DAYTON OUTPATIENT CENTER
Vein Management

PATIENT DEMOGRAPHIC FORM

(THIS FORM MUST BE UPDATED EVERY CALENDAR YEAR OR WHEN ANY INFORMATION CHANGES)

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST)	M.I.	DATE OF BIRTH	SOCIAL SECURITY NUMBER

SEX	AGE	MARITAL STATUS
☐ MALE ☐ FEMALE		☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ LEGALLY SEPARATED ☐ WIDOWED ☐ DOMESTIC PARTNER

RACE	ETHNICITY	PREFERRED LANGUAGE
☐ CAUCASIAN ☐ HISPANIC ☐ AFRICAN AMERICAN ☐ ASIAN ☐ OTHER	☐ LATIN ☐ OTHER_____	☐ ENGLISH ☐ OTHER_____

MAILING ADDRESS	APT/UNIT	CITY, STATE	ZIP CODE

HOME PHONE	CELL PHONE	WORK PHONE/EXT	E-MAIL ADDRESS

EMPLOYER	EMPLOYER ADDRESS

EMPLOYMENT STATUS	JOB TITLE
☐ FULL TIME ☐ PART TIME ☐ RETIRED ☐ DISABLED ☐ FULL-TIME STUDENT	

PRIMARY CARE PHYSICIAN ☐ NONE	LOCAL PHARMACY / PHONE NUMBER

ICE

EMERGENCY CONTACT		Due to HIPPA regulations; we are required to have the name of the person we are authorized to discuss your healthcare issues; in the event of a critical matter or emergency.	
NAME	RELATIONSHIP	NAME	RELATIONSHIP
PHONE NUMBER	ALT PHONE	PHONE NUMBER	ALT PHONE

INSURANCE

PRIMARY ☐NONE			SECONDARY ☐NONE		
INSURANCE COMPANY NAME AND ADDRESS			INSURANCE COMPANY NAME AND ADDRESS		
ID#	GROUP NAME OR NO.		ID#	GROUP NAME OR NO.	
SUBSCRIBER'S NAME ☐ SAME AS PATIENT		RELATIONSHIP	SUBSCRIBER'S NAME ☐ SAME AS PATIENT		RELATIONSHIP
SUBSCRIBER'S SOCIAL SECURITY NO.	SUBSCRIBERS DOB		SUBSCRIBER'S SOCIAL SECURITY NO.	SUBSCRIBERS DOB	

The above subscriber hereby authorizes their insurance company to issue indemnity checks to the above listed medical provider for services provided.

AUTHORIZATION

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services and authorize such physician or organization to submit a claim to my insurance carrier or Medicare for payment. I authorize any holder of medical and other information about me to release to insurance carriers or the Health Care Financing Administration and its agents or the Social Security Administration or its intermediaries or any agency, group or person(s) necessary to secure payment any information needed for this or related Medicare claim. For and in consideration of services rendered and to be rendered by the above listed medical provider, I hereby guarantee payment of all charges incurred for this account. The patient or his/her representative recognizing the need for healthcare, consents to the above listed medial provider rendering services ordered by the physicians, including medical or surgical treatment, laboratory procedures, X-ray examinations or other services rendered under the general and specific instructions of the physicians. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct

. * Privacy policy DOC Pain Management and its Affiliates do not share or sell your email address information. If you do not wish to receive e-mail correspondence from Dayton Outpatient Center or its affiliates please check this box. ☐

FINANCIAL POLICY

Patients are responsible for all co-pays, deductible and any other charges for the services performed by us and not paid by patient's insurance. Patients are responsible to verify with their insurance if we, the provider of medical services, are covered medical provider and also to find the benefits available to patient for our services. Patients are responsible to arrange the referral from their PCP and/or any other authorization, if required by the patient's insurance. Our staff is available to assist patient in this regard or to answer any question the patient might have. Co-payment and deductibles are expected at the time of service. We accept cash, checks, and credit cards. Self-pay patients are required to pay their charges on the date of service. **If at any time the patient defaults on this agreement resulting in collection proceedings, the patient understands that he/she shall be responsible for any and all of the a) interest, b) collection costs including but not limited to third-party collection fees and costs, and c) all legal fees and court costs.**

PATIENT SIGNATURE _____ **DATE** _____

revised 8/13 CLG

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Vein Management

CONSENT TO NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
Obtain payment from third-party payers.
Conduct normal healthcare operations such as quality assessments and physician certifications.
For judicial & administrative proceedings according to specific requirements.

I have been informed by you of *your Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that the Notice of Privacy Practices covers all entities of Dayton Outpatient Center practices such as Pain Clinic, Ambulatory Surgery Center, Physical Therapy, Counseling, Pharmacy, Dental Clinic, Family Medicine, Occupational Medicine and any other service areas). I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time 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 may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Unless there is an objection we may do any of the following:
Call patients to confirm an appointment and may leave a message
Call regarding an account (at the phone # provided by the patient)
Call and/or leave a message regarding treatment/test results.

We are only permitted to return calls left by our patients. *We will not return calls left by a spouse, family member, or friend.*

Patient Name: _____ SSN: _____

Patient Signature: _____ Date: _____

Representative Name: _____ Relationship to Patient: _____

Representative Signature: _____ Date: _____

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DAYTON OUTPATIENT CENTER
Pain Management

No Show Policy

1. Dayton Outpatient Center requires at least 24 hours notice to cancel an appointment in order to allow our staff to reschedule another person in need for that time slot.
2. Our staff will perform a reminder call the day before your appointments. A message will be left on the answering machine to the best number we have on our records that you have provided.
3. Every no show event will be documented in the chart and you will be assessed a fee payable prior to your next office visit, $50 for office visits & $100 for procedures.
4. At the next scheduled appointment after each no show, the Doctor/PA will discuss with you the reason for the no show, the importance of keeping scheduled appointments and review our no show policy. Your treatment plan may be adjusted accordingly based on any information obtained during this discussion.
5. After 3 no shows (consecutive or non-consecutive), no additional appointments will be scheduled for you. You will need to pay for all no shows before you can be scheduled for an appointment. If you report a need for an appointment that appears to be urgent or emergent, you will be transferred to the Doctor/PA for a telephone interview.

Your signature below indicates that you have read this policy, understand it and agree to comply with its requirements.

_____
Patient Name

_____ _____
Signature of Patient or Legally Responsible Person Date

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Vein Management

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, do hereby authorize the release of my protected health information (PHI), as indicated herein; between the following parties:

FROM: _____

_____

_____

_____

TO: **DOC Vein Management**
1010 Woodman Drive
Dayton, Ohio 45432
Fax:937-424-2486
Phone:937-252-2000

I authorize the use or disclosure of the following PHI: (Please list dates of service, condition or event for releases)

I request these records to be released for the following purpose:
Vein Management Treatment

I authorize this release effective for 180 days from the date of my signature below. If not specified, this authorization shall be effective for one (1) year. I understand, as set forth in the provider's Notice of Privacy Practices, I have the right to revoke this authorization, in writing at any time. I understand revocation is not effective to the extent the provider has relied on this authorized release.

I also make the following qualification: If the information specified above contains information related to treatment for drug and/or alcohol abuse or HIV test results; I understand I have the right to inspect or copy my PHI and I have the right to refuse to sign this authorization

Patient Name _____ Date of Birth _____ SSN _____

Patient Signature or Guardian, or Durable Power of Attorney _____ Date _____

Patient unable to sign due to: _____ Relationship to Patient _____

OFFICE USE ONLYDO NOT WRITE BELOW THIS LINE**

FOR OFFICE USE ONLY: (Make sure only minimum necessary information is released)

☐ **Surgery Records** ☐ **Pain Clinic Records** ☐ **Imaging Records** ☐ **Testing Records**

Indicate PHI released by checking boxes below

☐ Face Sheet	☐ Operative Reports	☐ Physician Orders
☐ H&P	☐ Radiology Reports	☐ Therapy Reports
☐ Discharge Summary	☐ Office Notes	☐ Emergency treatment
☐ Consultation Reports	☐ Pathology Reports	☐ Other: _____
☐ Laboratory Reports	☐ Physician Progress Notes	

Medical Record Clerk Signature _____ Date _____

DAYTON OUTPATIENT CENTER
Vein Management

PATIENT HISTORY FORM

(Must be filled out by new patients before seen by Physician)

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST)	M.I.	DATE OF BIRTH	SOCIAL SECURITY NUMBER

SEX ☐ MALE ☐ FEMALE	AGE	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ LEGALLY SEPARATED ☐ WIDOWED ☐ DOMESTIC PARTNER

EMPLOYMENT STATUS ☐ FULL TIME ☐ PART TIME ☐ RETIRED ☐ DISABLED ☐ FULL-TIME STUDENT	JOB TITLE / DATE LAST WORKED

PRIMARY CARE PHYSICIAN ☐ NONE	PHONE NUMBER

CAUSE OF PAIN

DATE PAIN STARTED	LOCATION OF PAIN	PAIN LEVEL /10	CONSTANT ☐ YES ☐ NO	PAIN WORSE ☐ AM ☐ PM ☐ None

WORK INJURY ☐ YES ☐ NO	BWC ☐ YES ☐ NO	CLAIM #	ACTIVE ☐ YES ☐ NO	ATTORNEY NAME / PHONE NUMBER

AUTO ACCIDENT ☐ YES ☐ NO	DATE OF ACCIDENT	ATTORNEY NAME / PHONE NUMBER

OTHER ACCIDENT ☐ YES ☐ NO	TYPE	ATTORNEY NAME / PHONE NUMBER

Any previous testing? ☐ YES ☐ NO ☐ MRI ☐ CT scan ☐ Xray ☐ EMG/NCV ☐ Ultrasound

Where was your testing? _____ Date of testing: _____

Are you having trouble sleeping due to pain? ☐ YES ☐ NO Trouble staying asleep? ☐ YES ☐ NO

Activities that worsen pain ☐ Lifting ☐ Bending ☐ Twisting ☐ Sitting ☐ Standing ☐ Other_____

Does stress affect your pain? ☐ YES ☐ NO Source of stress: _____

Anything help your pain? ☐ YES ☐ NO What helps? _____

MARK DRAWING BELOW ACCORDING TO WHERE YOU HURT

PART OF THE BODY

STABBING _____

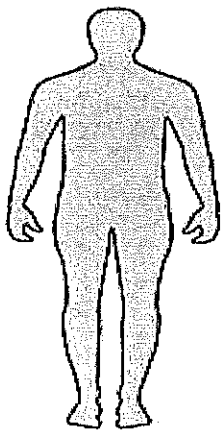
BURNING _____

ACHING _____

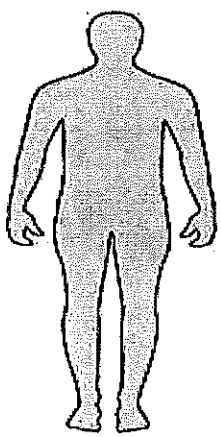
NUMBNESS _____

PINS & NEEDLES _____

JOINT PAIN _____



FRONT



BACK

DAYTON OUTPATIENT CENTER

Vein Management

MEDICAL HISTORY

PATIENT NAME (LAST, FIRST)	M.I.	DATE OF BIRTH	SOCIAL SECURITY NUMBER

HEIGHT	WEIGHT	TOBACCO USE ☐ YES ☐ NO	ALCOHOL USE ☐ YES ☐ NO
		How much? PPD YRS.	How much?

Please list your past surgeries with dates or provide list: _____

_____

Please list your current Medications or provide list: _____

_____

Please list your current Allergies or provide list: _____

_____

Have you ever been diagnosed with any of these? (check any that apply)

- ☐ Angina
- ☐ Arthritis
- ☐ Blood disorders
- ☐ Cancer
- ☐ CHF
- ☐ COPD/Emphysema
- ☐ Coronary Heart Disease
- ☐ Diabetes
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Intestinal Issues
- ☐ Kidney stones
- ☐ Liver Disease
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Ulcers/Gastritis

Have you ever had any of the following happen to you? (check any that apply)

- ☐ Head (history of trauma)
- ☐ Bloody stool
- ☐ Skin rash
- ☐ Painful joints
- ☐ Allergies
- ☐ Chest pain
- ☐ Passing out
- ☐ Bloody Urine
- ☐ Upset stomach/nausea
- ☐ Swelling
- ☐ Depression/Anxiety
- ☐ Hearing loss
- ☐ Diarrhea/Constipation
- ☐ Shortness of breath
- ☐ Weakness/Loss of strength
- ☐ Dizziness
- ☐ Eyesight changes
- ☐ Alcohol/Substance abuse

Have you ever had any Vein treatments? (check any that apply)

- ☐ Pain Medications
- ☐ Compression Stockings
- ☐ Veneseal
- ☐ Varithena Therapy
- ☐ Exercise
- ☐ Sclerotherapy
- ☐ Stab Phlebectomy
- ☐ Laser Therapy
- ☐ Weight Loss
- ☐ Endovenous Ablation
- ☐ Physical therapy
- ☐ Leg Elevation

I certify all my answers are true and are answered to the best of my knowledge.

Patient Signature _____ Date _____

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VEIN MANAGEMENT

Vein History Form

Today's Date: _____ ***Clinic Location:*** _____
Patient Name: _____ ***Date of Birth:*** _____

Symptoms:

Aching / Pain in legs	***Y/N***	***Heart Disease***	***Y/N***
Heaviness	***Y/N***	***Peripheral Arterial Disease***	***Y/N***
Tiredness / Fatigue	***Y/N***	***HIV***	***Y/N***
Itching / Burning / Warmth	***Y/N***	***Hepatitis***	***Y/N***
Leg Cramps	***Y/N***	***High Blood Pressure***	***Y/N***
Restlessness Leg	***Y/N***	***Diabetes***	***Y/N***
Throbbing	***Y/N***	***Cancer***	***Y/N***
Swelling	***Y/N***	***Leg Trauma / Surgery***	***Y/N***
Asthma / COPD	***Y/N***		

Do your symptoms interfere with your sleep? ***Y/N***
Are your symptoms worse later in the day? ***Y/N***
Are your symptoms worse with or after activity? ***Y/N***
Do your symptoms keep you from doing anything? ***Y/N***
Does prolonged sitting or standing aggravate your legs? ***Y/N***
How long have you had problems with your veins? _____ ***(months or years)***
Does your legs effect your daily living? If yes how? _____
_____
_____.

Do you have any Peripheral Arterial Disease (PAD) Symptoms?

Was diagnosed with PAD in past	***Y/N***
Have/had cramping leg pain that worsens with walking, forcing me to stop walking	***Y/N***
Feet/Toes become pale and painful with exercise or when elevating them	***Y/N***
Have/had ulcers on feet or toes	***Y/N***

Conservative Measures used currently or previously:

Pain Medication ***Y/N*** *Weight Loss* ***Y/N*** *Leg Elevation* ***Y/N*** *Job Change* ***Y/N***
Exercise ***Y/N*** *Prescribed Compression stockings/hose or leg wraps?* ***Y/N***
Please list your weight: _____***lbs and height:*** ____***ft*** ____***in***

Office Use Only
Blood Pressure _____/_____ ***R L*** ***Patient ID#*** _____
Staff Signature: _____ ***Date:*** _____
Provider Signature: _____ ***Date:*** _____