provide medical care to their insured members at a negotiated discount. If you are insured by one of these companies or through one of the networks, we are considered **In-Network** providers for you. We abide by the terms of our contract with them *which includes the collection of Co-Pays, Co-Insurance, and Deductible amounts. By contract, we collect these amounts at time of service for office visits and in advance for surgeries and may not waive them.*

We make every effort to obtain reliable information from the insurance companies/networks and obtain the benefits with the company. Based on that information, we collect your portion of the fee. If the information proves to be incorrect when the claim is filed, you may owe additional money or we may refund money to you. *You receive an Explanation of Benefits (EOB) at the same time as we receive payment. The EOB states the contracted amount, the amount of Patient Responsibility, and the discount for which the practice cannot bill a patient.* If the EOB is incorrect, we will file an appeal. Otherwise, the amount due from you stands as per the contract. If, in spite of our best effort, we have collected an incorrect amount from you, we will either refund any overpayment to you promptly or collect any underpayment from you promptly.

Prompt Pay Discount

We welcome patients to our practice who are not covered by insurance plans/payors with whom we are contracted. Some patients are covered by insurance plans/payors with whom we are NOT contracted and are considered Out-of-Network with our practice. Some patients are not insured at all. We believe our fee schedule reflects a usual and customary fee for the medical services provided. However, we do offer a discount for prompt payment at the time of visits and diagnostic testing. Payment for surgery is due on or before the day of surgery. We extend a discount for this timely payment. Our office manager will be pleased to discuss this policy with you.

Financial Policy for Sclerotherapy (cosmetic treatment)

Sclerotherapy for spider veins is considered a cosmetic procedure and is not covered as a medical benefit. This is true even if the spider veins cause symptoms such as aching and burning. Payment will be expected at the time of service. Treatment of spider veins involves time and injection agents, both of which are expenses covered in the treatment charge. Each treatment session is a separate charge. The response to the treatment is variable with some patients having an excellent result and some less than hoped for results. The charge for the service is the same regardless of the outcome of treatment.

Written Estimate

You may request a written estimate of your out-of-pocket expenses. We are glad to comply with this request as we want our patients to be informed about the financial implications of their medical care. Please ask our office manager if you want such an estimate.

If you have any questions about the above information or any uncertainty regarding payment for services, PLEASE do not hesitate to ask us.

Signature

Date

Printed name