Vein Centers Of Connecticut

PROUD MEMBER OF Midstate RADIOLOGY ASSOCIATES LLC

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

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

www.CTveindocs.com

PATIENT INFORMATION:

DATE OF SERVICE: _____

PATIENT NAME: _____ DOB: _____

STREET ADDRESS: _____ HOME PHONE: _____

CITY: _____ STATE: _____ ZIP: _____ CELL PHONE: _____

REFERRING PHYSICIAN: _____ PRIMARY PHYSICIAN: _____

PHARMACY NAME/ADDRESS: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

IDENTIFICATION#:_____ IDENTIFICATION#:_____

GROUP#:_____ GROUP #:_____

POLICY HOLDER/DOB: _____ POLICY HOLDER/DOB: _____

MEDICATIONS & HISTORY: LIST ALL CURRENT MEDICATIONS- PRESCRIPTIONS, OVER-THE-COUNTER DRUGS SUCH AS ASPIRIN, EXCEDRIN, ETC. AS WELL AS ANY VITAMINS & HERBAL SUPPLEMENTS.

_____ _____

_____ _____

_____ _____

DO YOU CURRENTLY SMOKE: _____ YES _____ NO _____ NEVER

ALLERGIES: _____ **REACTION:** _____

DO YOU HAVE ANY PROBLEM WITH LOCAL ANESTHESIA LIKE NOVACAINE: _____ YES _____NO

HAVE YOU HAD VEIN TREATMENT PREVIOUSLY: _____ YES _____ NO IF YES, WHEN: _____

CURRENT VEIN/LEG PROBLEMS: _____ LEFT _____RIGHT _____ BOTH

PLEASE CHECK ANY SYMPTOMS BELOW THAT APPLY TO YOUR VEIN PROBLEM:

Symptom:	**Right**	**Left**	**Symptom**:	**Right**	**Left**
Pain	_____	_____	Burning	_____	_____
Achiness	_____	_____	Itching	_____	_____
Restlessness	_____	_____	Bleeding	_____	_____
Heaviness	_____	_____	Swelling	_____	_____

Please add any additional symptoms: _____

SIGNATURE: _____**DATE:** _____

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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**

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Patient_____ Date of Birth_____

APPOINTMENTS AND CANCELLATIONS

When scheduling your appointment, we reserve time for your consultation, procedures, and follow-up visits. We assure that the doctor, sonographer, or vascular technologists as well as the appropriate equipment and exam room are available and prepared for your examination and treatment. We call to confirm your appointment a few days ahead of schedule.

To ensure the care of all our patients and the efficiency of our office, we require **at least 72 hours** notice to cancel or reschedule a procedure- Endovenous Laser Ablation, Radiofrequency Ablation, Venaseal Closure, or Ambulatory Phlebectomy. A Cancellation Fee of **$150** will be charged for missed or last-minute changes to these procedure appointments. This fee is not covered by insurance and would have to be paid before scheduling another appointment.

Patient Signature_____Date_____

PATIENT PHOTOGRAPH RELEASE

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.

_____**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, radio 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 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*

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Name:_____Date:_____

Please indicate if you are….

□ Existing patient □ New patient

Have you recently seen or heard our Vein Centers of CT ads?

□ YES □ NO

If "yes", please check **all** that apply:

Print - □ Newspaper □ Magazine □ Direct Mailing

Radio - □ Country 92.5 □ 96.5 □ Lite 100.5

TV - □ CH8 ABC □ CH3 CBS □ Local Channel

Internet - □ Online Search □ Social Media

Please indicate if you were referred to our office by…

□ Physician's Name _____

□ Family/Friend

□ Other _____

We send one or two emails per month with aesthetic promotions and the newest research in treating vein disease.

May we add you to our email list □ Yes □ No

Email address: _____

We appreciate you choosing **Vein Centers of Connecticut**, *and we look forward to taking care of your medical and aesthetic needs.*