Southern Arizona Laser & Vein Institute
6422 East Speedway Boulevard - Suite 150 - Tucson, Arizona 85710
Phone: (520) 318-3004 Fax: (520) 318-3061 www.SALVI-Tucson.com

A MESSAGE ABOUT OUR PATIENT HISTORY FORM

Dear Patients,

Thank you in advance for taking the time to accurately complete our SALVI patient questionnaire. This valuable tool helps us to help you. Due to increasingly stringent and severe insurance company regulations, we are required to submit all of this information to your insurance company prior to scheduling any treatments. Many insurance carriers now require digital photographs as well.

For your information, most insurance companies **REQUIRE** that Grade 2 (30 -40 mmHg) compression stockings be worn *prior* to approving any treatments, and that the stockings are beneficial in symptomatic improvement. The duration of wear ranges from 2 weeks to 3 months. Also, many insurance companies **REQUIRE** that you have documented "functional Impairment" such as skin ulcers, phlebitis, bleeding, stasis dermatitis **or** moderate to severe pain (grade 2 or 3 on functional pain questionnaire) *prior* to approving any treatments.

We at SALVI apologize for the burden of completing these forms and complying with these requirements. THESE ARE NOT OUR RULES. We hope you understand that we cannot supersede or overrule insurance company requirements. If we were to try to proceed with treatment prior to documenting completion of all requirements, your insurance company would NOT pay for the service and the bill would be your responsibility.

Thank you for being loyal and understanding patients. We are working hard for you and hope to achieve the excellent results we strive for and you deserve.

Sincerely,

Michael R. Probstfeld, M.D., FACS
Southern Arizona Laser & Vein Institute

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PATIENT REGISTRATION FORM

Account # _____ Date _____

Patient Name: _____ M _____ F _____
Last First Legal Nickname MI

Is this your legal name? Yes _____ No _____ If no, what is your legal name? _____

Marital Status: Single ____ Married ____ Divorce ____ Widow ____ Spouse's Name: _____

Street Address: _____ PO Box: _____ Apt/Suite: _____

City: _____ State: _____ Zip Code: _____ Phone # _____

Date of Birth: _____ Age: _____ Social Security #: _____ Cell #: _____

Your Employer: _____ Phone# _____ Occupation: _____

Primary Care Physician: _____ Phone #: _____

Referring Physician (if different) _____ Phone #: _____

INSURANCE INFORMATION

Are you covered by health insurance? Yes ____ No ____ **If No, please make payment arrangements with our business office.**

Primary Insurance _____ Policy # _____ Group # _____

Policy Holder Name _____ Policy Holder Date of Birth _____

Social Security Number _____ Copay _____

Secondary Insurance _____ Policy # _____ Group # _____

Policy Holder Name _____ Policy Holder Date of Birth _____

Social Security Number _____ Copay _____

If this visit related to an at work injury? Yes _____ No _____ If yes, Employer at time of injury _____

Date of Injury _____ Insurance Info _____ Claim # _____

EMERGENCY CONTACT

Emergency Contact _____ Relationship to Patient _____

Phone # _____ Cell # _____ Date of Birth _____

PLEASE COMPLETE AND SIGN THIS RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS

"I hereby authorize Southern Arizona Laser & Vein Institute to release to or to request from any insurance company, other physician or hospital, any information including the diagnosis and records of any treatment or examination rendered to me during surgical care. This includes any financial information. This information may be faxed. I also authorize and request my insurance companies to pay directly to the above named corporation the amount due on any pending insurance claim for medical and/or surgical treatment or service. I also understand that if it becomes necessary to refer my account to collections, I will be liable for the reasonable collection fees and court costs expended therein." I understand that there is a $25 pre-paid fee for all disability forms filled out by the physician. The physicians reserve the right to charge interest on unpaid accounts.

PATIENT SIGNATURE: _____ DATE: _____
(Or parent/guardian if patient is a minor) "Duplicate of this release & assignment is as valid as the original"

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FUNCTIONAL PAIN QUESTIONNAIRE

1) **Do you perform daily activities which require prolonged periods of standing? Yes No**

   If YES, please explain further:

   What activities require prolonged periods of standing?

   _____

   _____

   How many times during the day do you have to sit or take a break due to aching, cramping, burning, itching or swelling in the lower extremities?

   a. Never (0)
   b. Once per day (1)
   c. 2 – 3 times per day (2)
   d. 4 or more times per day (3)

2) **Do you take over-the-counter medications (e.g., aspirin, ibuprofen, NSAIDS, or a similar type of medication) or prescription medications for aching, cramping, burning or swelling of the lower extremities? Yes No**

   If YES, please explain further:

   What is the medication and dosage?

   _____

   _____

   How many days in an average **two week period** of time do you take the medication?

   a. 0 – 2 days (0)
   b. 3 – 4 days (1)
   c. 5 – 6 days (2)
   d. 7 or more days (3)

3) **Have you worn compression stockings for at least 2 weeks for your symptoms? Yes No**

   If YES, please explain further:

   What strength (in mmHg) were the stockings? 20 – 30 30 – 40 Other: _____

   Did the stockings result in significant improvement in symptoms? Yes No

   _____

SCALE: 0 = no symptoms 1 = mild 2 = moderate 3 = severe

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PATIENT HISTORY FORM

PLEASE MARK ALL QUESTIONS AS INDICATED

Date: _____ Last Name:_____ First Name: _____

Date of Birth: _____ Sex: Male Female Height: _____ Weight: _____

Do you have varicose veins: Yes No If yes, which leg is affected: Right Left Both

What are your symptoms (circle all that apply):

Pain Swelling Aching Fatigue Heaviness

Discoloration Ulcers Bleeding Other: _____

How long have you had varicose vein problems? _____

Are your symptoms getting worse? Yes No

Note: Your insurance company probably will not approve your treatment if Compression stockings have NOT been worn for at least three (3) months.

Have you worn compression stockings? Yes No Type: _____ How long: _____

Does walking or exercise relieve your symptoms? Yes No

Have you had any previous treatment? Yes No

If yes, what types of treatments have you had (circle all that apply):

Injections	Right	Left
Avulsion Phlebectomy	Right	Left
Stripping	Right	Left
Radiofrequency Closure	Right	Left
Laser Ablation	Right	Left
Laser for Spider Veins	Right	Left

Have you ever had blood clots? Yes No

Have you had any tests on your veins? Yes No

If yes, what types of tests have you had (circle all that apply):

Ultrasound / Duplex	Right	Left
X-rays	Right	Left
Venogram	Right	Left

THE FOLLOWING INFORMATION IS IMPORTANT FOR INSURANCE COVERAGE OF TREATMENT

Have you used any medications to treat your vein symptoms? **Yes** **No**

If yes , circle all medications that apply: Aspirin Ibuprofen Advil Tylenol Narcotic Analgesics Venostat

Herbals Creams Others: _____

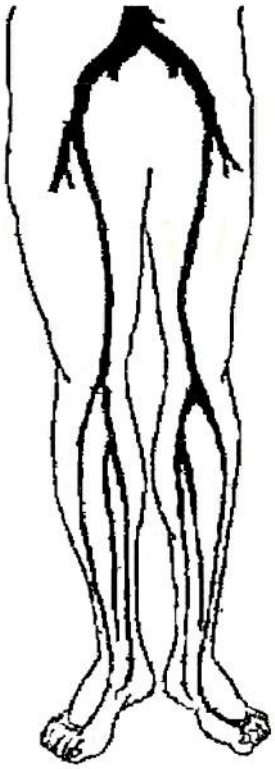
What are your goals for treatment of your veins (circle all that apply):

Relieve Pain Prevent Complications Decrease Swelling Work more comfortable

Treat existing ulceration or bleeding Enjoy recreational activities more Improve my appearance

Other: _____

On the diagram below, please indicate where your problem veins are located:



Does anyone in your family have varicose vein problems? Yes No

Have you had any pregnancies? Yes No If Yes, How many? _____

Any pregnancies planned in the future? Yes No

GENERAL MEDICAL HISTORY

Please indicate all allergies and the type of reaction: _____

_____

_____

_____

Please list all medications and strengths: _____

_____

_____

_____

Please list any prior operations with approximate dates: _____

_____

_____

_____

MEDICAL CONDITIONS MUST BE INDICATED (Please circle all that apply)

Diabetes	Patient Foramen Ovale	Heart Disease	Heart Attack	Valley Fever
Atrial Septal Defect	Pneumonia	High Blood Pressure	Stroke	Kidney Disease
Epilepsy or Seizures	Cancer or Leukemia	Hepatitis (type): _____		
Lung Disease:	Emphysema	COPD	Asthma	TB
G.I. Disease:	Diverticulosis	Crohns Disease	Ulcerative Colitis	Ulcers
Phlebitis	Macular Degeneration	Glaucoma	Anemia or low white blood cells or platelets	
Migraine Headaches	Thyroid Disease	Blindness	Arthritis	HIV
Mitral Valve Prolapse	Mental Illness	Trauma to your legs	Restless Leg Syndrome	

SOCIAL HISTORY

Do you smoke: Yes No How long: _____ Amount per day: _____

Do you drink alcohol Yes No Drinks per day _____ or per week _____

Do you use drugs Yes No Marital Status: Married Single Divorced Widowed

Type of Work: _____ Number of hours per day on your feet: _____

How did you hear about SALVI / Dr. Probstfeld: _____

Primary Care Physician: _____

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FINANCIAL POLICY

Thank you for choosing Southern Arizona Laser & Vein Institute for your surgical needs. The physicians and staff are committed to providing you with the highest quality of care. This following financial policy is in place to assist you with any questions you may have regarding your financial obligation to this practice. We ask that you please review and confirm with your signature below. All billing is completed as a courtesy to our patients on behalf of their health insurance provider. Patients are financial responsible for all medical services.

INSURANCE

Although we are participants of many insurance companies, it is ultimately your responsibility to confirm that Southern Arizona Laser & Vein Institute, or your individual doctor, is in fact a provider for your particular insurance. We will submit a claim for payment for your services to your insurance as a courtesy, but you are responsible for any co-pays or deductibles not covered by your insurance. These are collected at time of service. If you are billed for any balance, payment is required within 30 days of receipt of a bill. Secondary insurance claims are filed as a courtesy, and become the responsibility of the patient if payment is not received within 60 days of filing a claim. It is your responsibility to be aware of your benefits with your insurance. If your insurance information, copay, or coverage has changed at any time during your treatment, it is your responsibility to notify the office with the most current and up-to-date information.

PATIENT RESPONSIBILITY

Co-pays and deductibles are due prior to being seen. If you require a bill sent to you for your co-pay, a $10.00 processing fee will be added to your balance. It is your responsibility to provide us with any referral required from your insurance. Any service deemed "non-covered" by your insurance will be your responsibility. If you do not have insurance, or we are not contracted with your particular insurance, you will be required to pay for services prior to receiving them. "Self-pay" accounts are given a 30% discount, which is due prior to any services. NO payment arrangements are made for these accounts. If a circumstance arises where payment arrangements are made, the discount will be taken after all payments are received. If you fail to adhere to your payment agreement, your full balance will be assigned to a collection agency. If your account is referred to a collection agency, you will be responsible for all costs.

PAYMENT METHODS

For your convenience, acceptable forms of payments are; cash, check, money order, VISA, MasterCard, American Express, or Debit cards. Please note: if a personal check is returned for insufficient funds, there will be a $25.00 fee added to your account.

BILLING INQUIRIES

If you have any questions regarding a bill you received from our office, please feel free to contact our Business Office at (520) 318-3004. Our office hours are 8:00am – 5:00pm.

Thank you for allowing Southern Arizona Laser & Vein Institute to be an important part of your medical care. For any further questions or concerns our staff is available to assist you.

ACKNOWLEDGEMENT AND AUTHORIZATION

I have read, and understand, and agree to the above financial policy. Regardless of my insurance status, I am ultimately responsible for payment for any professional services rendered. I authorize the release of any medical information necessary to process a claim for benefits under my policy and assign payment to Southern Arizona Laser & Vein Institute.

Signature _____ **Date** _____

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Thank you for choosing Southern Arizona Laser & Vein Institute for your medical needs. The physicians and staff are committed to providing you with the highest quality of care. In consideration of your time and that of the physician, our office requires 24 hour notice to cancel or reschedule your scheduled appointment. Any cancellations or rescheduled appointments that do not provide 24 hour notice will be assessed a $25.00 fee.

After your initial consultation, a $ 150.00 deposit will be required at the time you schedule your procedure appointment.

This $ 150.00 deposit is used to reserve your appointment in our treatment facility and will be applied to any potential out-of-pocket expenses incurred by you or as assigned by your insurance.

Should you fail to appear at your appointment without re-scheduling it, this amount will be non-refundable.

In the event your insurance covers your entire procedural costs, this deposit will be refunded to you once the applicable insurance has completed processing the claim.

Patient Signature _____ Date _____