ELITE
VEIN SPECIALISTS

Dr. Peter Wrobel, MD
1710 Reynolds St. · Waycross, GA 31501
912.283.2200 Office · 912.283.2251 Fax

Patient Information

Patient Name:_____ Date of Birth:_____ Sex: _____

Social Security Number:_____ Driver's License Number:_____

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

Home Phone: ( )_____ Cell Phone: ( ):_____ Work: ( )_____

Name & Address of Employer:_____

Marital Status: Married_____ Single_____ Divorced_____ Widowed_____

Spouse Name: _____ Spouse Phone Number: ( )_____

Primary Care Dr.:_____ Pharmacy:_____

Person Responsible For Account:_____ Relationship: _____

Emergency Contact: _____ Phone Number:_____

Insurance Information

Primary Insurance Holder: Self_____ Spouse_____ Mother_____ Father_____

Name of Insured_____ Social Security Number:_____ DOB: _____

Name of Insurance Company: _____ Policy Number: _____

Group Number:_____ Member ID Number: _____

Employer of Policy Holder:_____

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

Secondary Insurance if available:

Name of Insured_____ Social Security Number:_____ DOB: _____

Name of Insurance Company: _____ Policy Number: _____

Group Number:_____ Member ID Number: _____

Employer of Policy Holder: _____

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

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PATIENT CONSENT FOR USE AND DISCLOSURE

OF PROTECTED HEALTH INFORMATION

With my consent, **Elite Vein Specialists** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Elite Vein Specialist's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Elite Vein Specialists reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer, Elite Vein Specialists,

1710 Reynolds Street, Waycross, Georgia 31501.

With my consent, Elite Vein Specialists may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Elite Vein Specialists may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Elite Vein Specialists may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Elite Vein Specialist restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Elite Vein Specialists use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Elite Vein Specialists may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date of Birth

_____

Patient's Name Date

_____

Print Name of Patient or Legal Guardian

Elite Vein Specialists may discuss my medical condition/information with the following:

Name of Person Relationship

_____

Person to contact in case of emergency:

_____

Name

_____

Phone

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FINANCIAL POLICY

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. **Payment is due at the time of service**. We accept Cash, Personal Checks, Visa and MasterCard. **If you are new patient: We require that your first visit be paid by; Cash, Visa or MasterCard.**

2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor—in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a **copayment or percentage at the time of your visit.**

3. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you. Our charges for your care are due at the time of service. If the insurance carrier sends the office a check we will in return send you a refund check.

4. Not all insurance plans cover all services. In the event you're insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____

Signature of patient (or responsible party, if minor) Date

_____

Please print name of the patient

IF YOU MISS AN APPOINTMENT WITHOUT CALLING TO RESCHEDULE OR CANCEL YOU WILL BE CHARGED A $ 25.00 NO SHOW FEE

ALL RETURN CHECKS HAVE A $ 25.00 RETURN FEE

Vein History and Medical Necessity

Patient: _____ Date: _____

Date of Birth: _____

1. Which of the following are causing you concern? (Circle all that apply)

Leg Swelling **Bulging Varicose Veins** **Leg Pain**

Restless Legs **Spider Veins**

2. How long have your veins been a problem? _____

3. Does your work or daily routine require you to be on your feet? **YES** **NO**
Please explain: _____

_____

Does this cause pain/discomfort? **YES** **NO**
Please explain: _____

_____

Does this create limitations in your work or daily routine? **YES** **NO**
Please explain: _____

_____

4. Does prolong sitting or standing aggravate your veins? **YES** **NO**
Please explain: _____

_____

5. Given the opportunity, would you sit and rest your legs throughout your work day or daily routine?
YES **NO**
Please explain: _____

_____

6. Have you ever noticed any of the following occur during activity or after prolonged standing? (Circle all that apply)

Aching **Fatigue** **Swelling** **Itching** **Pain** **Burning**

Exercise Intolerance **Feeling of Heaviness** **Skin Changes**

7. Have you ever had any of the following? (Circle all that apply)

Bleeding from a varicose vein or spider vein **Slow or non-healing skin ulcerations**

Significant, recurrent superficial phlebitis **Discoloration of the skin**

8. Have you ever been treated for ulcerations or a blood clot in your leg? **YES** **NO**

If yes, which leg? **RIGHT** **LEFT**

How was it treated? _____

_____

9. In past months or years, how have you attempted to manage your varicose vein symptoms? (Circle all that apply)

Attempted weight loss **Leg Elevation** **Medications (Motrin, Aspirin, etc.)**

10. Have you tried Compression or Support Stockings (panty hose, TED hose, thigh highs, leggings, etc.) to manage your vein issues?

YES **NO**

How long? _____

11. Did this ease your pain/discomfort? **YES** **NO** **OTHER**
Please explain: _____

_____

12. Do you experience any of the following symptoms? (Circle all that apply)

Chest Pains **Shortness of Breath** **Prolonged Bleeding** **Fevers** **Chronic Cough**

New onset of Leg Swelling **Fainting Easily** **Stroke**

13. Are you allergic to Lidocaine? **YES** **NO**

14. Are you on a blood thinner? **YES** **NO**

Current Medications and Dosage:

_____

_____

Other Medical Conditions:

_____

_____

Allergies:

_____

_____

Patient's Signature: _____ Date: _____

Provider's Signature: _____ Date: _____

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New Patient Survey

Thank you for taking the time to answer a few questions about how you heard about our office. The information that you share will not be shared with others and will be used to better understand how to reach our patients.

Name: _____

How did you hear about our office?

_____

Have you seen any of our ads in or on the following? (Please check all that apply):

□ Waycross Journal Herald

□ Waycross Shopper

□ www.eliteveinspecialist.com

□ Facebook

□ Radio (103.3)

□ In The Game Magazine

□ Okefenokee Living Magazine

□ Word-of-mouth

□ Google

□ Chamber of Commerce

□ Television Commercial

□ Referral: _____

□ Other (please specify): _____

_____

Thank you for taking the time to complete this brief survey. If you would like for someone to contact you regarding our services or if you have any questions, please notify our front office staff.

(For office use only)

Date: _____ Staff Signature: _____