Center for Vein Restoration

Welcome to the Center for Vein Restoration!

Thank you very much for choosing the Center for Vein Restoration as a partner in your vein health. We feel you and your Doctor have made the right choice to schedule an initial evaluation with us. Unfortunately many people continue to suffer from leg discomfort for far too long. We hope that at the conclusion of your therapy you will realize that the treatment was probably far quicker and easier than you imagined.

Here are a few of the reasons you are in good hands at our practice:

- Our exceptional doctors specialize in vein treatment, performing thousands of procedures each year**. Our physicians and vein centers have received numerous accolades from the *Washingtonian, Best of Bethesda* and *Best of Baltimore* magazines, as well as *What's up Annapolis* and *What's up Eastern Shore.***
- Treatment is performed on an outpatient basis in our vein centers and patients usually return to work or other daily activities the same day.
- We offer the full range of vein treatment options – laser and radiofrequency ablation, sclerotherapy and microphlebectomy – so you will receive the best solution for your specific needs.
- As your partner in complete vein care we evaluate and, if needed, treat your superficial and deep venous systems – a skill set provided by only select centers across the nation.
- Our office communicates with your health insurance plan to help obtain pre-approval for your treatments, help secure optimal coverage, and can offer financing options to manage coordination-of-benefit expenses.

During your initial appointment, our Doctor and team of vein specialists will evaluate your personalized needs and recommend an effective treatment plan. We look forward to meeting you and helping you enjoy healthy and happy legs once again!

Sincerely,

Sanjiv Lakhanpal, MD

Sanjiv Lakhanpal, MD, FACS
President & CEO

New Patient Instructions - Center for Vein Restoration

This information is provided to assist you in preparing for your initial appointment with us at the Center for Vein Restoration (CVR).

Please complete the following documents prior to your visit and bring them with you. This will help expedite the registration process.

1. **Patient Information Form** – this includes your personal and insurance information for us to register you with our practice.
2. **Medical Information Form** and **Pain Survey** – this captures your pertinent medical history and health information; please document all medications and supplements you may be taking at this time and any allergies that you may have.
3. **Patient Privacy and HIPAA Protection Form** – this explains our compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy regulations, and that our *Notice of Privacy Practices* is available for review (online and at registration) and we require your acknowledgement of certain authorizations and consents.
4. **Communication Preference and Messages Agreement Form** – this allows you to specify the best way for CVR to communicate with you by providing alternative methods and/or locations.
5. **Patient Consent, Assignment of Benefits and Acknowledgement Form** – this covers the collection of your consent to treat, assignment of insurance benefits and payment, and informs you of our general patient financial agreement and no show / cancellation policy.
6. **Practice Business Policy** – this informs you of CVR's business and financial policy, and your responsibility relative to payment and the possible need for insurance or physician referrals.

Most importantly, when you come for your visit, please be sure to bring the following documents as we need copies of them for our records:

- **A photo ID, such as: Driver's License, State ID, Military ID, etc.**
- **Your current insurance card(s)**
- **Your referral slip from your Primary Care Physician (if required by your insurance plan)**

Note: *Your initial consultation will take approximately two hours, so please plan accordingly. Please drink plenty of fluids, dress warmly, and bring loose fitting shorts (if possible) to facilitate your leg examinations.*

We look forward to seeing you at our office soon. If you have any questions or need any assistance regarding the above information, please feel free to contact us at any time at 1-855-830-8346.

Your appointment is on: _____ @ _____

At our CVR office in: _____

Have a great day! We look forward to meeting and serving you in the very near future.

Center for Vein Restoration

PATIENT INFORMATION - *Welcome to the Center For Vein Restoration - (Please complete all fields – Thank You)*				
NAME (Last, First, Middle)		SOC. SEC. NUMBER	BIRTH DATE	SEX
LOCAL ADDRESS		CITY	STATE	ZIP
SECONDARY / BILLING ADDRESS - (if applicable)		CITY	STATE	ZIP
HOME PHONE	CELL PHONE	EMAIL		
RACE / ETHNICITY	LANGUAGES	WORK PHONE	OCCUPATION	
EMPLOYER NAME (□ Retired / □ Disabled / □ None)	EMPLOYER ADDRESS	CITY	STATE	ZIP
REFERRED BY? □ Self-Referred → □ Physician - *(Please Complete ↓)*	HOW DID YOU HEAR ABOUT CVR?			
REFERRING PHYSICIAN - NAME & SPECIALTY:	OFFICE ADDRESS	CITY	STATE	ZIP
EMERGENCY CONTACT NAME	RELATIONSHIP	BEST CONTACT PHONE	EMAIL	

RESPONSIBLE PARTY INFORMATION - *(Please complete if different than patient information above)*			
NAME (Last, First, Middle)	SOC. SEC. NUMBER	BIRTH DATE	SEX
LOCAL ADDRESS	CITY	STATE	ZIP
SECONDARY / BILLING ADDRESS - (if applicable)	CITY	STATE	ZIP
HOME PHONE	WORK PHONE	RELATIONSHIP TO PATIENT: □ SELF □ SPOUSE □ PARENT □ GUARDIAN □ OTHER:	

PRIMARY INSURANCE		
NAME OF INSURANCE COMPANY	POLICY#	
POLICY HOLDER - NAME OF INSURED	GROUP#	
INSURANCE THROUGH EMPLOYER? *(If Yes, Please Document Employer Name and Address)*	COPAY AMOUNT	
CITY STATE ZIP	DEDUCTIBLE	
RELATIONSHIP TO PATIENT: □ SELF □ SPOUSE □ PARENT □ GUARDIAN □ OTHER:	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE - *(If Applicable)*		
NAME OF INSURANCE COMPANY	POLICY#	
POLICY HOLDER - NAME OF INSURED	GROUP#	
INSURANCE THROUGH EMPLOYER? *(If Yes, Please Document Employer Name and Address)*	COPAY AMOUNT	
CITY STATE ZIP	DEDUCTIBLE	
RELATIONSHIP TO PATIENT: □ SELF □ SPOUSE □ PARENT □ GUARDIAN □ OTHER:	EFFECTIVE DATE	EXPIRATION DATE

Assignment and Release: I certify that the information provided is correct. I hereby authorize the assignment of insurance benefits for the insured are to be made payable to Center for Vein Restoration (CVR) for services rendered and that CVR may release medical information for treatment, payment and healthcare operations. Payments received for services rendered to me by CVR may be applied to unpaid bills for which I am liable, subject to coordination of benefit rules. I acknowledge that I am fully responsible for all non-covered services, co-payments, coinsurance and deductibles. I further agree to be responsible for collection fees, court costs, and/or legal fees accrued in the event of default due to non-payment, and that a fee of $35.00 will be assessed for each returned check with insufficient funds.

SIGNATURE OF PATIENT / GUARDIAN _____ DATE _____

Center for Vein Restoration

PATIENT MEDICAL INFORMATION

Date _____

Patient Name: _____ Birthdate: _____ Age: _____

Chief complaint/reason for visit: _____

Date of first symptoms (required by insurance): _____

Symptoms: Describe _____

Family History: Varicose Veins? No Yes (please circle one)
Other Cardiac Conditions? _____

Medications – include dosage

_____

_____

_____

_____

Allergies – include reaction

Latex allergy: No Yes

_____

_____

_____

Over the counter medications/supplements: _____

Aspirin daily: No Yes

Plavix: No Yes

Coumadin: No Yes

Do you smoke: No Yes # Packs per day _____ Years _____ Date Quit: _____

Alcohol use: No Yes Occasionally Daily (please circle one)

Employed: No Yes Retired Job _____ Years _____

Bleeding / Clotting History

DVT / Blood clot _____ When _____

Frequent miscarriages: _____

Previous surgeries: _____
_____

Other hospitalizations: _____
_____

CVR Staff ONLY – Reviewed By (initial): *RN:* _____ *Physician:* _____

Center for Vein Restoration

Do you have?

	NO	YES	Comment		NO	YES	Comment
Arthritis				Asthma			
Cancer				Hypertension			
Diabetes				Depression/Anxiety			
Stroke				COPD			
GERD				Other			

Heart Disease: Atrial fibrillation CAD Stents _____

History of MI / Heart Attack: When: _____ Other: _____

Pregnant? No Yes Children: _____ Ages: _____

Height: _____ Weight: _____

How did you learn about Center for Vein Restoration? (please circle one)

Physician TV Ad CVR Employee Magazine Self Family/Friend Radio Newspaper

Other: _____

Your Referring Physician:

_____ _____ _____

Doctor's Name Address Phone

Your Primary Physician:

_____ _____ _____

Doctor's Name Address Phone

Others Physicians Involved In Your Care:

_____ _____ _____

Doctor's Name Address Phone

_____ _____ _____

Doctor's Name Address Phone

Pharmacy Preference:

_____ _____ _____

Pharmacy Name Address Phone/Fax

Patient Signature: _____ **Date:** _____

CVR Staff ONLY – Reviewed By (initial): *RN:* _____ *Physician:* _____

Patient Privacy and HIPAA Protection Form

Patient Name: _____ Date of Birth: _____

Maintaining the privacy of your information is paramount at Center for Vein Restoration (CVR). In support of CVR's compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy regulations, we established our ***Notice of Privacy Practices ('Notice')***. The Notice describes the ways in which CVR may use and disclose your medical information (called "Protected Health Information" or "PHI") and to inform you of your rights with respect to PHI in our possession. CVR limits the use and disclosure of your PHI to the minimum amount necessary. When release of PHI is required our staff will seek your written authorization prior to release and maintain a record of all PHI disclosures. *A copy of the Notice can be provided for your review at registration and can be accessed at the CVR website.*

To ensure your understanding of CVR's Patient Privacy and HIPAA Protections, please review the following consents and authorizations, and acknowledge with your dated signature where requested – Thank you.

Consent for Disclosure of Protected Health Information:

As permitted by the Privacy regulations, CVR will use your Protected Health Information to carry out Treatment, Payment and Healthcare Operations. This may include sharing PHI with your health insurance plan(s), other healthcare providers involved in your care, as well as persons you designate below. Please refer to our *"Notice of Privacy Practices"* for a more complete description. You have the right to revoke this consent at any time by notifying us in writing to the attention of the Privacy Officer, located at: 7474 Greenway Center Drive, Suite 1000, Greenbelt, MD 20770.

I consent and authorize Center for Vein Restoration to contact healthcare providers to release information related to my care, and to use and disclosure of my PHI for treatment, payment and healthcare operations.

_____ _____

Patient *(Guardian / Representative)* Signature Date

Designation of Others for Disclosure of PHI – *(Caregivers, Family, Friends or Personal Representatives)*:

HIPAA permits CVR to discuss information with your family or others involved in your care or payment. To protect your information, *please enter the names of the specific individuals that you want to grant access* in the table below. CVR will use professional judgment and disclose the minimum amount of PHI necessary to fulfill the request.

If you do not want anyone* other than yourself to have access to your PHI, please mark ☑ - *None* → ☐ *- NONE*

"Designee" - Print Name	*Relationship to Pt*	*Contact Phone*

** Please note that specific PHI 'restrictions' requires completion of CVR's Patient HIPAA Privacy Rights Action Request Form.*

Acknowledgement of Review and/or Receipt of the Practice's *Notice of Privacy Practices*:

I acknowledge that I was provided the opportunity to review the Practice's ***Notice of Privacy Practices*** ("*Notice*"), and if requested, a copy of the *Notice* has been provided to me. I understand the terms of the Practice *Notice* are subject to change and that I may request an updated copy of the *Notice* anytime from the CVR staff or by contacting the Privacy Officer at the address above or via email at privacy.officer@centerforvein.com.

_____ _____

Patient (Guardian) Signature Date

CVR Staff: I made a good faith effort to obtain a written patient acknowledgement of Notice receipt but was unable due to:

□ Patient refused to sign □ Patient unable to sign □ Other: Employee Initials _____ Date: _____

Center for Vein Restoration

Communication Preferences and Message Consent:

Patient Authorization to Receive Communications by Alternative Means

Patient Name: _____ **DOB:** _____

The HIPAA Privacy Law gives patients the right to request and receive provider communications that may contain their protected health information (PHI) through alternative methods or locations. The law also allows CVR to send communications to patients about appointments, treatment and healthcare operations, and the products and services we offer. The ability to communicate with patients and coordinate their care is important to their overall health care experience and outcome success.

To support your rights and ensure CVR can contact you, please define your communication and message preferences using this form.

Directions:

Please circle either "Yes" or "No" to the questions below and provide the requested contact numbers and information to inform CVR how best to communicate with you.

Yes / No 1. You may call my **home phone** (_____-_____-_____) and leave a voice message.

Yes / No 2. You may leave a **message with anyone** answering my **home phone**

Yes / No 3. You may call and leave a message on my **cell phone** (_____-_____-_____)

Yes / No 4. You may send **text message**s to my **cell phone**

Yes / No 5. You may leave a **message** on my **work voice mail** (_____-_____-_____) Ext _____

Yes / No 6. You may send email to my **email address** _____

Yes / No 7. Please direct written communications to my **home address**. *(If No, please define address below)*:

Alternative Address: □ Other Residence □ Work □ Other: _____

_____

_____

_____

Patient Communication Consent:

By my signature below, I give express written consent and authorize CVR to contact me using the alternative methods listed above, and I will hold CVR harmless from any liability that may arise from the release of information. I understand it is my responsibility to notify CVR in writing of any changes in my contact preferences indicated above. I also understand that I may *'opt-out'* of any communication(s) at any time, and that the consent will remain enforce unless otherwise revoked in writing by me and submitted to CVR.

_____ _____

Signature of Patient or Guardian Date

Center for Vein Restoration

Patient Consent, Assignment of Benefits and Acknowledgement Form

Patient Name: _____ **DOB:** _____

Please read and acknowledge the following consents, assignment and authorizations.

Consent for Diagnostic, Medical and/or Surgical Treatment: I wish to be evaluated and treated by the Center for Vein Restoration (CVR). I hereby agree and give my consent to the providers/staff of CVR to order, prescribe and provide diagnostic, medical and surgical treatment to me that they judge is appropriate in diagnosing and/or treating my medical condition(s).

Assignment of Insurance Benefits and Authorization to Pay Insurance Benefits: I authorize CVR to apply for benefits for services rendered to me or the patient under my health insurance policies providing benefits. I assign and authorize payment of benefits from my insurance plan(s) to CVR and grant permission to contact my employer or health plan(s) regarding insurance information and coverage of my health benefits.

No Show / Cancellation Policy: To accommodate scheduling of patient care and provide timely appointments, our practice has a No Show/Cancellation Policy. Any missed or no show appointments for diagnostic scans, visits or treatments that are not canceled 48 hours prior to the appointment time may be charged a $50.00 fee. Our office reserves time for your care in good faith; please extend the courtesy by contacting our office at least 48 hours prior to your appointment time to cancel or rescheduled an appointment – Thank You.

Patient Financial Agreement and Payment Policy: I understand that CVR will bill my health insurance plan(s) for care I receive. I agree that payments from my health plan(s) will go directly to CVR. I understand that CVR can bill me directly when: (1) I choose to have care that my health plan covers but I do not secure needed referral or an approval for the care from my health plan; (2) I choose not to use my health coverage and agree to pay for the care myself; (3) CVR does not participate with my health plan and I agree to pay for 'out-of-network' care; or (4) I receive care for service(s) or supplies that are non-covered by my health plan(s). I further agree to pay for any and all related collection costs related to my financial responsibility.

Authorization for Use of Copies: I permit a copy of these authorizations and assignments defined with my signature below to be used in place of the original on all insurance claim submissions and for the release of specific medical or other protected health information, whether manual, electronic or telephonic.

I understand and agree to the above consents, assignments and authorizations: *(Please sign and date below:)*

_____ _____

Patient / Responsible Party Date

Medicare Beneficiary Lifetime "Signature on File": *(To be completed only if patient has Medicare coverage)*

I request that payment of authorized Medicare benefits be made on my behalf to CVR for services furnished me by CVR providers. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) information needed to determine these benefits. I understand my signature below requests that payment be made and authorizes release of medical information necessary to pay the claim. My signature below authorizes releasing of the information to any other insurer. For 'assigned' claims, CVR agrees to accept the Medicare defined allowance as the basis for payment and I will be responsible for payment of the deductible, co-insurance, and non-covered services based on Medicare's Explanation of Benefits.

_____ _____

Medicare Beneficiary / Authorized Representative Date

QUALITY OF LIFE WITH VENOUS INSUFFICIENCY

Patient Name: _____ Date: _____

Dear Patient:

Many people complain of leg pain. We would like to find out how often these leg problems occur and to what extent they affect the everyday life of those who have them.

Below is a list of symptoms, sensations and types of discomfort that you may or may not be experiencing and which might make everyday life hard to bear to a greater or lesser extent.

For each symptom, sensation or discomfort listed, **please tell us if you have experienced what is described in each sentence**, and if the answer is **'yes'**, please describe the **'intensity'**.

- *There are five response options (1 through 5) and the scale progresses from "1" – relating to None/Never, to the highest rank of "5" – relating to Severe/Constant.*
- *Please **circle** the number that best describes your situation relative to the symptom, sensation of discomfort described.*
  - ✓ ***Circle "1"*** - if the discomfort described does not apply to you.
  - ✓ ***Circle 2, 3, 4 or 5*** - if you have felt the discomfort described, select the number that best describes the intensity of the discomfort (from 2 – 5) based on the scale presented.

During the past four (4) weeks….

1) Have you had any **pain** in your **ankles** or **legs**, and **how severe** has this pain been? *Circle the number that applies to you.*

No Pain	*Slight Pain*	*Moderate Pain*	*Considerable Pain*	*Severe Pain*
1	*2*	*3*	*4*	*5*

2) **How much trouble** have you had at **work** or with **your usual daily activities** because of your leg problems? *Circle the number that applies to you.*

No Trouble	*Slight Trouble*	*Moderate Trouble*	*Considerable Trouble*	*Severe Trouble*
1	*2*	*3*	*4*	*5*

3) Have you **slept poorly** or your **sleep interrupted** because of your leg problems, and if 'yes', how often? *Circle the number that applies to you.*

Never	*Rarely*	*Fairly Often*	*Very Often*	*Every Night*
1	*2*	*3*	*4*	*5*

_____ _____

Patient Signature *Date*

QUALITY OF LIFE WITH VENOUS INSUFFICIENCY

Please review the statements below and answer by circling the number that applies to your legs.

During the past four weeks, how much trouble have you had carrying out the actions and activities listed below because of your leg problems?					
	Share the Degree of Trouble with Legs?				
*For each statement below, indicate **when** and **how much** trouble you have experienced by circling the number that applies to you.*	***None***	***Slight***	***Moderate***	***Considerable***	***Could Not Do It***
4) Remaining standing for a long time?	**1**	**2**	**3**	**4**	**5**
5) Climbing several flights of stairs?	**1**	**2**	**3**	**4**	**5**
6) Crouching / Kneeling down?	**1**	**2**	**3**	**4**	**5**
7) Walking at a brisk pace or for long distances?	**1**	**2**	**3**	**4**	**5**
8) Travelling by car, bus, or plane?	**1**	**2**	**3**	**4**	**5**
9) Doing jobs at home (e.g. work, house projects, carrying your kids, etc.?	**1**	**2**	**3**	**4**	**5**
10) Going out for the evening, a party or social event?	**1**	**2**	**3**	**4**	**5**
11) Playing a sport, exerting yourself?	**1**	**2**	**3**	**4**	**5**

Leg problems can also affect your spirits. How closely do the following statements correspond to how you have felt during the past four weeks?					
	How have Problems Affected Your Spirits / Feeling?				
*For each statement below, indicate how your leg problems **affect your spirit** and **feelings** by circling the number that applies to you.*	***None***	***Slight***	***Moderate***	***Considerable***	***Could Not Do It***
12) I felt nervous/tense.	**1**	**2**	**3**	**4**	**5**
13) I got tired quickly.	**1**	**2**	**3**	**4**	**5**
14) I felt I was a burden.	**1**	**2**	**3**	**4**	**5**
15) I always had to be cautious.	**1**	**2**	**3**	**4**	**5**
16) I felt embarrassed about showing my legs.	**1**	**2**	**3**	**4**	**5**
17) I got irritated easily.	**1**	**2**	**3**	**4**	**5**
18) I felt as if I was handicapped.	**1**	**2**	**3**	**4**	**5**
19) I found it hard to get going in the morning.	**1**	**2**	**3**	**4**	**5**
20) I did not feel like going out.	**1**	**2**	**3**	**4**	**5**

TOTAL SCORE: _____

Thank You for Your Participation!

_____ _____

Patient Signature *Date*

_____ _____

CVR Staff Signature *Date*