Vein Centers Of Connecticut

PROUD MEMBER OF
Midstate RADIOLOGY ASSOCIATES LLC

22 Pine Street, Suite 210, **Bristol**, CT 06010 · 863 North Main Street Ext., **Wallingford**, CT 06492
Phone: 860-229-VEIN (8346) · Fax: 860-826-1391 · www.ctveindocs.com

This form is to introduce you to our facility and to help us better serve you. We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

Please complete the following:

Name:_____ Date of Birth: ___ / ___ /___

Address:_____

City / State / Zip _____

Home Phone # _____ Cell Phone # _____

Email Address:_____

How did you hear about us? : _____

Which phone # may we use to contact you? _____

Can we leave a message at this number?: _____

May we speak with your spouse / significant other / family regarding your treatment? _____

May we contact you via Email? ☐ Yes No Email address:_____

Would you like to receive our monthly promotional offers via email (you may opt out at any time)?
☐ Yes ☐ No

Please advise any additional requests for privacy below:

_____

_____

Print Client Name: _____

Signature of Client: _____ _____
(Client/ Parent or Guardian if patient is under 18) Date

Please print name if you are the Parent/Guardian:_____

Vein Centers Of Connecticut

PROUD MEMBER OF Midstate RADIOLOGY ASSOCIATES LLC

22 Pine Street, Suite 210, **Bristol**, CT 06010 · 863 North Main Street Ext., **Wallingford**, CT 06492
Phone: 860-229-VEIN (8346) · Fax: 860-826-1391 · www.ctveindocs.com

Personal Profile and Medical History:

Females: Are you pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

Medical History:

Please complete the following items and always inform of us any changes in your medical history and / or medications.

Medications (prescription and over the counter drugs, vitamins, herbs, and / or supplements):

_____

_____

***ALLERGIES** to any medications?* _____

_____

Symptoms: (please check all that apply)

- ☐ Acne
- ☐ Bleeding Disorders
- ☐ Burns/skin grafts
- ☐ Claustrophobia
- ☐ Seizures
- ☐ Shingles
- ☐ Skin Cancer
- ☐ Tattoos
- ☐ Thyroid Disease
- ☐ Vitiligo
- ☐ Permanent Makeup
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Hirsutism
- ☐ Hormone Replacement Rx
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Endocrine Disorders
- ☐ Epidermolysis Bullosa
- ☐ Heart Disease
- ☐ Hemorrhoids
- ☐ HIV/AIDS
- ☐ Precocious Puberty
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Implants
- ☐ Kaposi's Sarcoma
- ☐ Keloid Scars
- ☐ Lupus
- ☐ Polycystic Ovary Disease
- ☐ Port-Wine Stain
- ☐ Herpes
- ☐ Other:_____

Surgeries: _____

Please list any other pertinent medical information:_____

_____

_____

Vein Centers Of Connecticut

PROUD MEMBER OF Midstate RADIOLOGY ASSOCIATES LLC

22 Pine Street, Suite 210, **Bristol**, CT 06010 · 863 North Main Street Ext., **Wallingford**, CT 06492
Phone: 860-229-VEIN (8346) · Fax: 860-826-1391 · www.ctveindocs.com

PERSONAL PROFILE & MEDICAL HISTORY – Continued:

1. Have you used Accutane in the last 6 months? Yes No
   a. If yes, how recently?_____
2. Are you currently using glycolic acid or Retin A? Yes No
3. What products are you currently usng on your skin?

   a. Describe:_____

4. Do you have any active skin diseases or infections in the area to be treated? Yes No
5. Are you allergic to latex, lidocaine, or any lotions? Yes No
6. Have you had any permanent cosmetic tattooing to the area to be treated? Yes No
7. Do you have any metal or other implants? Where?_____ Yes No
8. Have you had any previous laser treatment or other skin treatments to the area to be treated? Describe:_____ Yes No
9. Are there any moles with hair in the area to be treated? Yes No
10. Do you have history of skin breakouts? Yes No
11. Do you have any scarring as a result from your breakouts/acne? Yes No
12. Have you been exposed to sun with the last 4 to 6 weeks? Yes No

    a. If yes, approximate date of last exposure _____ / _____ / _____
13. Do you use tanning beds? If yes, date of last use _____ / _____ / _____ Yes No
14. Do you burn easily in moderate sunlight? Yes No
15. Do you blush when nervous? Yes No
16. Do you frequently experience flakiness, tightness or dryness? Yes No
17. Do you use sunscreen on a regular basis? Yes No
18. Have you waxed, used depilatories, bleaches or other chemicals? Yes No
19. How much water do you normally consume daily? _____
20. Do you smoke? Yes No
21. Do you wear contact lenses? Yes No
22. Do you exercise? Yes No
23. Have you had microdermabrasion? Yes No
24. Have you had any chemical peels? Yes No
25. Have you had laser resurfacing? Yes No
26. Do you have wrinkle concerns? Yes No
27. Do you have scarring concerns? Yes No
28. Do you have sun damage concerns? Yes No
29. Do you have pigmentation concerns? Yes No
30. Do you have broken capillary concerns? Yes No

Vein Centers Of Connecticut

PROUD MEMBER OF
Midstate RADIOLOGY ASSOCIATES LLC

22 Pine Street, Suite 210, **Bristol**, CT 06010 · 863 North Main Street Ext., **Wallingford**, CT 06492
Phone: 860-229-VEIN (8346) · Fax: 860-826-1391 · www.ctveindocs.com

What services are you most interested in?_____

_____

Name of family doctor:_____ Phone # _____

I confirm that the answers to the questionnaire are true and correct. I also confirm that the consultant has clarified any questions I did not understand.

Print Patient Name:_____

Signature:_____ **Date:** _____
(Parent or Guardian if patient is under 18)

Physician's Signature:_____

---

*I understand that payment for any cosmetic services or products is expected in full at the time of service.

Signature:_____ **Date:** _____
(Parent or Guardian if patient is under 18)

Vein Centers Of Connecticut

PROUD MEMBER OF
Midstate RADIOLOGY ASSOCIATES LLC

22 Pine Street, Suite 210, **Bristol**, CT 06010 · 863 North Main Street Ext., **Wallingford**, CT 06492
Phone: 860-229-VEIN (8346) · Fax: 860-826-1391 · www.ctveindocs.com

Patient Photograph Release Form

PATIENT INFORMATION

*Patient's Name*_____*Date of Birth:*_____
Last *First* *MI*

I hereby acknowledge that photographs may be taken of me or parts of my body before and after treatment(s). The photographs will be taken by one of the members of the Vein Centers of Connecticut medical staff. I hereby give my consent for Vein Centers of Connecticut to use the photographs under one of the following circumstances.

Please initial one of the following:

_____**Internet:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Vein Centers of CT can be used on the company's website in order to inform the public about varicose vein and/or aesthetic treatment methods offered at Vein Centers of CT. Further, I release and discharge Vein Centers of CT, any employees of Vein Centers of CT, and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

_____**All Media:** Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Vein Centers of CT, can be used in any print or broadcast media, including, but not necessarily limited to newspapers, pamphlets, educational films, internet, and television, in order to inform the public about varicose vein and/or aesthetic treatment methods offered at Vein Centers of CT.
Further, I release and discharge Vein Centers of CT, any employees of Vein Centers of CT; and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

_____**Medical Care Only:** Photographs taken of me or parts of my body can be used solely for the purpose of my medical care at Vein Centers of CT. I authorize Vein Centers of CT to release these photos if so requested by my insurance carrier for the purpose of determining medical necessity in order to obtain required prior authorization and/or claim reimbursement. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at Vein Centers of CT.

By signing this form, I acknowledge my consent as initialed above, and I further recognize that this form will supersede any other photo consent forms with a date prior to the date written below may be revoked at any time by written request or by completion of a new form.

_____ _____
Signature (Patient or Parent/Guardian if Patient is under 18) *Date*

Vein Centers Of Connecticut

PROUD MEMBER OF Midstate RADIOLOGY ASSOCIATES LLC

22 Pine Street, Suite 210
Bristol, CT 06010
860-229-8346

860 North Main St. Ext.
Wallingford, CT 06492
860-229-8346

www.CTveindocs.com

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **DOB:** _____

E-mail address: _____

We will not share your e-mail address or use it to transmit medical or clinical information.

1) I have been offered a copy of the Vein Centers "Notice of Privacy Practices" posted in the office and on the website.

2) I give my permission for the **Vein Centers of Connecticut** to contact me at the following numbers and to leave a message on my answering machine or voicemail (if none, please leave blank):

MESSAGES CONCERNING APPOINTMENTS Phone (___) _____
Home / Mobile / Work (circle)

MESSAGES CONCERNING MEDICAL INFO Phone (___) _____
(For example lab or test results) Home / Mobile / Work (circle)

I give my permission for the Vein Centers of CT to communicate with the following persons regarding my health care:

Name: _____ **Phone #:**_____ **Relationship:** _____

Name: _____ **Phone #:**_____ **Relationship:** _____

This authorization will be valid from this date until written notice of changes and/or cancellations is received in the offices of HHC Medical Group.

3) **Assignment of Benefits**: I authorize direct payments from my primary and/or secondary insurance carrier to the **Vein Centers of Connecticut** or its designated billing agent for services rendered.

Guarantee of Payment/Precertification By Insurer: I will be responsible for payment of all non-covered services. If my health plan does not consider Vein Centers of Connecticut to be a participating provider or the care provided medically necessary, I will accept full financial responsibility for payment of incurred charges. The Vein Centers of CT will seek pre-authorization when required. I understand that if my insurance has a pre-certification or authorization requirement, it is my responsibility to notify carrier of services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payment and I will be responsible for all balances.

Consent for Treatment: I do voluntarily consent to the rendering of such care as the provider and/or medical personnel deem necessary for my health and wellbeing. This consent shall include medical examination and diagnostic testing as well as ambulatory surgical procedures. I acknowledge that neither the provider nor the office personnel has made any guarantee or assurance as to the results that may be obtained.

4) To better provide for your care and improve your patient experience, we seek to coordinate and integrate our care delivery through our new electronic medical record (EMR). We share access to the EMR across Midstate Radiology Associates, Hartford HealthCare (HHC) and HHC affiliated practices. The current EMR does not functionally allow us to limit access to your medical record by blocking it from HHC or affiliates staff.

By signing this authorization form, you understand and agree that you are allowing disclosure of and access to all your health information, including information relating to alcohol and substance abuse/use, mental or behavioral health, and HIV/AIDS. If health information about you includes any of these types of information, you specifically authorize the release of such information to, and access to such information by, all authorized health care providers and professionals at HHC and affiliates. You may revoke this authorization at any time except to the extent it has already been relied upon. Unless earlier revoked, this consent will expire if and when the Vein Centers of Connecticut EMR no longer exists.

We no longer use a paper system for documenting patient care, and we hope that you will find the EMR system facilitates your care across Hartford HealthCare. If you don't want your medical information stored in our EMR, we unfortunately cannot care for you in this practice. If you have any questions, please do not hesitate to ask us about our EMR.

☐ I choose to opt out of the EMR and decline to receive care at the Vein Centers of Connecticut.

_____ _____

Patient Signature **Date** **Parent or Guardian Signature / Date**
If patient is a minor (under age of 18) or has a guardian/conservator