VEIN INSTITUTE of PINELLAS

Patient Name:_____ Appt Date & Time:_____

Primary Care Physician:_____ Phone:_____

How did you hear about us?_____

Dear Patient,

Thank you for choosing VIP as your medical care provider. Enclosed in this packet you will find: our patient information, medical history forms, our financial policy and an authorization to release information.

Please complete these forms and bring them with you to the appointment.

As a courtesy, we will file for reimbursement from your insurance company. Please keep us updated with any changes to your insurance. ALL FEES INCLUDING CO-PAYMENTS, CO-INSURANCES, AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE.

Please remember to bring the following to your appointment:

*Photo ID
*Insurance card(s)
*Medication List

Please reframe from wearing any cologne, perfume or scented body lotion. These are chemical irritants that can cause problems for other patients and staff with breathing difficulties. We strive to ensure your comfort and safety by encouraging a fragrance-free environment.

We look forward to seeing you.

Sincerely,

VIP Providers and Staff

5500 MLK Jr. Street (9th Street)
2nd floor
St. Petersburg, FL 33703

4051 Upper Creek Drive
Suite 101
Sun City Center, FL 33573

3690 East Bay Drive
Suite M
Largo, FL 33771

PHC
OF PINELLAS

COMMITTED TO EXCELLENCE

WELCOME TO OUR OFFICE

PATIENT INFORMATION

Demographics

Last Name: _____ First Name: _____ Age: _____

Date of Birth: _____ Social Security: _____

Sex: Male / Female Race: _____ Primary Language Spoken: _____

Street Address: _____ City: _____ State: ____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Employer: _____ Occupation: _____

Employer Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse Name: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Pharmacy Information

☐ CVS ☐ Publix ☐ Target ☐ Sam's Club ☐ Walgreens ☐ Winn Dixie ☐ Wal-Mart

☐ Other _____

Pharmacy Phone: _____ Address: _____

I, _____ here by authorize the medical staff of Professional Health Care of Pinellas, Inc. to render medical services as deemed necessary. I also certify that no guarantee or assurance has been made as to the results that may be obtained. I understand that I am ultimately responsible for full payment of my treatment and care. My insurance policy is a contract between Professional Health Care of Pinellas and my insurance company(s). Professional Health Care of Pinellas will file my claim. I am required to provide the most correct and updated information about my insurance and will be responsible for any charges incurred if information provided is not correct or updated. **Patients are responsible for the payment of all co-pays, coinsurances, deductibles, procedures, treatments and explanations of any services not covered. Payment is due at the time services are rendered. Insurance companies will only pay for services that it determines to be "reasonable and medically necessary" under the Insurance Companies standards. Insurance companies may deny payment for services that they deem are screenings or not meeting medical necessity guidelines per the local coverage determinations. I permit this office to endorse co-issued remittances for the conveyance of credit to my account.**

Professional Health Care of Pinellas cannot waive co-payments or bill on your behalf. For your convenience we accept cash, check and most major credit cards.

X _____ Date: _____

Patient Signature

PATIENT CASE HISTORY

Patient Name: _____ Date: _____

Height: _____ Weight: _____

Chief complaint/Reason for visit: _____

Duration of Present Condition: _____

Medication Allergies

Are you allergic to any medications? ☐ Yes ☐ No

If yes, what medication(s) _____

What is your reaction to this medication? _____

Past Medical History

☐ High Blood Pressure ☐ Diabetes Mellitus ☐ Bleeding Problems ☐ Hepatitis / HIV ☐ Skin Cancer

Previous Surgery

Type	Date
_____	_____
_____	_____

Social History

Do you smoke? ☐ Yes ☐ No If so how many pack(s) per day? _____

Have you ever smoked ☐ Yes ☐ No

Family History (Please list)

_____

_____

_____

_____

_____

_____

_____

_____

REVIEW OF SYSTEMS

Please check off all that apply or select NONE if none apply

Patient Name: _____ Date: _____

Patient Name: _____ Date: _____

Eyes
- ☐ Visual Problems
- ☐ Blurry Vision
- ☐ Red Eyes
- ☐ NONE
- ☐ Other _____

Ears
- ☐ Hearing Problems
- ☐ Ringing In Ears
- ☐ Discharge
- ☐ NONE
- ☐ Other _____

Throat
- ☐ Swallowing Difficulty
- ☐ Frequent Sore Throats
- ☐ Speech Problems
- ☐ NONE
- ☐ Other _____

Oral
- ☐ Dental Problems
- ☐ Tongue Problems
- ☐ Canker Sores
- ☐ NONE
- ☐ Other _____

Neck
- ☐ Swollen Glands
- ☐ Thyroid Problems
- ☐ NONE
- ☐ Other _____

Chest
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ NONE
- ☐ Other _____

Heart
- ☐ Murmurs
- ☐ Pace Maker
- ☐ Palpitations
- ☐ Valve Problems
- ☐ Heart Failure
- ☐ Heart Attack
- ☐ Angina
- ☐ NONE
- ☐ Other _____

Intestinal
- ☐ Colitis
- ☐ Ulcer Gastritis
- ☐ Barrett's Esophagus
- ☐ Polyps
- ☐ Constipation
- ☐ NONE
- ☐ Other _____

Urinary
- ☐ Urinary Problems
- ☐ Frequency
- ☐ Burning
- ☐ Kidney Stones
- ☐ NONE
- ☐ Other _____

GYN
- ☐ Pregnant
- ☐ Breast Feeding
- ☐ Last Menstrual Period _____
- ☐ NONE
- ☐ Other _____

Spine
- ☐ Neck Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Scoliosis
- ☐ Herniated Disc
- ☐ Sciatica
- ☐ NONE
- ☐ Other _____

Upper Extremity
- ☐ Pain In Arm
- ☐ Carpal Tunnel
- ☐ Shoulder Pain
- ☐ Elbow Pain
- ☐ Wrist Pain
- ☐ NONE
- ☐ Other _____

Lower Extremity
- ☐ Pain in Legs
- ☐ Pain in Knees
- ☐ Pain in Hips
- ☐ Ankle Pain
- ☐ Tingling
- ☐ NONE
- ☐ Other _____

Systemic
- ☐ Weight Loss
- ☐ Fever
- ☐ Night Sweats
- ☐ Trouble Sleeping
- ☐ Loss of Energy
- ☐ Arthritis
- ☐ NONE
- ☐ Other _____

Neurological
- ☐ Headache
- ☐ Convulsions / Seizures
- ☐ Fainting
- ☐ ADD
- ☐ Stroke
- ☐ NONE
- ☐ Other _____

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Stress/Excess Worry
- ☐ Drug / Alcohol Issues
- ☐ NONE
- ☐ Other _____

Professional Health Care of Pinellas, Inc.

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

1839 Central Avenue | Saint Petersburg FL 33713 | 727-322-1054

Professional Health Care of Pinellas, Inc. originates, maintains paper and electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatments, any plans for future care or treatment and payment for the services or treatments we've provided. We use this information to:

- Plan your care and treatment
- Communicate with other healthcare professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", WE MAY USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol abuse notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment or healthcare.

To request from other healthcare entities or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.

To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies or individual(s) for payment of our services or treatments provided to you.

To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare payments on your answering machine, mobile voice mail, email or with a household family member.

[ ] Please check here if you do not want us to leave messages on your answering machine.

[ ] Please check here if you do not want us to leave messages with a household family member.

[ ] Please check here if you do not want us to leave messages on your mobile voice mail.

[ ] Please check here if you authorize us to send your healthcare information by email. Please understand that email is an unsecured medium of transmission and is potentially accessible by others. In addition to checking the box, we reserve the right to require you to send us an email authorizing transmission of your healthcare information to you by unsecured email.

To discuss your healthcare or payment information (only the minimum necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments. Please list by name and relationship the persons with whom we may share this information:

_____

_____

You have the right to request a copy of our "*Notice of Patient Privacy Practices*" prior to signing this authorization for a more complete description of health information uses and disclosures.
I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

Patient Name (please print):_____

_____ _____ _____
Signature Printed Name of Guardian or Representative Date

*If other than patient is signing, are you the parent, legal guardian, legal custodian or have a Healthcare Power of Attorney for the patient. Yes [ ] No [ ] RELATIONSHIP_____

FOR OFFICE USE ONLY
Patient refused to sign the form. Reason: _____

PHC OF PINELLAS

Professional Health Care of Pinellas, Inc.

HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et.seq., and regulations promulgated there under, as amended from time to time (collectively) referred to as "HIPAA".

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

Professional Health Care of Pinellas, Inc. will not condition treatment, payment, enrollment in a health plan or eligibility for benefits, as applicable, on your providing authorization for the requested use of disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that ***Professional Health Care of Pinellas, Inc.*** may use or disclose your personal health care information to other medical professionals relating to your treatment, payment, or health care options.

Further by signing this authorization you acknowledge that you have been provided a copy of, have read and understand Professional Health Care of Pinellas, Inc.'s HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While, ***Professional Health Care of Pinellas, Inc.*** has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from ***Professional Health Care of Pinellas, Inc.*** at any of its offices or by sending a written request with return address to 1839 Central Avenue, St. Petersburg, FL 33713, or 5500 MLK St. N. St. Petersburg, FL 33703 or 8133 54th Avenue N. St. Petersburg, FL 33709, depending on your primary care office. In accordance with your rights under, and subject to certain restrictions imposed by HIPAA, you may inspect or copy your Personal Health Information (PHI) in the designated record set maintained by ***Professional Health Care of Pinellas, Inc.*** for as long as the Personal Health Information (PHI) is maintained in the designated record set.

You have the right to revoke this authorization, in writing; at any time, except to the extent that ***Professional Health Care of Pinellas, Inc.*** has taken action in reliance on it. A revocation is effective upon receipt by ***Professional Health Care of Pinellas, Inc.*** of a written request to revoke and a copy of the executed authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purpose for which this authorization was originally obtained, to be determined in the reasonable discretion of ***Professional Health Care of Pinellas, Inc.*** or (d) six years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HIPAA. Professional Health Care of Pinellas, Inc. will provide you with a copy of this signed authorization, if requested.

PHC
OF PINELLAS

Acknowledged and agreed to by:

Patient: _____ _____
Signature Printed Name

Date: _____

Address: _____
_____
_____

Or, On behalf of Patient:

By: _____ _____
Signature Printed Name

Date: _____

Address: _____
_____
_____

Pinellas 727-210-8391

PATIENT NAME: _____

Part One: Venous History and Conservative Treatment

(Please check any symptoms or signs below that you have experienced)

A. Signs and Symptoms - My symptoms and signs include:

☐ Pain:

☐ Persistent pain ☐ Cramping at night/rest ☐ Cramping on walking ☐ Restlessness ☐ Tired legs
☐ Heavy legs ☐ Throbbing legs ☐ Painful feet/ankles ☐ Painful calves on standing
☐ Burning ☐ Itching ☐ Involuntary jerking when resting/sleeping ☐ Exercise intolerance
☐ Hot, red and scaling skin ☐ No pain

☐ Skin Changes:

☐ Discoloration ☐ 'Dermatitis'/rash ☐ Ulceration ☐ Infection ☐ Red warm areas
☐ Lumps ☐ Burning ☐ Itching

☐ Edema:

☐ Swelling of my ankles/feet ☐ of my lower legs ☐ Heavy Legs ☐ Indents in skin wearing socks?

☐ Surface Veins:

☐ Bulging varicose veins ☐ Blue/purple 'reticular veins' ☐ Red 'spider veins'
☐ Bleeding (with showering, shaving, light trauma, spontaneously) ☐ Lumps
☐ Intermittent phlebitis (red, warm, tender, firm areas) ☐ Veins at my ankle/instep

☐ Deep Vein Issues:

☐ Deep vein clots (DVT) ☐ Pulmonary emboli (PE) If yes, what year, what leg?_____

Symptoms are affecting my daily activities. Circle all that apply: Sleeping, Exercise, Sports, Shopping, Standing, walking, sitting, and Job function (if yes, what do you do? _____)

B. Conservative Treatments -To relieve my signs and symptoms I have tried the following:

☐ Leg Elevation, Putting my feet up
☐ Weight Reduction
☐ An Exercise Plan, Walking
☐ OTC Pain medications (Aleve, Tylenol, Advil, Motrin, Aspirin)
☐ Compression Stockings over three months
☐ Despite conservative treatments my symptoms and signs continue

A. Other History:

☐ Yes ☐ No ☐ Uncertain - I have a family history of vein problems ☐ Parent's ☐ Grandparent's ☐ Siblings
☐ Yes ☐ No - I have had past treatment: ☐ Vein stripping ☐ Ligation ☐ Injections ☐ Endovenous ablation
☐ Yes ☐ No - I am female under 50 years old. ☐ I am pregnant ☐ I am nursing
Duration: Since you first noticed signs or symptoms - ☐ <6 Months ☐ 6-12 Months ☐ 1-5 Years ☐ > 5 Years
Symptoms worsen temporarily with: ☐ Standing ☐ Walking ☐ Menses ☐ Heavy lifting ☐ Pregnancy ☐ Exercise
Symptoms improve temporarily with: ☐ Elevation ☐ Rest ☐ Sleep ☐ Walking
Likely causes of my vein issues are: ☐ Genetics ☐ Employment ☐ Trauma ☐ Pregnancy ☐ Sports

PATIENT NAME: _____

Part Two: General Medical History

A. **Vital Signs**
(Approximate) Blood Pressure: Systolic_____ / Diastolic_____

B. **Important questions that may influence prescription decisions:**

		Yes/No
Prostheses:	I have implants: joints/heart valves/grafts pins/plates/screws/rods or other	☐/☐
Heart Murmur:	I have a heart murmur that has required prophylactic antibiotics	☐/☐
Anticoagulants:	I use: ☐ Coumadin (warfarin) ☐ Plavix ☐ Ticlid ☐ Lovenox ☐ Daily Aspirin ☐ Other Anticoagulants: _____	

C. **Past Medical History** **I have been diagnosed with the following conditions:**

Vascular:	☐	Arterial Disease (PAD)	Hematologic:	☐ Bleeding Disorder
	☐	Deep Vein Clots (DVT)		☐ Hypercoagulable Blood
	☐	High Blood Pressure	Dermatologic:	☐ Cellulitis
	☐	Pulmonary Embolus (PE)		☐ Discoloration
	☐	Superficial Phlebitis		☐ Ulceration
Respiratory:	☐	Asthma		☐ Rash, Dermatitis
	☐	COPD	Neurologic:	☐ Seizures
Endocrine:	☐	Diabetes	Cardiac:	☐ Cardiac Arrhythmia
	☐	Thyroid/Adrenal		
Gastric	☐	Stomach Ulcers		

☐ Other:_____

D. **Do you smoke:** ☐ Yes ☐ No ☐ Quit? If quit, how many years did you smoke?_____ When did you quit?_____

E. **Past Surgical History:**
Check the boxes to the surgeries you had in the following areas:

☐ Heart	☐ Abdominal	☐ Spine	☐ Lung
☐ Orthopedic	☐ Veins	☐ Brain	☐ Chest

F. **Family History:** ☐ Vein Disease ☐ Diabetes ☐ Heart Disease ☐ Cancer
Who in the family had the history? _____

G. **Do you have HIV?** ☐ yes ☐ No

H. **Do you have Hepatitis?** ☐ yes ☐ No

I. **Do you have a history of cancer** ☐ yes ☐ No **type of cancer**_____ **what year**_____

J. **Do you have a history of Alcohol abuse?** ☐ yes ☐ No

K. **Rx Medication - I am currently taking the following prescription medications:** _____
_____
_____
_____
_____
_____

_____ _____ _____
Print Patient Name Signature of Patient Date