WESTERN VASCULAR
INSTITUTE

www.westernvascular.com

PATIENT WELCOME LETTER

Welcome to Western Vascular Institute. This organization is owned by Mitar Vranic, D.O. and Henry Tarlian, M.D.

We would like you to know that all physicians are board certified by the American Board of Surgery and are licensed in the State of Arizona. We have extensive training in the field of Vascular Surgery. Should you choose to have surgery at this organization, we will be the only ones performing your surgery and anesthesia services.

This organization also uses credentialed and licensed in the State of Arizona, mid-level providers, i.e. Nurse Practitioner. They provide care according to their scope of service.

Please be advised that if you have a grievance please ask for a grievance form from the receptionist.

If you have a suggestion, please place this in writing. This can be done anonymously and may be handed to the receptionist or mailed to the office.

We encourage all patients to participate in their care, ask questions about anything; surgery, medications, treatments, diet, etc.

This organization educates staff upon hire and annually thereafter in hand hygiene and we follow the CDC guidelines for hand hygiene. We encourage staff to stay home when they are sick. We provide tissues and garbage cans throughout the facility and encourage everyone to cover their mouth when coughing or sneezing and then wash their hands.

Should you have a procedure or surgery in this organization we want you to know that we value patient safety. Therefore, you may hear us performing certain tasks or asking certain questions that may surprise you. Even though we may know you we will ask you identifying information such as your date of birth or your address besides asking you to tell us your name. We take a pause or a "time out" before we actually start your procedure to assure once again that we have everything that we need and the entire team is in agreement. Only the physician performing your procedure will mark your surgical site. This organization adheres to strict infection control measures before, during, and after your procedure including but not limited to: procedural technique, the environment of care, care of equipment and instruments, and education of all staff in the most up to date infection control measures.

If anyone has concerns about patient care and safety in the organization, that the organization has not addressed, you are encouraged to contact a member of the organization's management team. If you feel the concerns were not resolved through the organization, you are encouraged to contact the Joint Commission by calling 800-994-6610 or emailing complaint@jointcommission.org.

P: 480.668.5000 | F: 480.668.5065 | New Patient Coordinator: 480.668.5000 ext. 331, 332 or 703

Mesa
7165 E. University Dr.
Suite 183
Mesa, AZ 85207

Testing Center
7165 E. University Dr.
Suite 105
Mesa, AZ 85207

Phoenix
3600 N. 3rd Ave.
Suite B
Phoenix, AZ 85013

Payson
708 S. Coeur d'Alene Ln.
Suite B
Payson, AZ 85541

Rev. 4/21
POS Reorder # 2105339

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PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

Rights

The observance of the following guidelines will provide more effective patient care and greater satisfaction for the patient, the physician and the individuals that make up the office organization. It is in recognition of these factors that these rights are affirmed.

The patient has the right to considerate and respectful care; cultural, psychosocial, spiritual, personal values, beliefs, and preferences will be respected and care will be given in a safe setting. Patients with vision, speech, hearing, language and cognitive impairments have the right to effective communication.

The patient has the right to receive from his/her physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternative, the patient has the right to know the name of the person(s) responsible for the procedures and/or treatment as well as the person(s) responsible for their sedation and anesthesia.

The patient has the right to every consideration of his/her privacy concerning his/her medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. The patient has the right to expect that all communications and records pertaining to his/her care should be treated as confidential. Those not directly involved in his/her care must have permission of the patient to be present.

The patient has the right to obtain from the physician complete current information concerning his/her diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. The patient has the right to be involved in decisions about their care, treatment and services and the patient has the right to have their pain assessed, managed, and treated as effectively as possible.

The patient has the right, and when appropriate, the patient's family to be informed of unanticipated outcomes of care, treatment, and services that relate to sentinel or adverse reviewable events.

The patient has the right to expect that within its capacity, this ambulatory facility must provide evaluation, service and/or referral as indicated by the urgency of the case. When medically permissible, a patient may be transferred to another facility only after he/she has received complete information and explanation concerning the needs for and alternatives to such a transfer.

The patient has the right to obtain information as to any relationship of this facility to other health care and educational institutions insofar as his/her care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, which is treating him/her.

The patient has the right to expect reasonable continuity of care. The patient has the right to expect that this facility will provide a mechanism whereby he/she is informed by his physician of the patient's continuing health care requirements following discharge.

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES CONTINUED

The patient with cognitive disabilities has the right to be treated with the consent of either a family member or surrogate. Such family member or surrogate must prove legal authority to represent the patient via legal guardianship, proof of health care proxy, or power of attorney. Proof of legal authority must be presented before treatment is rendered.

The patient has the right to know the mechanisms for grievance as well as suggestions.

The patient has the right to change their choice of physician.

The patient has the right to refuse care, treatment, and services in accordance with law and regulation.

The patient has the right to dispute information in their medical record.

The patient has the right to examine and receive an explanation of his/her bill and to expect ethical billing practices.

The patient has the right to exercise all rights without discrimination or reprisal, abuse or harassment.

Responsibilities

The patient has the responsibility to provide the physician with the most accurate and complete information regarding present complaints, past illnesses, hospitalizations, medications, allergies and unexpected changes in the patient's condition.

The patient is responsible for asking questions when they do not understand what they are told or what they are expected to do.

If the plan of care is agreed upon, the patient has the responsibility to follow the plan of care or express concerns with compliance. The patient and family are responsible for following the preoperative and post discharge care plan. The patient and family are responsible for the outcomes if they do not follow the care plan.

The patient is responsible to provide an adult to transport him/her home from the facility and remain with him/her for 24 hours, if required by his/her physician.

The patient is responsible to inform his/her physician about any living will medical power of attorney, or other directive that could affect his/her care.

The patient and family are responsible for following the practice's rules and regulations concerning patient care and conduct.

Patients and families are responsible for being considerate of the practice's staff and property.

The patient and family are responsible for promptly meeting any financial obligation agreed to with the practice.

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NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your health information
- Your privacy rights
- Our obligations concerning the use and disclosure of your health information

We may use and disclose your health information in the following ways

The following categories describe the different ways in which we may use and disclose your health information.

1. **Treatment** Physicians and staff may use or disclose your health information in order to treat you or to assist others in your treatment. Additionally, we may disclose your health information to others who may assist in your care, such as your spouse, children, or parents.
2. **Payment** Our practice may use your health information to bill and collect payment for the services you receive from us. We may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose this information to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your health information to bill you directly for services and items.
3. **Health care operations** We may need to use and disclose your health information to be able to run our practice at the highest clinical standards and as effectively as possible. This could be used to evaluate the performance of our physicians and staff, to determine if our treatment plans are effective, or determine if there are other services we should be offering. We may also compare our clinical data with other practices; review it with medical students, medical faculty, technicians, and others for teaching and learning purposes. We will strive to remove information that identifies you from this medical information.
4. **Disclosure required by law** Our practice will use and disclose your health information when we are required to do so by federal, state, or local law.
5. **Practice communication** We may want to call you by phone for reminder purposes and leave a message on your answering machine at home, work, or with a family member. You can request that our practice communicate with you about your health and related issues in a particular manner. For instance, you may wish to be contacted at work during business hours rather than at home. We will accommodate reasonable requests. We will enlist the help of a translator (including ASL) if needed. This person would be privy to some of your health information.

You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information

NOTICE OF PRIVACY PRACTICES CONTINUED

to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. ***Any restrictions need to be given to Western Vascular Institute, PLLC in writing.***

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If asked to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers' Compensation and similar programs.

Your rights regarding your health information

1. Communications- You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You have the right to be notified following a breach of your PHI.
3. You have the right to opt out of receiving such communications as marketing mailings.
4. You have the right to restrict certain disclosures of PHI to a health plan when you pay for treatments out of pocket in full.
5. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
6. You have the right to inspect and obtain copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to: Western Vascular Institute, PLLC, 7165 E University Drive #187, Mesa, AZ 85207.

NOTICE OF PRIVACY PRACTICES CONTINUED

7. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Western Vascular Institute, PLLC, Attention: Compliance Officer, 7165 E University Drive #187, Mesa, AZ 85207, (480) 668-5000. You must provide us with a reason that supports your request for amendment. Western Vascular Institute has 60 days to respond to your request.
8. Right to a copy of this notice. You are entitled to receive a copy of this notice of privacy practices. You may ask us to give you a copy of this notice at any time.
9. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Western Vascular Institute, PLLC, Compliance Officer at (480) 668-5000. All complaints must be submitted in writing to Western Vascular Institute, PLLC, 7165 E University Drive #187, Mesa, AZ 85207. You will not be penalized for filing a complaint.
10. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. This authorization stays in effect until you revoke it.

Redistribution of this Notice – We will prominently post any revisions of this Notice in our office.

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PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for choosing Western Vascular Institute, PLLC. ("Provider") as your healthcare provider!

The medical services you seek here imply an obligation on your part to ensure payment in full is made for services you receive. This Patient Financial Responsibility Agreement will assist you in understanding that financial responsibility.

Consent. I consent to treatment and services ordered by my Physician or Nurse Practitioner at and/or its associates. I understand my healthcare provider may perform medically necessary services, as well as 'elective' services, according to current standard of care guidelines. I do have the right to consider or decline services prior to them being performed. My consent to undergo such treatment and/or services will be considered a non-verbal agreement to pay for the services provided to me.

Responsibility. I understand I am ultimately responsible for all payment obligations arising out of my treatment and care and I guarantee payment for these services. I am responsible for deductibles, co-payments, co-insurance or any other patient responsibility amounts indicated by my insurance carrier or for any services not covered by my insurance.

Insurance Policy. It is my responsibility for knowing and understanding my insurance policy, both the coverage benefits and policy limitations. I understand I am personally responsible for payment when: (i) my health plan requires prior authorization/referral by a primary care physician (PCP) before receiving services, and I have not obtained such an authorization or referral; (ii) I receive services in excess of the authorization/referral; (iii) my health plan determines the services I received are not medically necessary and/or not covered by my insurance plan; (iv) my coverage has lapsed/expired at the time services are rendered; (v) I have chosen to utilize my out-of-network benefits; or (vi) I have chosen not to use my health plan coverage for services I receive.

Payment Arrangements. Whether or not I have insurance or are self-pay, payment of my account balance is due within thirty (30) days of receipt of my billing statement. I understand if I need to make special payment arrangements, I may contact the Billing Department to arrange a mutually agreeable payment plan. I agree to make payments on this plan pursuant to the plan agreement until my account is paid in full. If my account is over sixty (60) days past due, my account will be in default and may be referred to a collection agency or attorney.

Payments Accepted. I understand I can make payments by check, cash, money order, debit card, credit card (Visa, MasterCard, American Express or Discover) or CareCredit.

Payment by Check. If my check payment is returned or declined for any reason, my account will be charged a surcharge of $25.00 in addition to any costs assessed or charged by the bank. Checks returned to the office are also subject to further collections by the Maricopa County Attorney's office unless a valid method of payment is forwarded upon request. After two (2) returned checks have been received by Provider, my personal checks will no longer be accepted, and I will be responsible for using another method of payment.

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT CONTINUED

Ancillary Services. I may receive ancillary medical services while a patient of Provider such as anesthesia; interpretation of tests; imaging services; diagnostic testing, etc. I understand some physicians may not provide services directly in my presence but are actively involved in the course of my diagnosis and treatment. I authorize payment directly for these services under the policy issued to me by my insurance carrier. I may incur additional charges because of ancillary services. I agree to pay all remaining charges for services after benefits paid on my behalf are credited to my account as determined by my insurance carrier.

Collection of Anticipated Charges. For healthcare services, office and surgical procedures, Provider will collect my anticipated financial responsibility for such services prior to delivery for prenatal care; and prior to delivery or prior to scheduling an office or surgical procedure. Provider will contact my insurance carrier to determine an estimate of the anticipated amounts owed based on the current contracted amounts and fee schedules. I will not hold Provider responsible for incorrect/inaccurate information provided by my insurance carrier regarding my insurance benefits or benefit plans. Provider does not accept responsibility for incorrect information given by me or my insurance carrier regarding my insurance benefits or benefit plans. If an account balance remains due after the claim has been processed and amounts collected for anticipated charges have been applied, I understand I will be held responsible for the remaining amount and am ultimately responsible for payment.

Non-Payment on Account. Should collection proceedings or other legal action become necessary to collect my overdue or delinquent account, I understand Provider has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. I am responsible for all costs of collection including, but not limited to: (i) late fees and charges and interest due as a result of such delinquency; (ii) a $50.00 administrative default fee will be added to outstanding balances placed with a collection agency or attorney; (iii) Interest of 18% per year will be accrued on the principal balance owing; (iv) all attorney/court costs and fees incurred in the collection process; and I acknowledge that if my account is referred to a collection agency, attorney, court, or when the past due status is reported to a credit reporting agency, it may have an adverse effect on my credit history. Once my account is placed with a collection agency or attorney, I am responsible for communicating with their offices for payment. I may lose my ability to be seen at Provider as a result of my account being sent to a collection agency or attorney.

Choice of Venue. This Agreement will be governed by the laws of the State of Arizona and all legal action will be filed in Maricopa County, Arizona in accordance with Arizona law.

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT CONTINUED

Authorization to Contact.

I grant permission and consent to Provider and its agents, assignees, and contractors (which may include third party debt collectors for past due obligations): (1) to contact me by phone at any number associated with me, if provided by me or another person on my behalf; (2) to leave messages for me and include in any such messages amounts owed by me; (3) to send me text messages or emails using any email address I provided or any phone number associated with me, if provided by me or another person on my behalf; and (4) to use prerecorded/artificial voice messages and/or an automated telephone dialing system (an auto dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to me as provided herein or any related scheduled services and my account and understand this contact may result in charges to me.

I further agree to provide updated contact information to avoid unintended disclosures of my information and I accept and acknowledge that Western Vascular Institute and its agents, assignees and contractors (which may include third party debt collectors for past due obligations) will treat any email address or phone number I provide as my pri-vate email or phone number that is not accessible by unauthorized third parties. I understand that communication attempts will be made to my cellular phone during permitted calling hours based upon the time zone affiliated with the cellular phone number provided, unless notified otherwise.

I understand that my refusal to provide the informa-tion described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services.

WESTERN VASCULAR
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POLICIES

Payment Policy

Payment of Insurance and/or Medicare Benefits to:
Western Vascular Institute, 7165 E. University Drive, Suite 187, Mesa, AZ 85207-6415

I request payments be made directly to me or the provider listed on the claim for services furnished to me during the effective period of this authorization. I authorize the above listed provider(s) to release to the Social Security Administration, its intermediaries or carriers any information required for any claim to be paid and processed. I authorize the release of any information necessary to determine these benefits or the benefits payable for related services.

Patient Bill of Rights and Disclosure of Information

Your signature below indicates that you've received a "Patient Welcome Letter" that provides you with information about our organization and your rights as a patient with us.

Cancellation Policy

If you are unable to keep your appointment, you are obligated to inform our office within 24 business hours of your scheduled office visit or ultrasound appointment and 48 business hours for an in-office surgery or hospital surgery. If you do not cancel your appointment within that time frame, you will be subject to a non-cancellation fee as follows: Office visits $35.00, Ultrasounds $50.00, In-office surgery $150.00 and Hospital surgery $200.00. Your signature below acknowledges that you have read and understand our non-cancellation policy.

Consent for Electronic Chart Identification Policy

Western Vascular Institute uses an Electronic Medical Record (EMR) system to maintain your health care information. We use a digital photo to visually identify our patients. We will only use your picture for identification purposes. Your picture will never be disclosed or released outside this facility and will only be used that complies with our Notice of Privacy Practices and HIPAA law. Your signature below acknowledges that you have read and understood this policy.

Please Print Your Name:_____

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PATIENT FINANCIAL RESPONSIBILITY AGREEMENT & POLICIES

Patient Financial Responsibility Agreement

The entire Patient financial responsibility agreement is a laminated form provided by the front office staff. Copies of the signed financial forms can be printed upon request.

Acknowledgement. I understand I am ultimately responsible for payment for the services I receive at Provider, regardless of my health insurance coverage, I understand Provider will not act as administrator to resolve my personal financial agreements regarding my medical care. I have had the opportunity to read this Patient Financial Responsibility Agreement in its entirety and have had the opportunity to ask questions regarding the details of this Agreement. Any questions have been answered to my satisfaction.

I consent and agree to the aforementioned policies of Provider and understand they may be changed without notice.

Signed and agreed to this date: _____

_____ _____

Patient Name (print) **Signature**

Consent for Treatment & Insurance Authorization/Assignment

1. The patient or authorized representative recognizes the need for care and consents to ANY and ALL medically necessary services as ordered by the physician and at the discretion of the patient. These services may include lab procedures, medical treatment, minor or emergency surgical treatment, exam or other services rendered under the specific instructions of the physician.
2. I hereby authorize WESTERN VASCULAR INSTITUTE, PLLC to furnish information to insurance carriers concerning myself or my illness and treatment. I hereby assign to the providers of this practice ALL payments for medical services rendered to myself or my dependents. I understand that I am responsible for ANY amount NOT covered by insurance, including any attorney's fees.

Acknowledgment of Receipt Notice of Privacy Practices

By signing below, I acknowledge that I have received the Notice of Privacy Practices of Western Vascular Institute, which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this acknowledgment.

By signing below, you read, acknowledge and agree with the above-mentioned policies, patient rights & consents.

_____ _____

Signature of Patient or Patient Representative **Date**

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PATIENT DEMOGRAPHICS

PATIENT INFORMATION

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ ☐ Home ☐ Work ☐ Other

Phone: _____ ☐ Home ☐ Work ☐ Other

Sex: ☐ M ☐ F Date of Birth: _____ Age: _____

Social Security#: _____

Preferred Language: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced

Email Address: _____

Referring Physician: _____

Primary Physician: _____

Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Other

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White or Caucasian ☐ Other or Undetermined

PATIENT EMPLOYMENT INFORMATION

☐ Employed ☐ Retired ☐ Unemployed

Employer's Name: _____

Employer's Phone:

Occupation:

EMERGENCY CONTACTS

Name	Relationship	Phone

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PATIENT INSURANCE

PRIMARY INSURANCE

Insurance Company Name: _____

ID#: _____

Group/Policy#: _____

Subscriber's Name: _____

Subscriber's Phone#: _____

Relationship to Patient: _____

Subscriber's Employer: _____

Subscriber's SS#: _____

Subscriber's Date of Birth: _____

SECONDARY INSURANCE

Insurance Company Name: _____

ID#: _____

Group/Policy#: _____

Subscriber's Name: _____

Subscriber's Phone#: _____

Relationship to Patient: _____

Subscriber's Employer: _____

Subscriber's SS#: _____

Subscriber's Date of Birth: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

Please read and sign

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor, and authorize him/her to furnish information regarding my illness to my insurance carrier. ***I understand that I am responsible for any amount not paid for by my insurance.*** I authorize the clinic to obtain medication history electronically from my pharmacy benefit administrator.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

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PATIENT HISTORY FORM

Patient Name: _____ Date of Birth: _____

Are you currently taking Aspirin? ☐ Yes ☐ No ☐ 81mg ☐ 325mg ☐ Once daily ☐ Other: _____

Current Medications and Allergies Drug	Dosage (mg)	How many times daily?

Pharmacy: _____ **Phone:** _____

Cross Roads: _____

MEDICATION ALLERGIES:

_____

_____

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Please indicate if you have had any of the following by marking the corresponding check box:

PAST MEDICAL HISTORY

Cancer
☐ Type _____

Heart Disease
☐ Congestive heart failure ☐ High blood pressure
☐ Heart attack ☐ High cholesterol
☐ Artrial fibrillation ☐ Coronary artery disease
☐ Other: _____

Ear, Nose, Throat
☐ Type _____

Skin
☐ Type _____

Musculoskeletal
☐ Type _____

Vascular
☐ Abdominal aortic aneurysm ☐ Other: _____
☐ Carotid disease _____
_____

Endocrine
☐ Kidney disease
☐ Diabetes
☐ Other: _____

Respiratory
☐ COPD
☐ Asthma
☐ Other: _____

Neurological
☐ Stroke
☐ Other: _____

Psychiatric
☐ Type _____

Infections Disease (Check all that apply and please list when)
☐ C-diff _____ ☐ Hepatitis A, B, C, D, E (circle applicability)
☐ HIV _____ _____
☐ MRSA _____

PAST SURGICAL HISTORY

Cardiac Surgery
☐ Type _____

Lung Surgery
☐ Type _____

Musculoskeletal Surgery
☐ Type _____

Genitourinary Surgery
☐ Type _____

Gastrointestinal Surgery
☐ Type _____

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PAST SURGICAL HISTORY CONTINUED

Gynecological Surgery

☐ Type _____

Other Surgery:

☐ Type _____

Vascular Surgery

☐ Carotid Surgery
☐ Aneurysm Surgery
☐ Angioplasty/Stents
☐Right leg ☐Left leg ☐Both
☐ Amputation
☐Right leg ☐Left leg ☐Both
☐ Vein Ablations
☐Right leg ☐Left leg ☐Both

FAMILY MEDICAL HISTORY

If you have a family history of any of the following, please indicate which family member in the space provided.

Cancer
Who & Type? _____

Heart Disease
Who & Type? _____

Diabetes
Who & Type? _____

Renal
Who & Type? _____

Vascular
Who & Type? _____

Respiratory
Who & Type? _____

Psych/Social
Who & Type? _____

Other (explain): _____
Who & Type? _____

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SOCIAL HISTORY

Marital Status: _____

Tobacco Use:

☐ Never a smoker
☐ Current every day smoker
Packs per day: _____
☐ Former Smoker
Year quit: _____

Alcohol Use: ☐ Yes ☐ No

☐ Heavy Drinker
☐ Social Drinker

Drug Use: ☐ Yes ☐ No

Substance: _____

Comments: _____

Vein Complaint Form

Patient Name: _____ Patient DOB: _____

PATIENT SYMPTOMS

	Right	Left	Both
Edema/Swelling	☐	☐	☐
Varicose Veins	☐	☐	☐
Tiredness/Fatigue	☐	☐	☐
Burning	☐	☐	☐
Itching	☐	☐	☐
Cramping	☐	☐	☐
Restless Legs	☐	☐	☐
Ulcers	☐	☐	☐
Rash/ irritation	☐	☐	☐
Skin Discoloration	☐	☐	☐
Bulging Veins	☐	☐	☐
Bleeding	☐	☐	☐
Pain/Aches	☐	☐	☐
Heaviness/Fullness	☐	☐	☐
Throbbing	☐	☐	☐
Pain when walking (legs)	☐	☐	☐
Numbness	☐	☐	☐
Coldness of feet	☐	☐	☐

Symptoms interfere with daily life:

☐ Right ☐ Left ☐ Both

Aggravating Factors

- ☐ Prolonged sitting
- ☐ Prolonged standing
- ☐ Walking/Exercise
- ☐ Hot weather
- ☐ Menstrual Cycle/Pregnancy

Relieving Factors

- ☐ Elevation ☐ Sitting down/resting
- ☐ Walking/Exercise ☐ Cold packs
- ☐ Wrapping/compression stockings
- ☐ Massage ☐ Warm soaks/heating pad
- ☐ Hot baths/shower ☐ Medication

QUALITY OF PAIN

☐ Sharp ☐ Dull ☐ Pulling ☐ Throbbing

☐ Achy ☐ Tightness ☐ Heavy ☐ Discomfort

Compression Stockings

Regular use of prescribed: ☐ 15/20 ☐ 20/30 ☐ 30/40

Time(months): ☐ 0-3 ☐ 3-6 ☐ 6-12 ☐ 12-24

Previous history of:

	R	L	Both	Recurrent		R	L	Both	Recurrent
Venous Insufficiency	☐	☐	☐	☐	Lung Clots	☐	☐	☐	☐
Bleeding	☐	☐	☐	☐	Ulcer	☐	☐	☐	☐
Blood Clots	☐	☐	☐	☐	Phlebitis *(Vein Inflammation)*	☐	☐	☐	☐

History of the following treatment(s):

	R	L	Both		R	L	Both
Vein Procedure	☐	☐	☐	Vein Removal	☐	☐	☐
Vein Stripping	☐	☐	☐	Injections	☐	☐	☐

Provider Notes: _____

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