DESERT VEIN INSTITUTE

Welcome To Our Practice

Thank you for choosing our group for you venous needs.

(Please retain this copy for your records)

Desert Vein Institute affirms a dedication to value the individual rights of our patients. No procedures, polices, or treatments have been or will be designed to infringe on your rights as an individual.

You have the right to professional, respectful, and clinically appropriate care which is non-discriminatory with regards to age, race religion, sex, ethnicity, color national origin, marital status, sexual orientations, or handicap.

The physicians and staff of Desert Vein Institute feel that we can better serve your needs if you are familiar with our policies and procedures.

Office Hours: Our office is open Monday through Thursday 8:00am to 5:00pm
Friday 8:00am to 12:00pm. **Closed during lunch** 12:00pm – 1:00pm

Office Location: 1111 Shadow Lane Las Vegas, NV 89102

Insurance Claims: We participate with many insurance companies. This means we have signed a contract with them to provide care for the entities they cover. The contracts are not all the same, and certain services are not covered.

As a courtesy we will submit a medical claim on your behalf. It is your responsibility to provide accurate insurance information and to notify our office of any changes to your health insurance coverage. Your bill is based on the service you received. You are responsible for paying your bill if your insurance company does not cover all the cost.

Payment for Services: Patients are required to pay all co-pays, deductible and co-insurance prior to services rendered. For your convenience we accept cash, checks, Visa, MasterCard, American Express, Discover and Care Credit.

Medical Inquires: Our staff is available Monday through Friday during business hours to answer any and all questions. You may reach Manager Lori Vargo at 702-383-4040 Ext. 1039, Front office Beverly Gutierrez Ext. 1040 and Authorization Dept. Cynthia Gallegos Ext. 1017

Procedure Scheduling: Our office will submit for authorization if required on the first Friday after your visit. Please allow 7-10 business days for the authorization to be processed.

Disability Forms: FMLA is not required for in office vein procedures, but if needed they will be completed within 3-5 business days. There is a charge of **$15.00** per form. Forms can be picked up, faxed or mailed.

Medical Records: Will be available after receiving a written & signed request. There is a .50 cent charge per page.

DESERT VEIN INSTITUTE

Craig L. Iwamoto, M.D. * J. Dylan Curry, M.D. * Lee M. Reese, M.D.
Phone: 702.383.4040 Fax: 702.383.0526
1111 Shadow Lane Las Vegas, NV 89102

New Patient Information Packet

Date: _____

Dear _____,

Welcome to Desert Vein Institute. We would like to have you take a few moments and complete the enclosed information packet. Please bring the entire packet completely filled out along with your **insurance cards, referral forms from your primary care provider (if required) and your office co-payment to your appointment. (PHOTO I.D. IS REQUIRED)**

It is very important that you bring this information with you or make arrangements to have it here prior to your appointment so your appointment will not be delayed or possibly rescheduled.

YOUR APPOINTMENT IS SCHEDULED @ 1111 SHADOW LANE, LAS VEGAS, NV 89102

DATE/DAY: **TIME:** ☐ **AM** ☐ **PM**

Please call 24 hours before you scheduled appointment if you are canceling or need to reschedule.

Thank you!

DESERT VEIN INSTITUTE

PATIENT INFORMATION

Last Name:	**First Name:**		**Middle Initial:**	
Gender: □ Male □ Female	Social Security Number: - -		DOB: / /	
Marital Status: □ Divorced	□ Married	□ Separated	□ Single	□ Widowed
Race: □ American Indian/Alaskan Native □ Native Hawaiian/Other Pacific Islander	□ Asian □ White	□ Black or African American □ Other Race		
Ethnic Group:		Language:		
Address:	Apt#:	City:	State:	Zip:
Phone Number: ( )		□ Home	□ Cellular	□ Work
2nd Phone Number: ( )		□ Home	□ Cellular	□ Work
E-mail address:	@			
Preferred Contact: □ Phone	□ Mail	□ E-mail		
Preferred Reminder: □ Home Phone	□ Cell Phone	□ Work Phone		
May a voice message be left as a reminder for you?		□ Yes □ No		
Employer:		Occupation:		
Employer Phone: ( )		Employer Fax: ( )		
Employer Address:		City:	State:	Zip:
PCP Doctor Name:				
PCP Phone: ( )		PCP Fax: ( )		
PCP Address:		City:	State:	Zip:
Referring Doctor Name:				
Ref Dr Phone: ( )		Ref Dr Fax: ( )		
Ref Dr Address:		City:	State:	Zip:

INSURANCE COVERAGE INFORMATION

1st Insurance Name:			
Policy Number:	Group Number:		
Address to send claims:	City:	State:	Zip:
Policy Holders Name:	Relationship to Patient:		
Employers Name:	Occupation:		
Social Security Number: - -	Date of Birth: _____/_____/_____		
2ND Insurance Name:			
Policy Number:	Group Number:		
Address to send claims:	City:	State:	Zip:
Policy Holders Name:	Relationship to Patient:		
Employers Name:	Occupation:		
Social Security Number: - -	DOB: / /		

Name: **DOB:** / /

PATIENT'S MEDICAL HISTORY

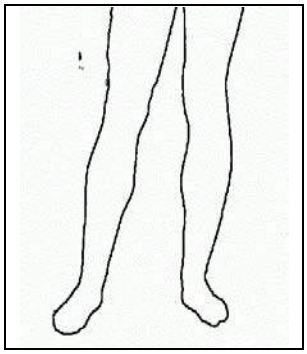
Reason for Visit:

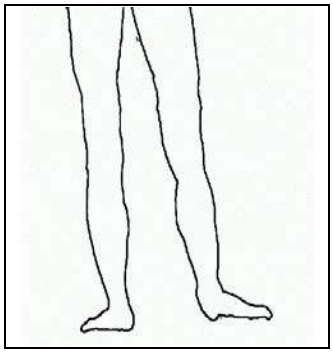
Past Medical History: Check yes or no

Heart Attack (MI):	□Yes □ No	Thyroid Problems:	□ Yes □ No
Heart Failure (CHF):	□ Yes □ No	Seizures:	□ Yes □ No
Atrial Fibrillation:	□ Yes □ No	Kidney Disease:	□ Yes □ No
High Blood Pressure:	□ Yes □ No	Liver Disease:	□ Yes □ No
Diabetes:	□ Yes □ No	HIV:	□ Yes □ No
High Cholesterol:	□ Yes □ No	Hepatitis:	□ Yes □ No
Stroke (TIA):	□ Yes □ No	Blood Clots:	□ Yes □ No
Emphysema:	□ Yes □ No	Varicose Veins:	□ Yes □ No
Anesthesia Problems:	□ Yes □ No	Bleeding Problems:	□ Yes □ No

Other Medical History:

Front **Back**





Social History:

Alcohol: □ Yes □ No Tobacco: □ Yes □ No Live Alone: □ Yes □ No

Surgical History: Check All That Apply

□ Heart Surgery □ Thyroid Surgery □ Carotid Artery Surgery □ Hernia - type: _____
□ Colon Surgery □ Gallbladder Surgery □ Hysterectomy □Colonoscopy/EGD if yes Date(s): _____
Other Surgical History: _____

Medications: Check One □ Yes □ No

List Medications: _____
_____

Drug Allergies: Check One □ Yes □ No

List Drug Allergies: _____
_____

Check All That Apply

Constitutional:	□ Fever	□ Chills	□ Weight Loss (unintentional)		□ Excessive Fatigue
Skin:	□ Rash	□ Itching	□ Melanoma	□ Skin Cancer	□ Psoriasis
Cardiac:	□ Chest Pain	□ Palpitations	□ Leg Swelling	□ Shortness of Breath with Walking	
Respiratory:	□ Wheezing	□ Chronic Cough	□ Coughing-up blood	□ Asthma	
GI:	□ Diarrhea	□ Black Stools	□ Blood in Stools	□ Constipation	□ Abdominal Pain
Urinary:	□ Burning with Urination		□ Frequent Urination	□ Blood in Urine	□ Prostate Problems
Musculoskeletal:	□ Calf Pain	□ Weakness	□ Joint Pain	□ Joint Swelling	□ Leg Swelling
Hematologic:	□ Hepatitis	□ Easy Bruising	□ Sickle Cell	□ Clotting Disorder	□ Varicose Veins
Endocrine:	□ Heat /Cold Intolerance		□ Excessive Sweating		
Immunologic/ID:	□ Tuberculosis		□ Immunosuppression	□ HIV	
Psychiatric:	□ Anxiety	□ Depression	□ OCD (Obsessive Compulsive)		□ Psychosis

Please answer the following questions:

Have you ever had vein stripping surgery?	□ Yes □ No	**If yes,** when and which legs?
Have you ever had vein injections?	□ Yes □ No	**If yes,** when and which legs?
Have you ever had a blood clot?	□ Yes □ No	**If yes,** when and which legs?
Have you ever had phlebitis?	□ Yes □ No	**If yes,** when and which legs?

Does anyone in your family have (or used to have) varicose veins, spider veins, leg ulcers?
Father: □ Yes □ No Mother: □ Yes □ No Brother: □ Yes □ No Sister: □ Yes □ No

Name: **DOB:** / /

Do you experience any of the following in your legs?

Aching/Pain?	□ Yes □ No	**If yes,**	□ Left	□ Right	or	□ Both
Heaviness?	□ Yes □ No	**If yes,**	□ Left	□ Right	or	□ Both
Tiredness/Fatigue?	□ Yes □ No	**If yes,**	□ Left	□ Right	or	□ Both
Itching/Burning?	□ Yes □ No	**If yes,**	□ Left	□ Right	or	□ Both
Swollen Ankles?	□ Yes □ No	**If yes,**	□ Left	□ Right	or	□ Both
Leg Cramps?	□ Yes □ No	**If yes,**	□ Left	□ Right	or	□ Both
Restless Legs?	□ Yes □ No	**If yes,**	□ Left	□ Right	or	□ Both
Throbbing?	□ Yes □ No	**If yes,**	□ Left	□ Right	or	□ Both

Have your veins gotten worse in recent months? □ Yes □ No **If yes,** describe how: _____
_____

Do you take medication (such as, Advil, Tylenol) for pain? □ Yes □ No **If yes,** what medications and how many times a day. _____

Do you elevate your legs to relieve discomfort? □ Yes □ No **If yes,** how long and how many times per day.
_____

Do you exercise? □ Yes □ No **If yes,** what do you do and how often?_____
_____

Do you wear compression stockings? □ Yes □ No **If yes,** what strength and for how long? _____
_____

Do you have any problems walking? □ Yes □ No **If yes,** describe the problem and if it interferes with your daily life.
_____

Have you had any test(s) done on your veins? □ Yes □ No **If yes,** what type of test(s) were done and where.
_____

What type of work do you do? _____

How many hours (per day) do you spend standing? At work: _____ At home: _____

Describe how your symptoms are/if interfering with your work or home activities.
_____
_____
_____

Patient Signature (Guardian/Parent): Date:

For Office Use Only - Physician Notes:
_____
_____
_____
_____
_____
_____

Name: **DOB:** / /

Pharmacy Information: **(Please bring your prescription bottle(s) to your first appointment)**

Pharmacy Name:

Address/Cross Streets: City: State: Zip:

Phone Number: ( ) Fax Number: ( )

Confidentiality and Authorization: Please list name(s) and relationships of **ALL** persons authorized to obtain medical and financial information. If no person is to be given this information, please indicate this by printing **"ALL PERSONS DENIED"**.

1. Name: Relationship:

Phone Number: ( ) □ Home □ Cellular □ Work

2nd Phone Number: ( ) □ Home □ Cellular □ Work

2. Name: Relationship:

Phone Number: ( ) □ Home □ Cellular □ Work

2nd Phone Number: ( ) □ Home □ Cellular □ Work

3. Name: Relationship:

Phone Number: ( ) □ Home □ Cellular □ Work

2nd Phone Number: ( ) □ Home □ Cellular □ Work

4. Name: Relationship:

Phone Number: ( ) □ Home □ Cellular □ Work

2nd Phone Number: ( ) □ Home □ Cellular □ Work

5. Name: Relationship:

Phone Number: ( ) □ Home □ Cellular □ Work

2nd Phone Number: ( ) □ Home □ Cellular □ Work

Name: **DOB: / /**

If you do not have medical insurance please inform the front desk at this time so that you can make arrangements with the billing department.

Insurance Authorization/Financial Policy

I authorize treatment and I understand that I am financially responsible for all charges and services rendered to my spouse, child or myself. I understand that Desert Vein Institute is billing my insurance as a courtesy and that I am ultimately responsible for seeing that my insurance carrier reimburses Desert Vein Institute. I authorize payment of medical benefits to the physicians of Desert Vein Institute. (A copy of this is as valid as the original)

Patient Signature (Guardian/Parent): Date:

Release of Information

The undersigned hereby authorizes and requests the physicians and the staff of Desert Vein Institute to provide any medical information necessary to process my medical claims with no limitation placed on dates, history or illness, diagnostic and therapeutic information, including and treatment for alcohol and/or drug abuse. I also give authorization for the physicians of Desert Vein Institute to obtain or provide any information from my previous/current physicians or hospitals involved in my care with no limitations placed on dates, history or illness, diagnostic and therapeutic information, including any treatment for alcohol and/or drug abuse.

Patient Signature (Guardian/Parent): Date:

If the patient is a minor or unable to sign, please complete the following:

Signature of Legal Representative: Witness: Date:

Relationship to Patient: Reason Patient is Unable to Sign:

Name: **DOB: / /**

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Desert Vein Institute to use and disclose protected health information **(PHI)** about me to carry out treatment, payment and health care operations **(TPO)**. The Notice of Privacy Practices provided by Desert Vein Institute describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Desert Vein Institute reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Desert Vein Institute

1111 Shadow Lane

Las Vegas, NV 89102

With this consent, Desert Vein Institute may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out **TPO**, such as appointment reminders, insurance items and call pertaining to my clinical care, including laboratory test results, among others.

With this consent, Desert Vein Institute may mail to my house or other alternative location any items that assist the practice in carrying out **TPO**, such as appointment reminder cards and patient statements.

With this consent, Desert Vein Institute may e-mail to my house or other alternative location any items that assist the practice in carrying out **TPO**, such as appointment reminder cards and patient statements. I have the right to request Desert Vein Institute restrict how it uses or discloses my **PHI** to carry out **TPO**. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am Consenting to allow Desert Vein Institute to use and disclose my **PHI** to carry out **TPO**. I may revoke my consent in writing except to the consent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Desert Vein Institute may decline to provide treatment to me.

Patient Signature (Guardian/Parent): Date:

Print Patient's Name: Print Name of Legal Guardian, if applicable:

Notice of Privacy Practices Statement

Notice of Information Practices and Privacy Statement For Desert Vein Institute

How We Collect Information about You: Desert Vein Institute and its employees collect data through a variety of means including but not necessarily limited to letters, phone calls, e-mails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

What We Do/Do Not Do With Your Information: Information about your financial situation and medical conditions and care that you provide to us in writing, via e-mail, on the phone (including information left on voice mails), contained in or attached to applications, or directly on indirectly given to us, is held in the strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Use Your Information: Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between Desert Vein Institute and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications and/or insurance.

If you apply or attempt to apply to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or unwillful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Limited Right to Use Non-Identifying Personal Information from Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of Desert Vein Institute. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission.

Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

COPY FOR PATIENT Revision Date: 05/01/2011

DESERT VEIN INSTITUTE

Craig L. Iwamoto, M.D. * J. Dylan Curry, M.D. * Lee M. Reese, M.D.

Phone: 702.383.4040 Fax: 702.383.0526
1111 Shadow Lane Las Vegas, NV 89102

Dear _____,

Please be aware that by making appointment for Radiofrequency, Laser & VenaSeal Ablation of your veins with our physicians you agree to abide by the cancellation policy of our practice.

There will be a $150.00 fee billed to you personally if you do not provide at least 48 business hours' notice of cancellation or change in your appointment date or time. Be aware that if your appointment is on a Monday you would need to cancel on the Thursday before.

There are no health insurance policies that cover fees for missed appointments or "no show" appointments.

Our staff will be happy to answer any further questions regarding this policy.

Acknowledgment of Receipt: _____ Date: _____

Witness: _____ Date: _____

PLEASE RETURN TO OUR OFFICE BEFORE YOUR PROCEDURE