AUSTIN VEIN INSTITUTE

Austin Vascular Institute

Patient Demographics

Last Name _____ First _____ MI_____ Sex: M F

Date of Birth___/___/___ Social Security # ____-____-____ Marital Status: _____

Address _____Apt #_____

City_____State_____Zip_____

Phone Numbers: Primary: (___) ____-_____ Secondary: (____)____-_____

Email: _____ How did you hear about us?_____

Employer's Name: _____Occupation:_____

Referring Physician: _____Primary Physician: _____

Insurance

Primary Insurance: _____ Insurance Phone #_____

Policy Holder's Name:_____ Date of Birth_____

Group # _____ Complete: ID #_____ SS #_____

Secondary Insurance: _____Insurance Phone # _____

Policy Holder's Name: _____ Date of Birth_____

Group # _____ Complete: ID #_____ SS #_____

Emergency Contact_____ Phone_____

**** Please let us know if you have a third insurance****

Assignment and Authorization of Benefits

Patients who do not have insurance coverage are expected to pay charges in full at the time services are rendered. I hereby assign all medical and or /surgical benefits , to which I am entitled, including Medicare, private insurance, and other plans to Austin Vascular Institute. I understand that I am responsible for all charges, copayments, co-insurance and deductibles. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record. I authorize insurance claims filed and benefits assigned.

_____ _____

Signature of Patient or Personal Representative **Date**

Form 2/09

Universal New Patient Intake Form

Mark any of the following conditions you or a family member has EVER experienced?

Condition	Self	Family	Please Explain
Sinusitis	☐	☐	_____
Hypothyroidism	☐	☐	_____
Skin cancer	☐	☐	_____
Abnormal moles	☐	☐	_____
Psoriasis	☐	☐	_____
Eczema	☐	☐	_____
Hives	☐	☐	_____
Asthma	☐	☐	_____
COPD	☐	☐	_____
Lung cancer	☐	☐	_____
Pneumonia	☐	☐	_____
Atrial fibrillation	☐	☐	_____
Murmur	☐	☐	_____
Angina (chest pain)	☐	☐	_____
Ankle swelling	☐	☐	_____
Heart attack	☐	☐	_____
High blood pressure	☐	☐	_____
Rheumatic/Scarlet fever	☐	☐	_____
Gastric reflux (GERD)	☐	☐	_____
Gastric bleeding	☐	☐	_____
Colon cancer	☐	☐	_____
Prostate/cancer enlargement	☐	☐	_____
Testicular cancer	☐	☐	_____
Pinched nerve	☐	☐	_____
Spinal stenosis	☐	☐	_____
Stroke/seizures/TIA	☐	☐	_____
Diabetes (type)	☐	☐	_____
Breast cancer	☐	☐	_____
Anemia	☐	☐	_____

Surgeries & Dates:

_____

Are you pregnant? ☐No ☐Yes Number of Pregnancies _____Number of Births _____

Universal New Patient Intake Form

Decreased appetite	☐ No ☐ Yes
Change in weight	☐ No ☐ Yes
High blood pressure	☐ No ☐ Yes
High cholesterol	☐ No ☐ Yes
Fatigue	☐ No ☐ Yes
Fevers	☐ No ☐ Yes
Cancer	☐ No ☐ Yes
Decreased vision	☐ No ☐ Yes
Double vision	☐ No ☐ Yes
Temporary blindness	☐ No ☐ Yes
Blurred vision	☐ No ☐ Yes
Detached retina	☐ No ☐ Yes
Temporal arteritis	☐ No ☐ Yes
Paralysis	☐ No ☐ Yes
Weakness	☐ No ☐ Yes
Seizure	☐ No ☐ Yes
Fainting	☐ No ☐ Yes
Headache	☐ No ☐ Yes
Migraine	☐ No ☐ Yes
Stroke	☐ No ☐ Yes
Numbness in limbs	☐ No ☐ Yes
Slurred speech	☐ No ☐ Yes
Decreased memory	☐ No ☐ Yes
Ankle swelling	☐ No ☐ Yes
Atrial fibrillation	☐ No ☐ Yes
Labored breathing	☐ No ☐ Yes
Dizziness	☐ No ☐ Yes
Congenital heart dis.	☐ No ☐ Yes
Rheumatic heart dis.	☐ No ☐ Yes
Murmur	☐ No ☐ Yes
Loss of consciousness	☐ No ☐ Yes
Palpitations	☐ No ☐ Yes
Chest pain	☐ No ☐ Yes
Chest discomfort	☐ No ☐ Yes
Unable to urinate	☐ No ☐ Yes
Painful urination	☐ No ☐ Yes
Prostate problems	☐ No ☐ Yes
Kidney/bladder dis.	☐ No ☐ Yes
Decr. urine stream	☐ No ☐ Yes
Kidney failure	☐ No ☐ Yes
Blood in urine	☐ No ☐ Yes
Excessive urination	☐ No ☐ Yes

Anxiety	☐ No ☐ Yes
Confusion	☐ No ☐ Yes
Depression	☐ No ☐ Yes
Delusions	☐ No ☐ Yes
Easy bruising	☐ No ☐ Yes
Anemia	☐ No ☐ Yes
Clotting disorder	☐ No ☐ Yes
Bleeding disorder	☐ No ☐ Yes
Pain in leg at rest	☐ No ☐ Yes
Leg pain when walking	☐ No ☐ Yes
Slow healing leg wound	☐ No ☐ Yes
Sensitivity to cold	☐ No ☐ Yes
Arterial disease	☐ No ☐ Yes
History of gangrene	☐ No ☐ Yes
Change in moles	☐ No ☐ Yes
Itching	☐ No ☐ Yes
Rash	☐ No ☐ Yes
Dry skin	☐ No ☐ Yes
Chronic skin problems	☐ No ☐ Yes
Sore throat	☐ No ☐ Yes
Sinus drainage	☐ No ☐ Yes
Hoarseness	☐ No ☐ Yes
Discharge from ears	☐ No ☐ Yes
Nose bleeds	☐ No ☐ Yes
Hearing loss	☐ No ☐ Yes
Ringing in ears	☐ No ☐ Yes
Painful swallowing	☐ No ☐ Yes
Indigestion	☐ No ☐ Yes
Vomiting	☐ No ☐ Yes
Vomiting blood	☐ No ☐ Yes
Gall bladder problems	☐ No ☐ Yes
Liver disease	☐ No ☐ Yes
Hemorrhoids	☐ No ☐ Yes
Diarrhea	☐ No ☐ Yes
Jaundice	☐ No ☐ Yes
Constipation	☐ No ☐ Yes
Abdominal pain	☐ No ☐ Yes
Bloody stools	☐ No ☐ Yes
Change in stool color	☐ No ☐ Yes
Change in bowel habits	☐ No ☐ Yes

Cough	☐ No ☐ Yes
Respiratory pain	☐ No ☐ Yes
COPD	☐ No ☐ Yes
Prod. of sputum	☐ No ☐ Yes
Coughing blood	☐ No ☐ Yes
Apnea	☐ No ☐ Yes
Wheezing	☐ No ☐ Yes
Bronchitis	☐ No ☐ Yes
Pneumonia	☐ No ☐
Bone/joint deformity	☐ No ☐ Yes
Joint swelling	☐ No ☐ Yes
Back pain	☐ No ☐ Yes
Muscle aches	☐ No ☐ Yes
Limited motion	☐ No ☐ Yes
Knee replacement	☐ No ☐ Yes
Hip replacement	☐ No ☐ Yes
Spinal problems	☐ No ☐ Yes
Thyroid disorder	☐ No ☐ Yes
Diabetes w/ insulin	☐ No ☐ Yes
Diabetes -no insulin	☐ No ☐ Yes
Extreme appetite	☐ No ☐ Yes
Extreme thirst	☐ No ☐ Yes
Lupus	☐ No ☐ Yes
Rheumatoid arthritis	☐ No ☐ Yes

FEMALE ONLY

Irregular periods	☐ No ☐ Yes
Breast problems	☐ No ☐ Yes
Menopause	☐ No ☐ Yes
Last pelvic exam	_____ mo / year
Last period	_____ year

OFFICE USE ONLY

Habits

Do you drink alcoholic beverages? □No □Yes *(#/week _____)*

Do you now or have you ever used tobacco? □No □Yes *(Packs/week _____)*Quit Date, if applicable _____

Do you exercise regularly? □No □Yes *(#of days / week _____)*

List of Medications (below)	Dosage	How Often Taken

Name of Pharmacy _____ Phone # _____

List ALL Allergies_____

Vein History

When did you first notice your enlarged or discolored veins?_____

Where are the veins you are seeking a medical opinion for located? ☐ Face ☐ Leg(s), *(Circle)* Right Leg / Left Leg / Both

Have you ever worn prescription grade compression stockings? ☐ No ☐ Yes, When and for how long?_____

Do you have a family history of vein problems? ☐ No ☐ Yes, What family member? _____

Please ☑ next to the symptoms that apply to you:

☐ Aching leg(s) ☐ Appearance ☐ Burning ☐ Cramps
☐ Dull Pain ☐ Heaviness ☐ Itching ☐ Leg Ulcers
☐ Restless Legs ☐ Sharp Pain ☐ Swelling ☐ Throbbing

☐ Tiredness ☐ Other: _____

Phlebitis (Clot in surface veins in legs)? ☐ No ☐ Yes, When _____

Deep Vein Thrombosis (Clot in deep veins)? ☐ No ☐ Yes, When _____

Pulmonary Embolus (Blood clot in lungs)? ☐ No ☐ Yes, When _____

Bleeding from veins? ☐ No ☐ Yes, When _____

Have you had sclerotherapy before? ☐ No ☐ Yes, When _____

Venogram (Vein X-Ray) ☐ No ☐ Yes, When _____

Have you ever had vein surgery? ☐ No ☐ Yes, When _____

Hemorrhoids? ☐ No ☐ Yes, When _____

IV drug use? ☐ No ☐ Yes, When _____

AIDS/HIV/hepatitis? ☐ No ☐ Yes, When _____

Trauma/injury to your legs? ☐ No ☐ Yes, When _____

Clotting disorder? ☐ No ☐ Yes, When _____

Notice of Privacy Practices

The staff at Austin Vein Institute understands the importance of keeping all healthcare and other personal information private. However to better the overall health care of the patient it is often necessary to communicate with other physicians participating in the patient's care.

I hereby authorize Austin Vein Institute to release or receive any clinical documentation to or from other relevant health care practitioners that are involved with my care. I also understand my rights as a patient of this practice, which are outlined in the *Notice of Privacy Policy*, and know that it is available to me at any time.

_____ _____

Signature of patient or personal representative Date

Notice of Financial Policy

Due to the complexities of each individual's insurance plan it is ultimately your responsibility as the patient to understand what benefits are covered. With that being said, we are eager to help you understand your individual insurance plan as best we can. Specific coverage issues, however, can generally only be addressed by the patient's insurance member services department (please see number provided on the insurance card). Our office **CANNOT** guarantee that your insurance will pay. We will make every attempt throughout your health care, to receive proper authorizations from your insurance company for planned treatments. However, if for some reason your insurance claim is denied you will be responsible for your bill.

Please understand that Austin Vein Institute is contractually obligated to collect copayments, deductibles as well as coinsurance charges. When billing out of network benefits, we may require a payment of the anticipated deductible/copayment portion of your billed charges, at the time services are rendered.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Once again, we welcome you to our office, and will be glad to answer any further questions that you may have.

_____ _____

Signature of patient or personal representative Date

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

NOTICE OF PRIVACY POLICY

Effective February, 2009

The following is the privacy of Austin Vein Institute as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without Your Consent

Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

Examples of treatment activities include: (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

Examples of payment activities include: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Examples of health care operations include:

(a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis.

As Required By Law

We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. *Examples of instances in which we are required to disclose your personal health information include*: (a) public health activities including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury in order to comply with Federal or state law; (b) disclosures regarding victims of abuse, neglect, or domestic violence including, reporting to social service or protective services agencies; (c) health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process; (e) law enforcement purposes for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death; (f) disclosures about decedents for purposes of cadaveric donation of organs, eyes or tissue; (g) for research purposes under certain conditions; (h) to avert a serious threat to health or safety; (i) military and veterans activities; (j) national security and intelligence activities, protective services of the President and others; (k) medical suitability determinations by entities that are components of the Department of State; (l) correctional institutions and other law enforcement custodial situations; (m) covered entities that are government programs providing public benefits, and for workers' compensation.

All Other Situations, With Your Specific Authorization

Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Miscellaneous Activities, Notice

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may contact you to raise funds for Covered Entity. If we are a group health plan or health insurance issuer or HMO with respect to a group health plan, we may disclose your personal health information to be sponsor of the plan.

Your Rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right To Request Restrictions On Use Or Disclosure

You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. *You may request restrictions on the following uses or disclosures*: to carry out treatment, payment, or healthcare operations; (b) disclosures to family members, relatives, or close personal friends of personal health information directly relevant to your care or payment related to your health care, or your location, general condition, or death; (c) instances in which you are not present or your permission cannot practicably be obtained due to your incapacity or an emergency circumstance; (d) permitting other persons to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of personal health information; or (e) disclosure to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law.

Right To Receive Confidential Communications

You have the right to receive confidential communications of your personal health information. We may require written requests. We may condition the provision of confidential communications on you providing us with information as to how payment will be handled and specification of an alternative address or other method of contact. We may require that a request contain a statement that disclosure of all or a part of the information to which the request pertains could endanger you. We may not require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential basis. We must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations. If we are a health care plan, we must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations if you clearly state that the disclosure of all or part of that information could endanger you.

Right To Inspect And Copy Your Personal Health Information

Your designated record set is a group of records we maintain that includes Medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy your personal health information contained in your designated record set, *except for* (a) psychotherapy notes, (b) information complied in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. We must provide you with access to your personal health information in the form or format requested by you, if it is readily producible in such form or format, or, if not, in a readable hard copy form or such other form or format. We may provide you with a summary of the personal health information requested, in lieu of providing access to the personal health information or may provide an explanation of the personal health information to which access has been provided, if you agree in advance to such a summary or explanation and agree to the fees imposed for such summary or explanation. We will provide you with access as requested in a timely manner, including arranging with you a convenient time and place to inspect or obtain copies of your personal health information or mailing a copy to you at your request. We will discuss the scope, format, and other aspects of your request for access as necessary to facilitate timely access. If you request a copy of your personal health information or agree to a summary or explanation of such information, we may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance. We reserve the right to deny you access to and copies of certain personal health information as permitted or required by law. We will reasonably attempt to accommodate any request for personal health information by, to the extent possible, giving you access to other personal health information after excluding the information as to which we have a ground to deny access. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. If we do not maintain the information that is the subject of your request for access but we know where the requested information is maintained, we will inform you of where to direct your request for access.

Right To Amend Your Personal Health Information

You have the right to request that we amend your personal health information or a record about you contained in your designated record set, for as long as the designated record set is maintained by us. We have the right to deny your request for amendment, if: (a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, (b) the information is not part of your designated record set maintained by us, (c) the information is prohibited from inspection by law, or (d) the information is accurate and complete. We may require that you submit written requests and provide a reason to support the requested amendment. If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services ("DHHS"). This denial will also include a notice that if you do not submit a statement of

disagreement, you may request that we include your request for amendment and the denial with any future disclosures of your personal health information that is the subject of the requested amendment. Copies of all requests, denials, and statements of disagreement will be included in your designated record set. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you as having received personal health information of yours prior to amendment and persons that we know have the personal health information that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to your detriment. All requests for amendment shall be sent to **Austin Vein Institute 7000 N. Mopac #320 Austin, TX 78731**.

Right To Receive An Accounting Of Disclosures Of Your Personal Health Information

Beginning April 14, 2003, you have the right to receive a written accounting of all disclosures of your personal health information that we have made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. *We are not required to provide accountings of disclosures for the following purposes*: (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) for a facility directory or to persons involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to 4/14/03. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent **Austin Vein Institute 7000 N. Mopac #320 Austin, TX 78731**.

Complaints

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. You may submit your complaint in writing by mail or electronically to our privacy officer, Amy Maddox at 7000 N. Mopac #320 Austin, TX 78731, (512) 346-2727 or amym@austinvascular.com. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

Amendments to this Privacy Policy

We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this Privacy Policy, or changes in the law affecting this Privacy Notice, by mail or electronically within 60 days of the effective date of such revision, amendment, or change.

On-going Access to Privacy Policy

We will provide you with a copy of the most recent version of this Privacy Policy at any time upon your written request sent to Austin Vein Institute 7000 N. Mopac #320 Austin, TX 78731. For any other requests or for further information regarding the privacy of your personal health information, and for information regarding the filing of a complaint with us, please contact our privacy officer Amy Maddox at the address, telephone number, or e-mail address listed above.