## Varicose Vein Patient Form

**Patient Name:** __________________________________________  
**Date:** ______________  

**# Years with Varicose or Spider Veins:** ______  
**Referred by:** __________________________________________

### Leg Veins

**Vein/Skin Conditions**

- [ ] _ None  
- [ ] Small Red “Spider” Veins  
- [ ] Diagnosed Vein Disease  
- [ ] Skin Discoloration  
- [ ] Purple Veins

### Leg & Ankle Problems

- [ ] Aches  
- [ ] Pain  
- [ ] Swelling

**Please explain any “yes” answers**

### Methods Used to Relieve Leg Discomfort

- [ ] No Discomfort  
- [ ] Leg Elevation  
- [ ] Flexion/Extension of Feet  
- [ ] Walking

### Compression Stockings

- [ ] Do you wear compression stockings?  
- [ ] If yes, the stockings were bought  
- [ ] What type of compression stockings?  
- [ ] Did the stockings resolve your symptoms?

### Family History

**Spider or Varicose Veins**

- [ ] I don’t know  
- [ ] None  
- [ ] Sibling  
- [ ] Child

**Deep Thrombosis, Stroke, or Clot Disorder**

- [ ] I don’t know  
- [ ] None  
- [ ] Sibling  
- [ ] Child

### Patient Medical History

**Conditions Patient Had / Has**

- [ ] None  
- [ ] Anemia  
- [ ] Atherosclerosis  
- [ ] Ankle Skin Changes  
- [ ] Bleeding Blood Disorder  
- [ ] Chest Pain/Discomfort  
- [ ] Constipation

- [ ] Crohn’s Disease/IBS  
- [ ] Deep Vein Thrombosis  
- [ ] Diabetes with insulin  
- [ ] Diabetes No insulin  
- [ ] Easy Bruising  
- [ ] Hepatitis  
- [ ] High Cholesterol

- [ ] HIV / AIDS  
- [ ] Hypertension  
- [ ] Kidney Disease  
- [ ] Leg Ulcers  
- [ ] Heart Disease  
- [ ] Migraine Headaches  
- [ ] Mitral Valve Prolapse

- [ ] Pulmonary Embolus  
- [ ] Rupture/Bleeding Vein  
- [ ] Stroke  
- [ ] Superficial  
- [ ] Thrombophlebitis  
- [ ] Trauma to Leg
### Conditions Patient Had / Has

Do you have any allergy to medications or substances?  _Yes_  _No_  Please List_________________

Do you have any current illnesses?  _Yes_  _No_  If yes, please describe______________________________

Please list any current medications, vitamins, or herbal supplements that you are taking:
____________________________________________________________________________________
____________________________________________________________________________________

### Female Patients Only

Are you now, or are planning to be pregnant?  _Yes_  _No_  Are you breast feeding?  _Yes_  _No_

How many pregnancies have you had? __________  Miscarriages? ________  Live Births? __________

### Social History

Occupation: _______________

Long time on your feet?  _Yes_  _No_  Explain________________________

Does walking [increase, decrease, stay the same] the discomfort? ________________________________

Do you smoke?  _Yes_  _No_  How many packs per day? ________

Do you drink alcohol?  _Yes_  _No_  How many drinks per day? ________

### Past Surgeries

Check those that apply and explain

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Date</th>
<th>Type of Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
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<tr>
<td>Head/Neck</td>
<td></td>
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<tr>
<td>OB/GYN</td>
<td></td>
<td></td>
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<tr>
<td>Breast</td>
<td></td>
<td></td>
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<tr>
<td>Orthopedic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Past Vein Treatment(s)

Check those that apply and explain

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Leg</th>
<th>Date</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stab Phlebectomy</td>
<td>Left</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicose Vein Injections</td>
<td>Left</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endovenous Laser Ablation</td>
<td>Left</td>
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<tr>
<td>Ligation and/or Stripping</td>
<td>Left</td>
<td></td>
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</tr>
<tr>
<td>Radio-Frequency Ablation</td>
<td>Left</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spider Vein Injections</td>
<td>Left</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spider Vein Laser Therapy</td>
<td>Left</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What were the results of the above treatments?          __________________________________________
____________________________________________________________________________________

What would you most like to correct about your legs? _________________________________________
____________________________________________________________________________________

### For Office Use Only

Reviewed by: _________________________________  Date: _______________________

For Office Use Only
Patient Name: Last ____________  First ____________  ___Male  ___Female

Patients’ Mailing Address: ____________________________________________________
City: ______________  State: ______________  Zip: _____________________________
Date of Birth: _____/_____/______  Social Security Number: _____-____-_____
Marital Status: ___ Single   ___ Married   ___ Divorced   ___ Widowed
Is the patient a full-time student?  ___ Yes  ___No  If yes, where? ________________

Patient’s Employer: ________________  Work Phone: _________________________
Home Telephone: ________________  Cell Phone: ___________________________
Email Address: ___________________________  @ ____________________________ . COM

Name of person who carries this insurance policy: ________________________________
Mailing Address: ____________________________________________________________
City: ________________  State: ________________  Zip: __________________________
Date of Birth: ____/_____/______  ___ Male  ___Female  SSN: _____-____-_____
Employer: _________________________  Cell/Home Phone: _____________________
Relationship to Patient: ___ Self   ___ Spouse   ___ Child   ___ Other
Name of Insurance: __________________________________________________________
Policy #: __________________________  Group #: _____________________________

Emergency Contact: ________________  Relationship: _________________________
Home/Cell Phone: ________________  Work Phone: _________________________

Pharmacy Name: _____________________  Location of Pharmacy: _________________

By signing below I attest that the above is correct and true. Also I have read and seen
Finesse Surgical Solutions’ HIPPA policy:

Signature: ____________________________  Date: _________________________
Financial Policies

Our office has contracts with most (local) insurance companies. We will be glad to file your claim minus any deductibles owed and/or copay. We will file your claim to your primary and secondary carriers but not a third policy. Our office does not file any claims for Worker’s Compensation or Motor Vehicle Accidents. You must pay for any charges related to these two carriers. We will provide you with an itemized statement to present to your insurance company so that you may be reimbursed.

Our office accepts assignment on Medicare, Medicaid, and Tricare claims. This means that we will file your claim for all covered services and they will reimburse us directly. Every Medicare patient has a deductible each year. Medicare patients pay 20% of the allowed charges after any deductible has been met at the time of service. Our office will file a secondary claim once. If your secondary insurance does not respond to the claim within 60 days we will forward the claim to you for payment.

**If your insurance requires a predetermination prior to any procedure our office will do the necessary paper work to obtain their approval. Prior to your procedure an attempt will be made to verify your benefits and estimate the dollar amount that you will need to bring on the day of your surgery/procedure. We will file the claim to your insurance company. We will provide them with any medical documentation that they may request so that your claim will be paid. By law insurance carriers have 45 days to process clean claims. Occasionally we encounter problems with insurance companies that delay payment on our patient’s claims. If this happens to your claim, we ask that you contact your carrier and find out what information they need and inform our office. If after 90 days the claim has not been paid we will forward a bill to you for payment. __________________ Initial

Since many of our services are done in “staged procedures” (over multiple dates), we will send refunds for overpayment(s) to patients once all treatment is completed and all claims have been paid by insurance companies. __________________ Initial

If you do not have insurance we require payment in full at the time of service. We except cash, check, Care Credit, Master Card, Visa, and Discover Card. __________________ Initial

**Due to the large block of time that most of the vein procedures require, our clinic requires a $300.00 deposit when scheduling a surgery. This deposit will be applied towards the cost of your procedure. We require 72 (business days) hour notice of cancellation to receive a deposit refund. __________________ Initial

Failure to keep office appointments charges: 1st $25, 2nd $50 and 3rd $100 Cosmetic Appointments require $100 to reserve initial consultation. The patient will forfeit the $100 if they fail to cancel appointment or reschedule 24 (business) hours prior to scheduled time. __________________ Initial

I hereby assign medical and or surgical benefits, to include major medical benefits, to which I am entitled, (Medicare, Medicaid, HMO, PPO, Private Insurance) payable to James W. Schlotter, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all medical information necessary to secure the payment. I have read, understand and agree to the above policy.

Signature of insured/patient: ___________________________________________ Date: __________________
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can have access to this information. Please review it carefully.

Uses and Disclosures

**Treatment.** Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

**Payment.** Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

**Health care operations.** Your health information may be used as necessary to support the day-to-day activities and management of James W. Schlotter, M.D, F.A.C.S. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

**Law enforcement.** Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

**Public health reporting.** Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state’s public health department.

**Other uses and disclosures require your authorization.** Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

**Additional Uses of Information.** Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

**Information about treatments.** Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.
**Individual Rights.** You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information (a charge for copies will apply).
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

**The practice of James W. Schlotter, M.D., F.A.C.S. duties.** We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also required to abide by the privacy polices and practices that are outlined in this notice.

**Right to Revise Privacy Practices.** As permitted by law, we reserve the right to amend or modify our privacy polices and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

**Requests to Inspect Protected Health Information.** You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our Receptionist or Office Manager. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

**Complaints.** If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Office Manager  
James W. Schlotter, M.D.  
1347 Thorpe Lane  
San Marcos, TX 78666

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

**Contact Person.** The name and address of the person you may contact for further information concerning our privacy practices is: **Michelle Schlotter**

This notice is effective on or after April 3, 2003.
Office Policy for Failure to Cancel Appointments

Office visits and surgeries need to be cancelled 48 (business) hours prior to scheduled appointment. Failure to speak directly with our office staff to reschedule or cancel will result in a fee of:

- $25 for 1st failure to cancel
- $50 for 2nd failure to cancel
- $100 for 3rd failure to cancel

The above fee will need to be paid when rescheduling your appointment.

While most of our patients are very good at keeping their scheduled appointments we do have patients who fail to notify us that they will not be coming in. Many of our procedures and appointments are anywhere from 45 minutes to 2 hours long. When a patient fails to cancel at least 48 hours prior to their appointment it leaves a large block of empty time that could have been given to another patient. This causes financial and schedule disruptions to our practice.

We appreciate your understanding while we implement this policy into our practice.