



FOOT, ANKLE
& LEG VEIN
CENTER

Walk with Comfort and Look Great Doing It!

OFFICE USE ONLY

___ Dr. Schoenhaus ___ Med Info
___ Dr. Gold ___ Notes
___ Dr. Kane ___ Chart

WELCOME TO OUR OFFICE

Patient Name: _____ DOB: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Alternate Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ E-mail: _____

Occupation: _____ Employer: _____

How did you hear about us? _____

**This information is required for Electronic Health Records which is mandated by the Government to comply with Meaningful Use*

Ethnicity: ___ Caucasian ___ African American ___ Hispanic ___ Asian ___ Pacific Islander ___ American Indian ___ Other Race ___ Declined

Language: ___ English ___ Spanish ___ Other _____

INSURANCE INFORMATION:

Primary Insurance: _____ Secondary Insurance: _____

PRIMARY CARE PHYSICIAN:

Dr. _____ City: _____ State: _____

Phone: _____ Date of Last Office Visit: _____ Hgb A1C (Diabetics): _____

EMERGENCY CONTACT:

Name: _____

Relationship: _____ Phone: _____

Do you have a Living Will/Advanced Directive? _____

RELEASE OF INFORMATION:

Name: _____

Relationship: _____ Phone: _____

Signature of Patient/Guardian: _____ Date: _____



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MEDICAL INFORMATION

Patient Name: _____ Height _____ Weight _____ Shoe Size _____

What are you being seen for today? _____

Was this caused by an injury? _____ If yes, Date of Injury _____ Any previous treatments? _____

MEDICATIONS AND DOSES/See attached

Have you had any of the following vaccines? ___ Flu Shot ___ Pneumovax ___ Shingles ___ COVID

PHARMACY

Name: _____ Location: _____ Phone: _____

ALLERGIES

___ Aspirin ___ Latex ___ Dyes ___ Penicillin ___ Lidocaine ___ Codeine ___ Shell Fish ___ Sulfa ___ **NONE**

HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS

___ Arthritis	___ Vascular Disease	___ Kidney Disease	___ HIV	___ Depression
___ Osteoporosis	___ Hepatitis	___ Neuropathy	___ IBS	___ NO PAST ILLNESSES
___ Bleeding Disorders	___ Heart Disease	___ Hypertension	___ Reflux Disease	
___ Blood Clots	___ High Cholesterol	___ Epilepsy	___ Stomach Ulcers	
___ Stroke	___ Diabetes	___ Lung Disease	___ Thyroid Disease	

Other: _____

Past Surgical History

___ Heart Surgery	___ Spine	___ Cancer	___ Vein Surgery	___ NO PAST SURGERIES
___ Pacemaker	___ Joint Replacement	___ Gynecological	___ Vascular Surgery	

Have you had any procedures done on your feet or legs? Yes ___ No ___

If yes, please explain _____

Current Information

Pregnant? ___ Yes ___ No	Do you smoke cigarettes/cigars? ___ Yes ___ No
Do you have a history of drug use ___ Yes ___ No	If yes, how many per day _____
Do you drink alcohol? ___ Yes ___ No	Are you a former smoker ___ Yes ___ No
How many per day? _____	

Family Medical History

Mother: ___ Alive ___ Deceased	Medical Illnesses: _____
Father: ___ Alive ___ Deceased	Medical Illnesses: _____
Sister: ___ Alive ___ Deceased	Medical Illnesses: _____
Brother: ___ Alive ___ Deceased	Medical Illnesses: _____

I authorize Foot, Ankle & Leg Vein Center and/or any healthcare professional to perform a physical examination, diagnostic testing, procedures and to prescribe a therapeutic regimen. I also authorize Foot, Ankle & Leg Vein Center and the staff to release and/or collect information including diagnosis acquired in the course of my exam to/from any healthcare facilities, physicians or insurance carriers.

Patient/Guardian Signature: _____ Date: _____

Vein Questionnaire

Patient name: _____

1. Have you discussed your varicose veins with any other doctor?

If yes, name of doctor _____ Date: _____

Recommended treatment: _____

2. How long have you had problems with your leg veins? _____

3. Do you have... (Please check all that apply)

☐ Aching/Throbbing ☐ Night cramps ☐ Skin changes ☐ Varicose (bulging)
☐ Ankle/Leg swelling ☐ Leg pain ☐ Spider veins ☐ Tenderness
☐ Red/warm areas ☐ Ulcerations ☐ Hard Lumps

4. Have you ever experienced bleeding due to your varicose veins? Yes ☐ No ☐

5. What activities do you have to decrease due to your symptoms?

6. What type of treatment have you had in the past for various veins and when?

Ligation/Stripping? Right leg, Date _____ Left leg, Date _____

Injection treatment? Right leg, Date _____ Left leg, Date _____

Laser treatments? Right leg, Date _____ Left leg, Date _____

Patient signature _____ Date: _____

FOR OFFICE USE ONLY

ATTRIBUTE	ABSENT (0)	MILD (1)	MODERATE (2)	SEVERE (3)
ACHING /THROBING	NONE	OCCASIONAL	DAILY	DAILY WITH MEDICATION NEEDED
VARICOSE VEINS	NONE	FEW	MULTIPLE	EXTENSIVE
SWELLING / EDEMA	NONE	EVENING ONLY	AFTERNOON	MORNING
SKIN COLOR CHANGES	NONE	LIMITED, OLD	DIFFUSE	WIDER / RECENT
INFLAMMATION / PAIN REDNESS	NONE	MILD REDNESS	MODERATE CELLULITIS	SEVERE (3)
SKIN HARDENING / INDURATION	NONE	FOCAL AREA	< 1/3 LOWER LEG	> 1/3 LOWER LEG
NO ACTIVE ULCERATIONS	NONE	1	2	>2
ACTIVE ULCERATION SIZE	NONE	< 2 CM	2 – 6 CM	>6 CM
ULCERATION DURATION	NONE	< 3 MONTHS	3 - 12 MONTHS	>1 YEAR
COMPRESSION THERAPY	NONE	INTERMITTENT	MOST DAYS	EVERY DAY

Left _____ Right _____



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FINANCIAL POLICY

PLEASE read & understand Foot Ankle & Leg Vein Center's financial policy that is as follows:

I understand that it is ultimately my responsibility to understand my insurance contract and what I will be responsible for financially.

I understand and agree that **I am responsible** for any co-pay, co-insurance and deductible amounts that are part of my insurance contract.

'We have prepared this to help you understand the complexities of medical insurance, realizing how confusing it can be. To begin, we would like to highlight a misconception; medical insurance was not designed to pay for all medical care. Most contracts have limits and/or various degrees of payment.

All levels of payment by insurance companies, including allowed fees, usual and customary (UCR), are governed by the premiums paid. They have nothing to do with the actual charges by a physician. *Our fees are based upon a combination of our cost, our time, and our constant dedication to supplying our patients with the highest quality medical care.* The treatment recommended by our office is never based on what your insurance company will pay; your treatment should not be governed by your insurance contract.

I hereby **accept responsibility** to pay for any service(s) provided to me that is **not covered by my insurance**, along with (DME products: ace bandages, shower bags, stockings, orthotics, walking boots, post-op shoe, creams, lotions, etc.). All products are non refundable. **Payments are due at time of service.** If the balance or payment arrangements are not paid within the first 30 days of the statement, then the account will be sent to a collection agency. At which time the current balance will incur an additional 35 % collection fee.

Our office has a policy for any Self Pay Treatments with the Doctor and our Medical Pedicure Program that are "canceled "in less than a 24 hours from your scheduled appointment time or you should "No Show" there will be a \$50.00 fee. The reason for this is to encourage our patients to take their appointments as seriously as we do. That time is reserved for you and if you do not keep your appointment then other patients who need an appointment the schedule permits are being obligated to wait longer than necessary.

*Signing below means you have read and agree to all terms of this policy.

I hereby authorize payment of medical benefits billed to my insurance to Foot, Ankle & Leg Vein Center.

Print Patient Name: _____

Patient Signature : _____ Date : _____



CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plan for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

Date:	Initials:	Reason:
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Photo and Promotional Release Form

I hereby consent to be interviewed, recorded, photographed, videotaped or filmed by representative of the Foot, Ankle and Leg Vein Center for purposes of publication, display or broadcast (print, web, digital display and all other forms of media).

I agree that such Interviews, recording, articles, quotes, photographs, films, audio or video and/or any reproductions of same in any form, are the property of Foot, Ankle and Leg Vein Center, and I relinquish any present or future claim for reimbursement for said photographic or film reproduction of my likeness or for said testimonials by me.

I hereby release the Foot, Ankle and Leg Vein Center, its affiliates, employees, representatives and agents from any and all claims, demands, costs and liability that may arise from the use of these interviews, recordings, photographs, videotapes or films, and/or any reproductions of same in any form, as described above, arising out of being interviewed, recorded, photographed, videotaped or filmed.

I acknowledge that I have read this consent form in its entirety, or has been read (or translated) to me, and I have had the opportunity to ask questions about it and understand it.

Name/ Parent or Legal Guardian name*(print)

Signature/ Signature Parent or Legal Guardian*

Date

Witness

Date

Parent or Legal Guardian name and signature required for individuals under age 18

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