Vein Healthcare Center

35 Foden Road | South Portland, Maine 04106

tel: 207-221-7799 | fax: 207-221-3544 | info@veinhealthcare.com | www.veinhealthcare.com

Demographic Information

Contact Information

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Sex: ☐Male ☐Female

Address: _____

City: _____ State: _____

Zip: _____ Social Security Number: _____

Home Phone _____ Work Phone _____

Cell Phone: _____ Other Phone: _____

Which phone number should we use first? _____

Email: _____

When we confirm your visit, how would you like us to reach you? ☐Phone ☐Postcard ☐E-mail

Emergency Contact Information

Name: _____

Phone: _____

Relationship to you: _____

Insurance Information (Required, please complete all fields)

How will you pay for medical services? ☐Insurance ☐ Self pay ☐ Other _____

Primary Insurance	Secondary Insurance
Insurance Name: _____	_____
Group #: _____	_____
ID/Member #: _____	_____
Insurance Type: _____	_____

Scheduling Preferences

☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday ☐AM ☐PM ☐No preference

Additional Information

How did you hear about the Vein Healthcare Center?

I hereby authorize my insurance benefits to be paid directly to the Vein Healthcare Center. I understand that I am responsible for all charges and responsible to pay for non-covered services. I also authorize the release of pertinent medical information necessary to process my insurance request.

Signature: _____ Date: _____

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Medical Information

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: ☐Male ☐Female

Primary care provider: _____

Primary care provider address: _____

Primary care provider phone: _____

Vein History

Do your legs bother you? ☐Yes ☐No If yes, please check all that apply:

- ☐ Aching
- ☐ Cramping
- ☐ Throbbing
- ☐ Pain
- ☐ Swelling
- ☐ Itching
- ☐ Heaviness
- ☐ Ulcers
- ☐ Numbness

Other/Comments:

Have you ever worn compression stockings? ☐Yes ☐No If yes, when and for how long?

Have you had past vein treatment or had leg veins examined by a physician? ☐Yes ☐No If yes, please describe:

Do you ever take Aspirin, Tylenol, or Ibuprofen for your leg symptoms? ☐Yes ☐No

Do your legs prevent you from doing any activities (e.g. standing for long periods, swimming, wearing shorts, sleeping)? ☐Yes ☐No If yes, please describe:

Have you had injury to your legs requiring casting? ☐Yes ☐No

Please check any of the medical conditions below that you have experienced:

- ☐ Deep Vein Thrombosis (DVT)
- ☐ Superficial Vein Phlebitis
- ☐ Venous Stasis Ulcer
- ☐ Bleeding from Varicose Veins
- ☐ Vein Treatment
- ☐ Other

Medical History

Do you see a doctor regularly for any medical condition? ☐Yes ☐No If yes, please describe:

Please check any health or disease related issues you might have:

- ☐ AIDS
- ☐ Anemia
- ☐ Bleeding/Clotting Disorder
- ☐ Cancer
- ☐ Cataracts
- ☐ Colitis
- ☐ Deep Vein Thrombosis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Lung Disease
- ☐ Nervous Breakdown
- ☐ Pneumonia
- ☐ Stroke
- ☐ Ulcers
- ☐ Other? _____

Medical Information

Have you had any serious injuries? ☐Yes ☐No If yes, please list the date and type of injury:

Past Surgeries

Please list past surgeries:

Family History

	Major Illness	Age	Deceased?
Mother:	_____	_____	☐Yes ☐No
Father:	_____	_____	☐Yes ☐No
Sibling 1:	_____	_____	☐Yes ☐No
Sibling 2:	_____	_____	☐Yes ☐No
Sibling 3:	_____	_____	☐Yes ☐No

Social History

Current/Past occupation?: _____ Marital status: _____

Do you smoke? ☐Yes ☐No How much? Quit date? _____

Do you drink alcohol? ☐Yes ☐No If yes, how much? _____

Do you exercise? ☐Yes ☐No If yes, please describe: _____

Medication

Please list current medications:

OB History (Women only)

Is there a chance that you are pregnant? ☐Yes ☐No How many times have you been pregnant? _____

How many children have you birthed? _____ Complications?

Allergies

Please list allergies:

Medical Conditions *(circle any that apply)*

General Health: ☐Recurrent infections/fever, ☐fatigue, ☐recent weight gain or loss, ☐night sweats, ☐decreased appetite. Comments:

Emotional: ☐Depression, ☐anxiety attacks, ☐crying spells, ☐alcohol/drug problems, ☐problems falling asleep, ☐nervousness, ☐suicidal thoughts. Comments:

Eyes: ☐Wear glasses or contacts, ☐eye infections, ☐blurred vision. Comments:

Medical Information

Medical Conditions *continued*

Head, Ears, Nose, Mouth, Throat:	Ear infections, headaches, fullness in head, sore throat, nose bleeding. Comments:
Heart:	Chest discomfort, tightness, heart murmur, swollen ankles, shortness of breath, rheumatic fever, high blood pressure. Comments:
Lungs:	Difficulty breathing, cough, wheezing, cough blood or mucus, sleep on more than one pillow. Comments:
Lymphatic/Blood Vessels:	Excessive bleeding, bruise easily, swollen lymph nodes. Comments:
Muscle/Bone/Joints:	Joint pain, stiffness, swelling, muscle pain, muscle cramping or spasms, neck/back pain. Comments:
Nervous System:	Fainting or loss of consciousness, convulsions, seizures, dizziness, memory changes. Comments:
Reproductive:	Burning pain when urinating, frequent urination, sudden impulse to urinate, irregular periods, clots, cramps, prostate problems. Comments:
Skin/Breasts:	Sore, rash/itching, lumps/growths, changes in moles, hair loss, swollen glands, tenderness or pain in breasts, discharge from breasts. Comments:
Stomach and Intestinal:	Special diet, change in appetite, heartburn, nausea/vomiting, problems swallowing, black stools, ulcers, constipation, use antacids. Comments:
Other:	Please describe any other medical conditions you may have:

Additional Medical Information

Please share any details about your health that you feel may be relevant and not previously mentioned?:

Vein Healthcare Center

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

You have the right to refuse to sign this consent

Vein Healthcare Center provides this form in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). By signing this form, I understand that my health information may be used and/or disclosed by Vein Healthcare Center to carry out treatment, payment, or other healthcare operations, and that for a more complete description of such uses and disclosures I should refer to Vein Healthcare Center's Notice of Privacy Practices (the "Notice") a copy of which has been provided to me. I understand that I may request a copy of this Notice to review prior to signing this form if such Notice has not been provided to me.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or other healthcare operations, in accordance with the Notice. I also understand that I can also revoke this consent at any time, but that I can only do so in writing. Revoking consent will not apply to information already disclosed.

_____

(Print Name)

_____

(Patient Signature)

_____

(Date)

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Patient Responsibility Policy

At the Vein Healthcare Center, we are committed to providing you with high-quality medical care. To ensure that we can continue offering these services, we ask for your understanding and cooperation with the following financial responsibilities:

1. Patient's Financial Responsibility
As a patient, you are responsible for the payment of all services rendered, regardless of insurance coverage. You will be responsible for any applicable co-payments, co-insurance, deductibles, or non-covered services at the time of service. If we are unable to verify your insurance or if you do not have insurance, you will be responsible for the full payment of services.

2. Insurance Verification and Billing
We will make every effort to verify your insurance information and file claims on your behalf. However, it is ultimately your responsibility to ensure that your insurance coverage is active, accurate, and provides benefits for the services you receive. You agree to promptly notify us of any changes to your insurance information. Providing evidence of your insurance plan does not hold VHC responsible for verifying the accuracy of this information. You also understand that all cosmetic treatments or treatments deemed not medically necessary by my insurance must be paid in full at the time services are rendered. It is my responsibility to inquire about final costs before I choose to have treatments performed.

3. Co-Payments, Deductibles, and Non-Covered Services
Co-payments, deductibles, and any amounts for services not covered by insurance are due at the time of service. If you are unsure of your financial responsibility, we encourage you to contact your insurance provider in advance. If we are unable to collect these amounts during your visit, you will receive a bill for the outstanding balance.

- ***Aetna Patients:*** *I understand that under my Aetna policy, I will incur an $80 charge when I receive Ultrasound Guided Sclerotherapy service code 76942 as Aetna does not cover the ultrasound guidance of the needle placement. Payment will be due at time of service***.**

4. Estimates for Out-of-Pocket Expenses
We may provide estimates of your out-of-pocket expenses based on the information available from your insurance provider. However, please be aware that these estimates are not guaranteed. Actual charges may differ due to factors such as changes in coverage, insurer provider errors, or unanticipated procedures. You will be responsible for paying any balance not covered by insurance, even if it differs from the estimate provided.

5. Payment Plans
If you are unable to pay your balance in full, please contact our billing department to discuss the possibility of setting up a payment plan. We are committed to working with you to make payment arrangements.

6. Past Due Accounts and Collection
Any outstanding balance not paid within 30 days of the date of service will be considered past due. If payment is not received or arrangements are not made, your account may be referred to a collection

agency. You will be responsible for any additional collection costs, including but not limited to attorney fees, court costs, and collection agency fees. I understand that if I have an outstanding balance, it must be paid in full before seeing the provider, unless other payment arrangements have been approved by the billing department prior to the appointment.

7. Self-Pay Patients

If you do not have insurance, you are responsible for the full cost of your treatment at the time of service. We recommend discussing the cost of services with our office in advance to understand your financial responsibility.

8. Authorization for Treatment

By signing this policy, you authorize Vein Healthcare Center to treat you and agree to be financially responsible for all services provided, including any laboratory tests, imaging services, or referrals to specialists.

9. Consent to Release Insurance Information

You consent to the release of any necessary information to your insurance carrier or other third parties involved in the processing of claims related to your care. This may include information such as medical records or treatment details required to process the claim.

10. Missed Appointments and Cancellations

Please refer to our Cancellation and No-Show Policy for information regarding missed appointments and the associated fees. Failure to provide the required notice or failure to attend scheduled appointments may result in charges for the missed visit.

11. Exclusion of Non-Service Animals: Service animals are welcome in the office and treatment areas of the medical office, provided they are under control at all times. Animals that are not service animals, including emotional support animals, comfort animals, or pets, are not allowed in treatment areas or office spaces.

12. Unauthorized Recordings Prohibited: Patients and visitors are prohibited from making video or audio recordings within the office unless explicitly authorized by VHC management. This includes recordings made on personal devices such as mobile phones, cameras, and other recording equipment.

13. Prohibited Weapons: All employees, visitors, and individuals entering the Vein Healthcare Center premises are prohibited from carrying any dangerous weapon, whether concealed or open, unless explicitly permitted as part of their official duties. Dangerous weapons include, but are not limited to, firearms, knives, explosives, or any items that could be used to intimidate, harm, or injure another individual.

14. Acknowledgment and Agreement

By signing this Financial Responsibility Policy, you acknowledge that you understand and agree to the terms outlined above. If you have any questions or concerns about your financial responsibility, please speak with our billing department before your visit.

Patient Acknowledgment and Signature

I, the undersigned, acknowledge that I have read, understand, and agree to the Patient Responsibility Policy outlined above. I agree to pay for all services rendered, including co-pays, deductibles, and any other charges not covered by insurance. I understand that I am responsible for making payment arrangements in the event of financial difficulty. I acknowledge that any out-of-pocket estimates provided are not guaranteed and that I am responsible for any balance due.

Patient Name (Printed): _____ Patient Date of Birth: _____

Patient Signature: _____ Date: _____

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Cancellation and No-Show Policy

At Vein Healthcare, we are committed to providing the best possible care to all our patients. To ensure that we can continue to serve everyone efficiently, we ask for our patients cooperation with the following attendance policy:

- **Cancellation Notice:** We understand that situations arise in which you must cancel your appointment. If you need to cancel, please provide at least 24 hours' notice to allow us to offer the appointment to another patient. You can cancel or reschedule by:
    - **Phone:** 207-221-7799
    - **Email:** **info@veinhealthcarecenter.com**
- **Consequences of Repeated No-Shows:** If you accumulate **three (3) no- shows in a 12 month period**, we may refer you back to your **Primary Care Physician (PCP)** for continued care.
- **Emergency and Extenuating Circumstances:** We know that unexpected situations sometimes arise. In the case of emergencies or extenuating circumstances, exceptions may be made at the sole discretion of practice management. Please contact us to discuss your situation prior to scheduling any further appointments to discuss your situation.
- ***Questions?:*** *If you have questions about our cancellation policy please call 207-221-7799 ext. 105, or email the practice manager at info@veinhealthcenter.com .*

Thank you for your understanding and cooperation in helping us serve all our patients efficiently.

Vein Healthcare Center

Appointment Reminder Form

Please check the box with the preferred method of communication you choose to be notified of your upcoming appointments at Vein Healthcare Center.

- ❑ Email and text message
- ❑ Email only
- ❑ Text message only
- ❑ I prefer a telephone call reminder
- ❑ I do not wish to receive appointment reminders

Email Address: _____

Mobile Phone Number: _____

Patient Name Printed: _____

Patient Signature: _____ Date:_____

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Vein Healthcare Center

The Vein Healthcare Center is near the Portland Jetport and the Maine Mall and is easily accessible from I-295, I-95, U.S. Route 1, and other local routes.

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DETAILED DIRECTIONS TO THE VEIN HEALTHCARE CENTER

From Greater Portland, Mid-Coast, and Down East including Freeport, Boothbay, and Belfast

I-295 South to exit 3, Westbrook Street. At the traffic light, turn right on to Westbrook Street. Continue through the next traffic light. At the second light, Western Avenue bears off to the right. Continue on Western Avenue. At the next light turn left on to Foden Road and then immediately right in to our parking lot.

From the South, including Saco, Portsmouth, Boston and Connecticut

I-95 North to exit 46, (Portland Jetport). Turn right at the traffic light on to Skyway Dr. towards the Jet Port. At the light, turn right on to Johnson Rd/Western Ave. Continue through the next traffic light (passing Staples on the left). Our parking lot entrance is immediately after the Coca Cola plant on the right.

From the North, including Augusta, Bangor, Lewiston/Auburn, and Canada

I-95 South to exit 46, (Portland Jetport). Turn right at the traffic light on to Skyway Dr. towards the Jet Port. At the 2nd light, turn right on to Johnson Rd/Western Ave. Continue through the next traffic light (passing Staples on the left). Our parking lot entrance is immediately after the Coca Cola plant on the right.