LA VEIN CENTER

Larisse K. Lee, MD

Vascular and Endovascular Surgery

PATIENT INFORMATION

Last Name | First | Middle | Sex

Social Security Number | Marital Status

Date of Birth | Age

Home Address

Home Phone | Cellphone | Work Phone

Email Address

What is the best way to reach you?

Occupation | Employer

Work Address

Emergency Contact Name | Relationship | Phone Number

Primary Care Physician Name | Phone | Fax

Address

Referring Physician Name | Phone | Fax

Address

4955 Van Nuys Blvd. Suite 704 Sherman Oaks, CA 91403 P 818.325.0400 F 818.325.0404 www.laveincenter.com

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INSURANCE INFORMATION

Primary Insurance

Company _____ Policy Number _____ Group Number _____

Policy Holder Name _____ DOB _____ Relationship _____

Employer Name _____

Secondary Insurance

Company _____ Policy Number _____ Group Number _____

Policy Holder Name _____ DOB _____ Relationship _____

Employer Name _____

How did you hear about LA Vein Center?

Referred by Doctor _____
Referred by Family/Friend _____
Internet Search _____
Online Review _____
Magazine _____
Newspaper _____
Other _____

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AUTHORIZATIONS AND CONSENTS

Patient Name _____

Date of Birth _____

FINANCIAL POLICY

It is the patient's responsibility to ensure coverage by their insurance. As a courtesy, we will work with your insurance company for approval and billing. Patients are responsible for deductibles, co-insurance amounts, and payments that are not covered by their insurance. Co-payments are required at time of service and will be collected by our staff at check-in. We accept cash, checks, Visa, MasterCard, and American Express. There will be a $40 charge on all returned checks. Should collections become necessary, the patient will pay the LA Vein Center all outstanding charges and costs, including collection fees and reasonable attorney fees, incurred in collecting outstanding payment.

I (the patient) permit payment by my insurance company directly to the LA Vein Center and Larisse Lee MD PC.

I (the patient) understand that I am financially responsible for all charges, whether or not they are covered by my insurance company.

I (the patient) authorize release of any information that is required to process claims.

Signature _____ Date _____

PHOTO CONSENT

I (the patient) authorize medical photos (with my name or identification) to be taken for authorization for procedures from insurance companies. I understand that this is a requirement of many insurance companies.

I (the patient) authorize photos (without my name or identification) to be used for patient education or marketing purposes.

☐ Yes
☐ No

Signature _____ Date _____

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LA Vein Center - Notice of Privacy Practices

This notice describes how your medical information may be used and disclosed. It also describes how you may access your medical information. Please review it carefully.

This notice is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The United States Department of Health and Human Services (HHS) established a Privacy Rule to help insure that personal health care information is protected. The Privacy Rule was created to provide a standard for healthcare providers to obtain their patient's consent for uses and disclosures of health information about the patient, to carry out treatment, payment, or health care operations.

At the LA Vein Center, we respect your right to privacy and we strive to take precautions to protect your privacy and personal medical records. When it is appropriate and necessary, we will provide the minimum information to those who are in need of your health care information. This pertains to treatment, payment, and healthcare operations in order to provide the best care for you. We will obtain written authorization for any other disclosures of your information. We will not share any information for marketing or advertising, without your consent.

You have a right to access your medical records. If you would like us to provide copies, we may charge you a fee for copying and mailing records. You may not be able to get all your medical information in certain special circumstances. If you believe your records are inaccurate or incomplete, you can ask that they be corrected. You can ask for a list of instances when we have disclosed your health information for reasons other than your medical treatment at the LA Vein Center.

We reserve the right to change privacy policies and will inform you in writing of these changes if and when they occur.

If you would like further information, please refer to the United States Department of Health and Human Services at www.hhs.gov/ocr/hipaa/

I hereby acknowledge that I have received a copy of the LA Vein Center Notice of Privacy Practices.

_____
Print Name

_____ _____
Signature Date

LA VEIN CENTER

Consent to Call:

This functionality allows **L.A. Vein Center** to keep track of patient consent to receive automated calls and text messages, including Athena Communicator communications. Receipt of prior written and oral consent is required by **L.A. Vein Center**, per federal regulations. Selecting "No" means the patient will no longer receive Athena Communicator automated calls via their mobile phone.

☐ YES

☐ NO

Consent to Medication History.

The signed consent allows **L.A. Vein Center** to access the patient's current and past medication list.

☐ YES

☐ NO

Patient's Signature Date

Witness' Signature Date

LA VEIN CENTER

L.A. Vein Center's Fee and Insurance Explanation

Thank you for scheduling a new patient appointment. Dr. Larisse Lee at L.A. Vein Center will discuss your diagnosis and treatment options based on your individual situation. These options may include:

- **VENOUS DUPLEX EXAM**- If Dr. Larisse Lee recommends a venous duplex exam this will be completed at the L.A. Vein Center. If your insurance plan requires an authorization/referral, this will need to be obtained before you can proceed with any further medically necessary testing. The test and return office visit to discuss the results may be scheduled the same day if possible, or another day when Dr. Larisse Lee is available. You will be charged with an office consultation when your test results are reviewed with you. Most insurance plans cover venous duplex exams and office consultations, if they are shown to be medically necessary as determined by the insurance company. (Subject to the patient's deductible, co-insurance and out of pocket maximum). Dr. Larisse Lee will also indicate whether your diagnosis and treatment of plan is considered medically necessary or cosmetic.

- **VENOUS SURGERY**- If surgery is recommended, L.A. Vein Center will obtain pre-certification and/ or pre-determination of medical necessity with your insurance company before surgery is scheduled. It is your responsibility to provide L.A. Vein Center with current insurance card(s) and notify our office if you have any changes involving your insurance plan. Venous surgery is subject to the patient's deductible, co-insurance and out of pocket maximum. It is your responsibility to verify your benefits with your insurance company, which we strongly recommend.

- **AESTHETIC TREATMENTS**- L.A. Vein Center offers many cosmetic treatments such as SmartLipo Laser Liposuction, Sclerotherapy, Radiesse, Belotero Balance and Xeomin. You will be responsible for payment on the day services are rendered.

- **SCLEROTHERAPY (INJECTION THERAPY)** - If cosmetic sclerotherapy is recommended, you will be given an estimated fee and approximate number of treatments anticipated to achieve your desired results. Sclerotherapy for spider veins and reticular veins is considered cosmetic and is not covered by insurance companies.

You will be responsible for payment for Sclerotherapy, compression hose (if dispensed at L.A. Vein Center) and "co-pays" on the day services are rendered. We accept cash, check, MasterCard, Visa, American Express, or Discover. L.A. Vein Center will only file a claim that Dr. Larisse Lee considers "medically necessary." **IF DR. LARISSE LEE DETERMINES YOUR CLAIM TO BE COSMETIC, PAYMENT MUST BE RENDERED AT THE TIME OF SERVICE.**

Please sign to verify you have received and read this information.

Signature: _____ Date: _____

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PATIENT HEALTH HISTORY

Patient Name _____

Date of Birth _____ Age _____

CHIEF COMPLAINT

What is the reason for your visit? _____
When did you first notice this problem? _____
Has it improved/gotten worse/stayed the same? _____
What would you like to achieve from your visit? _____

SYMPTOMS

Please check the symptoms you have experienced:

Leg pain	☐ R	☐ L
Leg/Ankle swelling	☐ R	☐ L
Leg fatigue	☐ R	☐ L
Leg heaviness	☐ R	☐ L
Leg itching	☐ R	☐ L
Leg ulcers (sores)	☐ R	☐ L
Leg bleeding	☐ R	☐ L
Leg cramping	☐ R	☐ L
Restless legs	☐ R	☐ L
Skin discoloration	☐ R	☐ L
Phlebitis	☐ R	☐ L

WHAT MAKES YOUR SYMPTOMS WORSE:

Prolonged standing _____
Prolonged sitting _____
Walking _____
Working _____ Please describe _____
At end of day _____
Other _____

WHAT MAKES YOUR SYMPTOMS BETTER:

Leg elevation _____
Compression stockings _____
Medication _____ Name _____
Other _____

ARM: RT/LT
BP: _____ **O2:** _____ **HR:** _____ **HT:** _____ **WT:** _____

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What is your occupation?_____
Does your occupation require prolonged standing or sitting?_____
Do you have any travel plans in the near future?_____
(If so, when and where?) _____
Do you have any upcoming surgeries?_____
Are you Pregnant?_____
Have you recently delivered a baby?_____if so, when?_____
Are you nursing?_____
How many pregnancies have you had?_____

ALLERGIES

Do you have any allergies? (Includes medications, foods, latex, tape, Iodine, Lidocaine)

_____

PAST MEDICAL HISTORY

Please list all your past medical problems (i.e. hypertension, high cholesterol, etc.)

DVT	☐Y	☐N
Asthma	☐Y	☐N
Diabetes	☐Y	☐N
Fibromyalgia	☐Y	☐N
Heart Disease	☐Y	☐N

Other_____

PAST SURGICAL HISTORY

Please list all your past surgeries.

Vein Stripping	☐Y	☐N
Vein Ablation	☐Y	☐N
Phlebectomy	☐Y	☐N
Sclerotherapy	☐Y	☐N

Other _____

SOCIAL HISTORY

Do you smoke? _____ How many cigarettes a day? _____ When did you start/quit?_____
Do you drink alcohol? _____ How many drinks a week? _____
Do you use recreational drugs?_____ Please list _____
Religion?(i.e. Jehovah's Witness) _____

FAMILY HISTORY

Please list health conditions that run in your family.

Varicose or spider veins	☐Y	☐N	Who? _____
DVT	☐Y	☐N	Who? _____
Blood clotting disorder	☐Y	☐N	Who? _____

Other _____

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MEDICATION

Please list your medications below:

_____

REVIEW OF SYSTEMS

Please check if you have experienced any of the following:

CONSTITUTIONAL

☐Fever ☐Weight Gain ☐Weight Loss ☐Other _____

EYES

☐Dry Eyes ☐Irritation ☐Vision Change ☐Other _____

ENMT

☐Difficulty Hearing ☐Nosebleeds ☐Sore Throat ☐Other _____

CARDIOVASCULAR

☐Chest Pain ☐Shortness of Breath while walking ☐Heart Palpitations ☐Heart Murmur

☐Other _____

RESPIRATORY

☐Cough ☐Wheezing ☐Shortness of Breath ☐Other _____

GASTROINTESTINAL

☐Abdominal Pain ☐Vomiting ☐Diarrhea ☐Other _____

GENITOURINARY

☐Incontinence ☐Difficulty Urinating ☐Frequent Urination ☐Other _____

MUSCULOSKELETAL

☐Muscle Pain ☐Joint Pain ☐Back Pain ☐Other_____

SKIN

☐Rash ☐Itching ☐Dry Skin ☐Other_____

NEUROLOGIC

☐Loss of Consciousness ☐Weakness ☐Numbness ☐Other _____

PSYCHIATRIC

☐Depression ☐Sleep Disturbance ☐Alcohol Abuse ☐Other_____

ENDOCRINE

☐Fatigue ☐Increased Thirst ☐Hair Loss ☐Other_____

HEMATOLOGIC

☐Swollen Glands ☐Bruising ☐Other_____

ALLERGIES

☐Running Nose ☐Itching ☐Hives ☐Other_____

INFECTIOUS DISEASE

☐HIV+ ☐Hepatitis B/C ☐Recent Fever ☐Other_____