Steven L. Kaufman, M.D., Ph.D., F.A.C.S.
1136 East Stuart Street, Suite 4102, Fort Collins, CO 80525
phone: (970) 498-8346 or toll free: (866)884-VEIN fax: (970) 419-8346 www.totalvein.net

To Our New Patient:

We at Total Vein Care wish to take a moment to welcome you to our practice and thank you for choosing us. We look forward to helping you address your vein health concerns, and we will do all we can to ensure you a successful resolution.

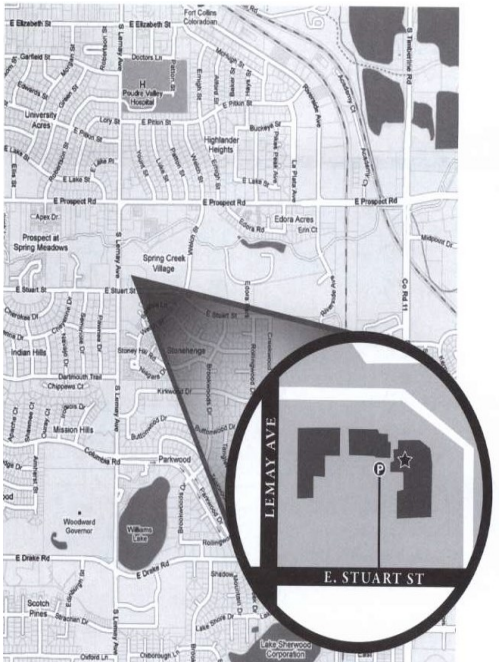
Our goal is to provide the highest quality of care possible in a friendly and caring environment. We appreciate the trust and confidence you have placed in us.

In an effort to make your visit a pleasant and efficient one, enclosed are several patient information forms to be completed before your initial appointment.

If your insurance company requires a referral or authorization for you to see a specialist, please contact your primary care physician for the necessary referral or authorization.

Your visit or co-pay is payable at the time of service by cash, check, or credit card. If you have insurance, please bring your insurance card and a photo ID to your first visit so that we can bill your insurance company.

Appointments can be rescheduled by calling our office at **970-498-8346.** We request the courtesy of 24 hours notice for cancellations. Please keep in mind we have patients waiting sometimes for weeks to be seen. A last minute cancelled appointment or just not showing up prevents us from being able to offer that appointment time to someone else.



We look forward to seeing you at our office. Thank you for giving us the opportunity to serve you.

Sincerely,

Steven L. Kaufman, M.D., Ph.D., F.A.C.S

Patient Registration
Please fill out completely

Patient Information

*Today's Date*_____

Last Name_____ First Name _____

Gender _____ Birthdate _____/_____/_____ Age_____ SS#_____-_____-_____

Married ☐ Single ☐ Divorced ☐ Widowed ☐ Ethnicity: _____

Driver's License # _____ State: _____

Address _____ City_____ State ____ Zip _____

Home Phone _____ Cell _____ Email_____

Employer _____ Employer Phone _____

Primary Physician _____ City _____ Phone_____

Referring Physician _____ City _____ Phone_____

How did you hear about Total Vein Care?

Referred by my doctor ☐ From a family member ☐ Internet ☐ (If so, where?) _____

Insurance Information

Financial Guarantor (Policy holder or person other than patient guaranteeing payment)

Last Name _____ First Name _____

Gender _____ Birthdate _____/_____/_____ Age_____ SS#_____-_____-_____

Relationship to patient _____ Driver's License # _____

Address _____ City_____ State ____ Zip _____

Home Phone _____ Cell _____ Email_____

Employer _____ Employer Phone _____

Primary Insurance

Insurance _____ Member/Policy # _____ Group # _____

Policy Holder's Name _____ Phone # _____

Secondary Insurance

Insurance _____ Member/Policy # _____ Group # _____

Policy Holder's Name _____ Phone # _____

Emergency Contact (Close friend or relative that we can contact in an emergency)

Name _____ Phone _____ Relationship _____

Signature of Patient, Insured or Guarantor_____

Initials:_____ (The parties to this agreement acknowledge that signing their initials in place of a signature (including an electronic copy) may be used for any and all purposes for which the original signature may have been used.

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FORT COLLINS, CO. 80525

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the **Notice of Privacy Practices.**

I have been made aware of the privacy policies of Total Vein Care and have received (or reviewed or been given the option to receive and review) a copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name_____
(Print)

Name of person you approve to receive your personal information _____
(Print)

Relationship to Patient_____

Contact Consent

I wish to be contacted in the following manner, including automated appointment reminders (check all that apply), be sure to fill in phone numbers.

- ☐ Home Telephone #: _____
  - ☐ Can leave a message with detailed information
  - ☐ Leave a message with a call back number only
- ☐ Work Telephone #: _____
  - ☐ Can leave a message with detailed information
  - ☐ Leave a message with a call back number only
- ☐ Written Communication
  - ☐ Okay to mail to my home address
  - ☐ Okay to EMAIL: _____

Signature_____

Initials:_____ **(**The parties to this agreement acknowledge that signing their initials in place of a signature (including an electronic copy) may be used for any and all purposes for which the original signature may have been used.

Date_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this **Notice of Privacy Practices** Acknowledgement**,** but was unable to do so as documented below:

Date: _____ Initials:_____ Reason: _____

Office Visit Acknowledgement

Dear New Patient,

In an effort to ensure that our patients are fully informed of our office policies please read the below statement, then sign and date.

I, _____,
understand that this appointment is a New Patient Ultrasound and Consultation with Dr. Steven L. Kaufman, M.D. and/or Heather Roth, N.P., Total Vein Care. I acknowledge that this is not a Free Screening and will be billed to my insurance company. I also understand that Total Vein Care does not have any control over how much my insurance company compensates and what will be applied to my deductible and/or coinsurance. I am aware that I will be responsible for any remaining balance that is not paid by my insurance company.

Signature: _____

Initials:_____ (The parties to this agreement acknowledge that signing their initials in place of a signature (including an electronic copy) may be used for any and all purposes for which the original signature may have been used.

Witness: _____

Date: _____

Financial Policy

Total Vein Care is dedicated to providing you the best care possible. If you have health insurance, we are committed to helping you receive your maximum allowable benefits. Therefore:

- **As a courtesy**, we will attempt to verify your benefits with your insurance company via phone, and when necessary, we will obtain pre-authorization or pre-determination of benefits prior to your procedure. ***You share in the responsibility by knowing what your plan covers and for verifying your benefits with your insurance company.*** We will do our best to obtain a financial estimate regarding your responsibility of procedure charges, and this information is based on the verbal information obtained from your insurance company. Because these are ***estimates only***, the final cost for services is not fully known until the claim has been adjudicated by your insurance company. The estimated charges that are your responsibility pursuant to your insurance policy are due the ***day of your procedure***. We accept cash, checks, MasterCard, Visa, Discover and American Express. We also accept Care Credit.
- I request that payment of authorized insurance and Medicare benefits be made payable to Total Vein Care on my behalf for services furnished to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. In the event that my account is turned over to a collection agency, I agree to pay all reasonable costs of collection and understand that I may no longer be a patient at this office. I understand and agree to pay a returned check charge of $25.00 for each check that is returned for any reason. In case of default, I agree to pay any and all costs of collecting this account including, but not limited to, attorney fees and court costs.
- Please note the estimate we obtain is for your ***procedure only***. It does **NOT** include **ANY** charges that may occur from the New Patient visit or Post-Op appointments. Again, we have no control over how the insurance companies pay or apply charges.
- TVC will file an insurance claim with your insurance company and an explanation of benefits will be sent to you and TVC. Any overpayment by you will be refunded and any amount owed by you will be due at this time. We emphasize our relationship is with you and not your insurance company. In the event that your insurance carrier denies payments or pays less than expected, you are responsible for any balance on your account. The insurance company's decisions and payment amounts are not within our control; however, we are happy to assist you in the insurance appeal process. If it becomes necessary to collect your unpaid balance using a collection agency, you will also be responsible for any charges incurred as a result of the collection activity (usually 20-50% of unpaid amount) as well as any legal or court fees incurred.
- Self-pay and previous balance amounts are due and payable at the time of service. Insurance co-payments are mandated by your insurance company and MUST be paid at each visit. Patients with insurance claims pending will be sent statements for full amount due until the account is satisfied. I agree that if the insurance company denies benefits for some reason, I am responsible for the full amount owed for services provided.
- I authorize the holder of medical information about me to release any and all information to Centers for Medicare or Tricare Services, its agents, my insurance carrier(s), or other entities as needed to determine these benefits or the benefits or the benefits for my dependents or myself. If I have health insurance coverage under an HMO, I authorize Total Vein Care to release information concerning any diagnosis and treatment to my primary care or referring physician after each visit.
- Failure to cancel your office visit within 24 hours of your scheduled appointment will result in a $50 charge. Failure to cancel your surgery within 48 hours of your scheduled surgery will result in a $300 charge. Any cancellation fees are due by you and are not billable to your insurance company.

AGREEMENT

I, (print name) _____understand that I am financially responsible for services rendered and any balance after insurance processing. I have read and understand the terms and conditions of my financial obligation and agree to honor the office policies outlined above.

Patient Signature: _____Date:_____

Initials:_____ (The parties to this agreement acknowledge that signing their initials in place of a signature (including an electronic copy) may be used for any and all purposes for which the original signature may have been used.

Vein Health History

Please Check All That Apply:

	Right	Left
Heaviness/Fatigue	☐	☐
Pain/Discomfort	☐	☐
Severity of Pain	☐ Mild (1-3) ☐ Moderate(4-6) ☐ Severe(7-10)	
Quality of Pain	☐ Achy ☐ Crampy ☐ Dull ☐ Sharp ☐ Throbbing ☐ Tenderness	
Spider Veins	☐	☐
Varicose Veins	☐	☐
Swelling/Edema	☐	☐
Severity of Edema	☐ Mild ☐ Moderate ☐ Severe	
Skin Discoloration	☐	☐
Restless Legs	☐	☐
Itching	☐	☐
Burning	☐	☐
How long have you had symptoms?	_____	
Is one leg worse than the other?	☐ R ☐ L ☐ Same	

Leg Ulcers: *(Check All That Apply)*	**Right**	**Left**	How long has ulcer(s) been open? _____	
Active:	☐	☐		
Healed:	☐	☐	How long did it take to heal?	
Bleeding from veins:	☐	☐		
How long since last episode?	_____		Require Transfusion? ☐ Yes ☐ No	
Vein History: *(Check all that apply)*	**Right**	**Left**		
Phlebitis	☐	☐	How long ago? _____	# of episodes: _____
Deep Vein Thrombosis	☐	☐	How long ago?_____	# of episodes: _____
Pulmonary Embolus	☐	☐		
Trauma to Legs	☐	☐		
Prominent labial/vulvar veins	☐	☐		
Prominent abdominal veins	☐	☐		
Pelvic pain w/ prolonged sitting	☐	☐		
Pelvic pain w/ intercourse	☐	☐		
Have you had a work-up for clotting problems? ☐ Yes ☐ No				
Diagnosis of Lymphedema? ☐ Yes ☐ No				

Symptoms are worsened by:

- ☐ Prolonged standing
- ☐ Prolonged sitting
- ☐ Walking/Exercise
- ☐ Heat
- ☐ Premenstrual
- ☐ Pregnancy
- ☐ After Exercise

Symptoms interfere with my daily living:

- ☐ Work
- ☐ Leisure Activity
- ☐ Routine Activity
- ☐ Air Travel
- ☐ Long car ride
- ☐ Childcare
- ☐ Sleep

Conservative measures attempted to control symptoms:

- ☐ Leg Elevation
- ☐ Compression Stockings
- ☐ Exercise
  -Times per week _____
- ☐ Warm Soaks
- ☐ Weight loss
- ☐ Cold Soaks
- ☐ Avoidance of prolonged sitting/standing

****Compression Stocking Use:**

First Used: _____ Use Currently? ____

# of years used: ____

Months used continuously in past year: ____

Compression Strength:

- ☐ 15-20 mm
- ☐ 20-30 mm
- ☐ 30-40 mm

☐ Pain Medications:

___ Advil/Ibuprofen Dose: ____mg ____ X per day
___ Tylenol Dose: ____mg ____ X per day
___ Other Dose: ____mg ____ X per day

*****At least 3 months recent continuous stocking use is required for ablation preauthorization for most insurances*****

I have achieved relief of symptoms with:

- ☐ Leg Elevation
- ☐ Exercise
- ☐ Weight Loss
- ☐ Avoid prolonged sitting or standing
- ☐ Therapeutic compression stockings
- ☐ Warm Soaks
- ☐ Cold Soaks
- ☐ Pain Medication

Prior Vein Treatments: If so, when? _____ By whom? _____

- ☐ Radiofrequency Ablation
- ☐ VenaSeal Ablation
- ☐ Clarivein Ablation
- ☐ Laser Ablation
- ☐ Varithena Microfoam Injection
- ☐ Phlebectomy
- ☐ Ultrasound Guided Sclerotherapy
- ☐ Vein Stripping/High Ligation
- ☐ Injection Sclerotherapy
- ☐ Other Treatment:_____

Medical History:	**Years**		**Years**		**Years**
☐ Atrial Fibrillation (A-Fib)	_____	☐ Easy Bruising	_____	☐ Migraine Headaches	_____
☐ Aortic Aneurysm	_____	☐ Gout	_____	☐ Migraine Headaches w/ Aura	_____
☐ Anemia	_____	☐ Heart Disease	_____	☐ Osteoporosis	_____
☐ Arthritis	_____	☐ Coronary Artery Disease	_____	☐ Pace Maker	_____
☐ Asthma	_____	☐ Heart Valve Disease	_____	☐ Peripheral artery disease	_____
☐ Atherosclerosis	_____	☐ Heart Murmur	_____	☐ Patent Foramen Ovale	_____
☐ Blood disorders/bleeding	_____	☐ Hemorrhoids	_____	☐ Peptic Ulcer Disease	_____
☐ Blood Clot	_____	☐ Hepatitis Type ___	_____	☐ Prosthetic Heart Valve	_____
☐ Blood Transfusion	_____	☐ High Blood Pressure	_____	☐ Pulmonary Embolus	_____
☐ Emphysema/ COPD	_____	☐ High Cholesterol	_____	☐ Seizures	_____
☐ Cancer of _____	_____	☐ HIV	_____	☐ Stroke/TIA	_____
☐ Carotid Disease	_____	☐ Hormone Problems	_____	☐ Superficial Thrombophlebitis	_____
☐ Cirrhosis	_____	☐ Irritable Bowel Syndrome	_____	☐ Thyroid Disease	_____
☐ Crohn's Disease	_____	☐ Kidney or Bladder Disease	_____	☐ Trauma to Leg(s)	_____
☐ Depression	_____	☐ Liver Disease	_____	☐ Ulcerative Colitis	_____
☐ DVT	_____	☐ Lumbar Spine Disease	_____	☐ Thyroid Disease	_____
☐ Diabetes	_____	☐ Lupus	_____	☐ Other Medical Problems:	

<u>Female Medical History:</u>

Pregnancies	How Many? _____	☐ Pregnant now/planning pregnancy soon
Vaginal Deliveries	How Many? _____	☐ Currently Breastfeeding
C-Section	How Many? _____	☐ Contraceptives/Birth Control
Stillbirth/Miscarriage	How Many? _____	☐ Hormone Therapy

Vaccination History:

Influenza Vaccine? ☐ Yes ☐ No If so, when? _____
Pneumonia Vaccine? ☐ Yes ☐ No If so, when? _____
COVID-19 Vaccine? ☐ Yes ☐ No *Brand*: _____ # of doses:_____ Dates of doses:_____ _____

Surgical History:	**Year**		**Year**		**Year**
☐ Appendectomy	_____	☐ Hernia Repair	_____	☐ Prostate Surgery	_____
☐ Breast Surgery ☐ R ☐ L	_____	☐ Hip Replacement ☐ R ☐ L	_____	☐ Shoulder Surgery ☐ R ☐ L	_____
☐ C-Section	_____	☐ Hysterectomy	_____	☐ Skin Cancer Surgery	_____
☐ CABG	_____	☐ Knee Replacement ☐ R ☐ L	_____	☐ Thyroid Surgery	_____
☐ Gallbladder	_____	☐ Lung Resection ☐ R ☐ L	_____	☐ Tonsillectomy	_____
☐ Hemorrhoidectomy	_____	☐ Plastic Surgery	_____	☐ Other Surgery:	

Family History:

Is there a history in your **family** of spider or varicose veins?

☐ Mother ☐ Siblings ☐ Grandparents

☐ Father ☐ Aunt/Uncle ☐ Child

Is there a history in your **family** of deep venous thrombosis, stroke or clotting disorders? ***(Note which)***

☐ Mother _____ ☐ Siblings _____ ☐ Grandparents _____

☐ Father _____ ☐ Aunt/Uncle _____ ☐ Child _____

Do any major medical problems run in your family? Include consideration of the following: ***diabetes, heart disease, respiratory problems, high blood pressure, kidney disease, cancer, bleeding problems, breast problems, thyroid problems, thyroid problems, or gastrointestinal problems****. Please list your primary relatives and the status of their health:*

	Age	**Health Problems**	**If deceased, age at death**	**Cause of death**
Father				
Mother				
Siblings				
Brother ☐ Sister ☐				
Brother ☐ Sister ☐				
Brother ☐ Sister ☐				
Children				

Social History:

Marital Status:	☐ Single	☐ Married	☐ Divorced	☐ Widowed
Children:	☐ Yes ☐ No	Number of Children: ___		
Occupation:	_____		☐ Full-Time	☐ Part-Time
Job w/ Prolonged:	☐ Heavy Lifting	☐ Repetitive Movement	☐ Standing	
	☐ Moderate Lifting	☐ Sitting	☐ Walking	
Alcohol Use:	☐ Never	☐ Yes	☐ Drinks/week	☐ # Per Occasion
Street/Recreational Drug Use:	☐ Never	☐ Within last 90 days		
Smoking/Tobacco Use:	☐ Never	☐ Quit ___ # of years ago	☐ Yes ___ Packs/day	Total Years Smoked _____
_____ Age Started	Have you ever thought of quitting? ☐ Y ☐ N		__Are you ready to quit? ☐ Y ☐ N	

Medication Allergies: ☐ None ☐ Yes

If yes, to what and what was your reaction?

_____

_____

Prior reaction to Lidocaine ☐ Iodine ☐ or Latex ☐? ☐ None If yes, reaction? _____

Medications (☐ None **)** *(More lines for addition medications on next page)*

Medication Name	*Dose*	*# Per Day/Frequency*	*Reason for Taking*

Review of Systems *(Please check all that apply):*

Constitutional Symptoms:
- ☐ Problems w/ general health
- ☐ Recent weight loss
- ☐ Recent weight gain
- ☐ Fever
- ☐ Fatigue
- ☐ Night Sweats

Eyes
- ☐ Decreased vision
- ☐ Loss of vision
- ☐ Discharge
- ☐ Double vision
- ☐ Eye Pain
- ☐ Floaters
- ☐ Red Eyes
- ☐ Tears

ENT/Mouth
- ☐ Sore throat
- ☐ Hoarse voice
- ☐ Hearing loss
- ☐ Tinnitus (ringing in ears)
- ☐ Sinus problems

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Mood swings
- ☐ Insomnia
- ☐ Hyperactivity

Respiratory:
- ☐ Chronic/Freq. cough
- ☐ Cough/spit up blood
- ☐ Wheezing

Gastrointestinal
- ☐ Difficulty/pain swallowing
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting of blood
- ☐ Duo/gastric ulcer
- ☐ Indigestion
- ☐ Jaundice
- ☐ Hemorrhoids
- ☐ Rectal bleeding
- ☐ Pain on defecation
- ☐ Black tarry stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Changes in bowel habits
- ☐ Abdominal pain

Endocrine:
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Altered menses
- ☐ Fatigue
- ☐ Excessive thirst
- ☐ Excessive urination
- ☐ Steroid use
- ☐ Blood in urine
- ☐ Pain/burning w/ urination
- ☐ Frequent/reoccurring bladder infections
- ☐ Kidney infections
- ☐ Difficulty passing urine
- ☐ Urinating more than 1 time per night
- ☐ Incontinence

Cardiovascular:
- ☐ Chest Pain
- ☐ SOB with walking
- ☐ SOB while lying down
- ☐ Swelling in legs/ankles
- ☐ Palpitations

GU- Male:
- ☐ Infection of penis
- ☐ Impotence
- ☐ Enlarged prostate
- ☐ Penile discharge
- ☐ Infected prostate
- ☐ Infection of testicle

GU- Female:
- ☐ Irregular periods
- ☐ Vaginal discharge
- ☐ Nipple discharge
- ☐ Hernia

Musculoskeletal
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Ankle Pain
- ☐ Shoulder Pain
- ☐ Wrist Pain
- ☐ Back Pain
- ☐ Muscle spasms
- ☐ Decreased range of motion

Blood/Lymphatic System:
- ☐ Enlarged Lymph nodes
- ☐ Fever
- ☐ Bruising
- ☐ Bleeding Tendencies
- ☐ Chronic Sores

Integument:
- ☐ Rashes
- ☐ Skin lesions
- ☐ Ulcers
- ☐ Itching
- ☐ Heavy sweating
- ☐ Hair loss
- ☐ Easy skin bruising
- ☐ Eczema

Neurological
- ☐ Convulsions
- ☐ Dizziness
- ☐ Fainting spells
- ☐ Loss of consciousness
- ☐ Frequent headaches
- ☐ Migraines
- ☐ Disturbances of vision
- ☐ Disturbances of smell
- ☐ Disturbances of taste
- ☐ Difficulty speaking
- ☐ Involuntary movement
- ☐ Tremors
- ☐ Abnormal numbness
- ☐ Drooping of face
- ☐ Nervousness
- ☐ Mental Illness

Allergy/Immunology:
- ☐ Rashes
- ☐ Itching
- ☐ Hives
- ☐ Recurrent infections
- ☐ Other:

Medication Name	*Dose*	*# Per Day/Frequency*	*Reason for Taking*