

ACKNOWLEDGEMENT FORM

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Vein Centers for Excellence of Kansas City's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the content of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____ **Date:** _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ **Witnessed by:** _____

If the patient refuses to sign, indicate your attempt to obtain a signature below.

[] Patient refused to sign this Acknowledgement

Date: _____

Time: _____

Employee Name: _____

**Vein centers for Excellence of Kansas City
11409 Ash – Suite B
Leawood, Kansas 66211
Craig I Schwartz, D.O., FACOS, FICS
(913)451-VEIN(8346)**

PATIENT INFORMATION

You have been scheduled to see Dr. Schwartz. Please complete and bring the enclosed information to your appointment on _____.

If these forms are not fully completed, please arrive 15 minutes before your appointment time.

| | |
|--|---|
| NAME _____ LAST FIRST M.I. | HEALTH INSURANCE _____ |
| ADDRESS _____ | PRIMARY CARRIER _____ |
| CITY _____ STATE _____ ZIP _____ | INSURANCE ADDRESS _____ |
| HOME PHONE _____ CELL _____ | INS. ID # _____ |
| EMAIL _____ | |
| AGE _____ DATE OF BIRTH _____ | GROUP # _____ |
| SOCIAL SECURITY NUMBER _____ | Policyholder's Name & Date of Birth _____ |
| OCCUPATION _____ | Policyholder's SS # _____ |
| (If retired, please list prior work | Secondary Carrier _____ |
| EMPLOYER _____ | Insurance Address _____ |
| WORK PHONE _____ | Insurance ID# _____ |
| MARITAL STATUS _____ | Group # _____ |
| SPOUSE NAME _____ | |
| FAMILY DOCTOR _____ | CONTACT PERSON OTHER THAN YOUR SPOUSE _____ |
| | RELATIONSHIP _____ Phone _____ |
| REFERRING DOCTOR OR ANY OTHER MEDICAL DOCTORS YOU CURRENTLY SEE _____ | ADDRESS _____ |
| NAME OF PREFERRED PHARMACY _____ | SPOUSE'S OCCUPATION _____ |
| TOWN/CITY _____ | SPOUSE'S EMPLOYER _____ |
| PHONE NUMBER _____ | WORK PHONE _____ |

YOUR FIRST VISIT IS A CONSULTATION WITH THE DOCTOR. IF YOU HAVE ANY QUESTIONS REGARDING THE INFORMATION ENCLOSED PLEASE CALL OUR OFFICE.

PLEASE BRING YOUR INSURANCE CARDS AND A PAIR OF SHORTS WITH YOU.

List All Medications You Now Take, The Dose And How Often:

_____ None

| Medication | Dose Frequency |
|------------|----------------|
| 1 _____ | _____ |
| 2 _____ | _____ |
| 3 _____ | _____ |
| 4 _____ | _____ |
| 5 _____ | _____ |
| 6 _____ | _____ |
| 7 _____ | _____ |
| 8 _____ | _____ |
| 9 _____ | _____ |
| 10 _____ | _____ |
| 11 _____ | _____ |
| 12 _____ | _____ |
| 13 _____ | _____ |
| 14 _____ | _____ |
| 15 _____ | _____ |

Drug Allergies _____

Do you have allergy to Latex _____

Do you Have A History of Allergy or Reaction to X-Ray Dye or Iodine?

SOCIAL HISTORY

Type of Work _____

Coffee _____ (cups per day)

Tobacco _____ (packs per day) for _____ years

Quit? _____ What Year? _____

Alcohol _____ Amount _____

FAMILY HISTORY

Age State of Health & Diagnosis Age at Death and Cause of Death

Father _____

Mother _____

Brothers _____

Sister _____

Father's Father _____

Father's Mother _____

Mother's Father _____

Mother's Mother _____

MEDICAL HISTORY

The following information will help your physician plan your care. PLEASE PRINT AND COMPLETE EACH SECTION

Appointment Date _____ Name _____

Sex Male _____ Female _____ Age _____ Date of Birth _____

Height _____ Weight _____

For What Problem Are you Seeking Care? _____

How Long Has It Been Present? _____

If Pain Is Present, Please Describe How Often _____

Severity (1=Minimal to 10=Severe) _____

Quality (Sharp, Dull, Cramps, Burning, Etc.) _____

What Makes Pain Better? _____

What Makes Pain Worse? _____

Approximate Date and Hospital of Last

EKG _____ Chest X-Ray _____

Blood Work _____ Carotid Ultrasound _____

Arteriogram _____ Cardiac Cath _____

Mammogram _____

Check and/or List All Illnesses You Have Been Treated For In The Past And At Present

| | | | |
|------------------|---------------------------|-------------------------|------------------------|
| ___ None | ___ Heart Attack | ___ Angina | ___ Diverticulitis |
| ___ Heart Murmur | ___ Mitral Valve Prolapse | ___ High Blood Pressure | ___ Chronn's Disease |
| ___ Stroke | ___ Asthma | ___ Low Blood Pressure | ___ Ulcerative Colitis |
| ___ Blood Clots | ___ Stomach Trouble/Ulcer | ___ Bleeding Disorder | ___ Hepatitis |
| ___ COPD | ___ Emphysema | ___ Kidney Problems | ___ Seizures |
| ___ Bladder | ___ Arthritis | ___ Diabetes | ___ Tuberculosis |
| ___ Cancer | ___ Depression | ___ Cirrhosis | |
| ___ Other | _____ | | |
| ___ Other | _____ | | |
| ___ Other | _____ | | |

Check and/or List All Surgeries You Have Had:

| | | | |
|---------------|-----------------------------------|--------------------------|---------------------|
| ___ None | ___ Cardiac Cath | ___ Gallbladder | ___ Lung Surgery |
| ___ Appendix | ___ Hysterectomy | ___ Tonsils | ___ Colon Surgery |
| ___ D & C | ___ Tubal Ligation | ___ Hernia | ___ Thyroid Surgery |
| ___ Pacemaker | ___ Cataract | ___ Heart Surgery/Bypass | ___ Ulcer Surgery |
| ___ Prothesis | ___ Plates, Pins, Screws in Bones | | |
| ___ Other | _____ | | |
| ___ Other | _____ | | |

LATEX ALLERGY SCREENING AND QUESTIONNAIRE

Name _____ Social Security/Employee ID# _____

| Have you ever suffered from: | Yes | No | If yes, please explain |
|--|-----|----|-------------------------|
| > Allergic rhinitis, conjunctivitis | | | |
| > Asthma, chronic bronchitis | | | |
| > Eczema, hives, unexplained rash | | | |
| > Hay fever, sinus problems | | | |
| > Reactions to bandaids or adhesive tape | | | |
| Have you reacted from handling: | Yes | No | If yes, please explain: |
| * Poinsettia plant | | | |
| * Balloons, rubber gloves, other rubber products | | | |
| * Elastic or other stretchy fabric or clothing | | | |
| * Elastic bandages | | | |
| Have you had the following after a dental visit: | Yes | No | If yes, please explain: |
| • Itching, tearing | | | |
| • Sneezing, runny nose | | | |
| • Unexplained fatigue, drowsiness | | | |
| • Facial swelling, itchiness, redness | | | |
| Have you ever reacted after eating: | Yes | No | If yes, please explain: |
| ➤ Avocados | | | |
| ➤ Bananas | | | |
| ➤ Tropical fruit, kiwi, papayas | | | |
| ➤ Chestnuts | | | |
| Have you had: | Yes | No | If yes, please explain: |
| ▪ Many surgeries | | | |
| ▪ Many urinary catheters | | | |
| ▪ Spina bifida | | | |
| ▪ Many drug and/or environmental allergies | | | |
| ❖ IF YOU ARE SENSITIVE TO NATURAL LATEX RUBBER, HAVE YOU BEEN TESTED? | Yes | No | If yes, please explain: |
| ❖ DO YOU WEAR A MEDIC ALERT BRACELET? | | | |
| ❖ HAVE YOU BEEN TOLD BY A DOCTOR THAT YOU ARE ALLERGIC TO LATEX? | | | |
| ❖ DOES YOUR JOB INVOLVE FREQUENT CONTACT WITH LATEX PRODUCTS? | | | |
| | | | |

VEIN CENTERS FOR EXCELLENCE OF KANSAS CITY

VARICOSE/SPIDER VEIN TREATMENT INFORMATION

General Information:

- Bring a pair of shorts with you to each visit.
- **Try on your compression stockings before washing and bring them with you to each visit.**
- **Do not wear any lotion on your legs the day of treatment. Females: Shave before you come.**
- On average, each spider vein requires 3 to 5 treatments before resolution.
- Fees reflect a 20-30 minute session.
- Laser and Photoderm patients: **NO** sun exposure or tanning bed use for 4 weeks prior to treatments, and no artificial tanner use for 2 weeks prior to treatments.

Vein Surgery Patients: (You will need a driver to bring you and drive you home.)

- Pick up prescriptions the day before surgery at your pharmacy and take as instructed.
- No one other than the patient and medical staff are allowed in the surgery room.
- You may resume normal activities 2 days after surgery.
- You may resume exercise after 1 week.
- Do not swim or use a hot tub for 2 weeks after surgery.
- Do not take aspirin, aspirin products, or Vitamin E supplements for 5 days before surgery. If you are on Coumadin – quit taking seven (7) days prior.
- You should eat a normal breakfast before coming in for surgery. You can also take all normal medications except the aspirin products.
- **Take the valium (diazepam) 30 minutes prior to your appointment and DO NOT DRIVE!! BRING THE REMAINING VALIUM (diazepam) WITH YOU TO YOUR APPOINTMENT.**

Insurance/Billing Information:

- Please direct insurance questions to Kathy at 913-451-8346.
- Pre-certifications must be taken care of by the patient.
- Spider vein treatments, compression hose, and medications must be paid in full at the time of visit. Please request a receipt if you would like to submit the claim to your insurance company.
- At the patients' request, a pre-determination of benefits letter will be sent to the insurance company. This letter requests that you be notified in writing as to whether the surgery procedure will be covered. We will not get a response in our office. It is up to the patient to follow up with their own insurance company if you do not get a response.
- **It is expected that if your insurance company sends payment to you directly, you will mail the check with the EOB to our office promptly. Once we receive payment, any office discounts that apply will be offered at that time.**

Cancellation Policy – No Exceptions

- **A \$200 fee will be charged if TWO(2) WEEK notice is not provided, and increased to a \$500 fee for any cancellation or reschedule within 48HOURS(2 business days) of scheduled procedure or apt.**
- **48 hour notice (2 business days) must be given for cancellation or reschedule of spider vein treatment sessions, or \$100.00 fee will be charged.**
- **Initial consultations, which are not cancelled within 48 hours (2 business days), will not qualify for the courtesy/complimentary consultation.**