BOSTON VEIN CARE
PATIENT PERSONAL INFORMATION

Name: _____ Date of Birth: _____

Address: _____ City, State, and Zip: _____

Cell Phone: _____ Is it OK to leave a message? Y N

Home Phone: _____ Is it OK to leave a message? Y N

Email: _____ Best number to reach you: ___Home ___Cell

Marital Status: ___Married ___Single ___Divorced ___Widowed

Ethnicity/Race: _____ Preferred Language: _____

Referring Physician: _____

Primary Care Physician_____ Address: _____

City, State Zip: _____Phone: _____Fax: _____

Do you want us to send your record to your referring or primary care doctor ☐ Y ☐ N

EMERGENCY CONTACT
Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Relationship: _____

EMPLOYMENT INFORMATION
__Employed __Unemployed __Retired

__Self Employed

Employer Name: _____

Employer Phone: _____

Employer Address: _____

PRIMARY INSURANCE
Insurance Company: _____

ID Number: _____

Group/Policy Number: _____

SECONDARY INSURANCE
Insurance Company: _____

ID Number: _____

Group/Policy Number: _____

Are you primary policyholder, ☐ Yes ☐ No, if no complete section below?

Subscriber Name: _____ Subscriber Phone: _____

Subscriber Date of Birth: _____Address_____

Cardiovascular screening Questionnaire

Name: _____ **Date:** _____

Date of Birth: _____ **Age:** _____

Reason for visit:_____

Past History

□ Diabetes □ Hypertension □ High Cholesterol □ Smoking □ Obesity

□ Chest pain/angina □ Arm or shoulder Pain or Heaviness □ Neck, Jaw, or throat discomfort □ Blue lips or fingernails □ Leg pain at rest □ Leg pain while walking

YOU ARE* HERE *TODAY DUE TO?

1. □ Leg Pain □ Yes □ No □ Other_____
   If other explain_____
2. Affecting □ Right Leg □ Left leg. How long have you noticed these problems?_____
3. Do you have pain on walking/ ambulation: □ Yes □ No, if yes after what walk distance _____. Does it make to stop □ Yes □ No, if yes after what distance _____. Does it come back after walking same distance □Yes □ No. Over few months this walk distance to pain has □ unchanged, □ shortening. How it is affecting daily living or quality of life_____
4. Pain wake you up at night □ Yes □ No, if yes, where is pain located _____. Does it improve if leg is hung by the bed _____, does it make to sleep in recliner _____.
5. Nature of pain□Aching □ Throbbing □ Resting cramps □ Night cramps
6. Severity of pain: On scale of 1 to 10_____ Pain is: □ Continuous □ Periodic
7. Pain is made worse by;_____
8. The pain are relieved by; _____
9. Leg Swelling: Yes No , If yes swelling is made worse by; □ standing for prolonged period □ towards the end of the day, □ Other_____
10. Leg Swellings is relieved by; □ sitting and stretching the legs, □ lying down and elevating the legs □ others_____
11. Have you tried compression socks □ No, □ Yes, If yes for how many weeks _____
12. □ Skin discoloration □ Gangrene □ Venous Bleeding □ Phlebitis
13. Ulceration/wounds □ Yes, □ No, if yes, for how long_____, what have you tried to help those wounds_____
    _____

If you are diagnosed with PAD, what interventions or treatments you have tried so far:
_____

Family History relation (like mother, dad) conditions & age of onset

_____
_____
_____

REVIEW OF SYSTEMS

GENERAL: ☐ Feel sick, ☐ weight loss, ☐ weight gain, ☐ Other_____

SKIN: ☐ Rash ☐ Itching, ☐ Bruising ☐ Bleeding

CARDIAC: ☐ Chest Pain ☐ Palpitation ☐ Shortness of breath, on exertion/on rest ☐ Leg swelling

CIRCULATION: ☐ Pain in legs, calf or hips ☐ on walking/ ☐ on rest ☐ need to stop due to pain ☐ Phlebitis of leg veins ☐ Discoloration of feet or legs ☐ Sores or ulcers on feet or legs ☐ Blood clot in vein ☐ Blood clot in artery.

CHEST: ☐ Cough ☐ Asthma ☐ Tuberculosis ☐ Bronchitis

GIT: ☐ Vomiting ☐ Constipation ☐ Diarrhea ☐ Blood in stools ☐ Jaundice ☐ Liver disease

NERVOUS SYSTEM: ☐ Headache ☐ Dizziness ☐ Numbness ☐ Falls ☐ Stroke/TIA ☐ Dementia

BLOOD: ☐ Anemia ☐ Sickle Cell ☐ Hemophilia ☐ Swollen glands

METABOLISM: ☐ Increased thirst ☐ Increased urine ☐ Diabetes ☐ Intolerance to heat or cold.

MUSCULOSKELETAL: ☐ Weakness ☐ Stiffness ☐ Join pain ☐ Joint swelling ☐ Arthritis ☐ Gout.

PSYCHAITRIC: ☐ Anxiety ☐ Depression ☐ Bipolar ☐ ADHD ☐ Addiction.

Other complaint or concern_____

Current Medications: (please list all prescriptions, non-prescription medications and nutritional supplements)

CURRENT MEDICATIONS	DOSE (Strength)	SCHEDULE (How many & times per day)	HOW LONG HAVE YOU TAKEN?

Drug/Food Allergies:

Do you have history of allergy: ☐ No, if yes please describe reaction in following lines?

- ☐ Medications:_____
- ☐ Food/Environmental:_____

Social History

Do you drink alcohol? □ No □ Yes, if yes, how many drinks a week on average_____
Do you smoke or use any type of tobacco product?
□ Never smoked □ X-Smoker Last smoked:_____
□ Current smoker, how many cigarettes a day:_____ How Many Years:_____

Your Height _____, Last Weight_____

For Females Only

Have you had a total Hysterectomy (Ovaries and Uterus Removed)?	YES	NO	Age: _____
Do you take Birth Control Pills?	YES	NO	
Have you gone through Menopause?	YES	NO	
Are you taking hormone replacements?	YES	NO	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature _____ Date _____

(Please do not write below this line, for office use only)

I have reviewed patient's history and review of systems

_____	_____	_____
Physician Name	**Signature**	**Date**

BOSTON VEIN CARE
GENERAL CONSENT OF TREATMENT

AUTHORIZATION FOR TREATMENT: I voluntarily consent to rendering of medical care, treatment and diagnosis, including such diagnostics, therapeutics or medical procedures to be performed at Boston Vein Care by Muzzamal Habib, MD, his designee, or assistant as is necessary in his judgment, or by personnel in Boston Vein Care.
I understand that medical diagnosis and treatment may involve a substantial risk. I understand that absent emergency or extraordinary circumstances, major therapeutic and diagnostic procedures will not be performed on me unless or until I have had the opportunity to discuss such procedures and risks associated therewith to my satisfaction with Dr. Habib or other health care professional and I have consented to such procedure. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantee has been made to me promising any specific result or outcome from any diagnostic or therapeutic treatment performed on me in Boston Vein Care.
I understand that I have right to refuse or withhold my consent to any proposed diagnostic or therapeutic procedure. I have been afforded the opportunity to set forth below any limitation to the general consent I have granted herein:

_____
_____

USE AND RELEASE OF INFORMATION: I understand that Boston pain care will keep a record that contains my medical, personal and other information related to my diagnosis, care and treatment in electronic, paper, and other forms. I understand that Boston Vein Care may release any information about me, my health, the health services provided to me, or payment for my health services, that may be a necessity: (1) for my treatment (to other healthcare providers or facilities that need the information for my continued care): (2) for any purposes related to payment by me or a third-party for services (to determine eligibility, to process insurance claims, for utilization and review, or for billing and collection purposes, as necessary to obtain payment); or (3) for the health care operations of Boston Vein Care or affiliated healthcare provider that has had relationship with me (quality assessment, training programs, planning, etc.).

TELEMEDICINE: I understand that Boston Vein Care may use telemedicine during the course of my treatment. Telemedicine uses audio and video equipment to permit a two way, real-time, interactive communication between patient and physician or other practitioner who may be located at a distant site. The information gathered during telemedicine consult will be maintained in my medical record, and privacy and confidentiality of my medical information will be maintained at all times. Boston Vein Care will not record the actual audio or video transmission unless otherwise specified by my physician or practitioner. I understand that I have the right to withdrawal my consent for telemedicine at any time without affecting the right to future care or treatment. I also understand the alternative methods of care may be available to me, and I may choose other options at any time.

CONSENT TO PHOTOGRAPH/ VIDEO RECORDING: Boston Vein Care PC is permitted to photograph and/or video the medical or surgical progress and can use the same for scientific, educational, marketing or medical research purposes.
NO SHOW/LATE APPOINTMENT CANCELLATION POLICY: I understand Boston Vein Care has a strict no show policy where patient is supposed to notify at least 48 hours in advance for any cancellations or change in appointment. If I am not able to give 48 hours' notice, I understand that the Practice will charge my credit card on file a late cancellation /no show fee of $50 for a routine visit or $75 for longer visits like ultrasound, sclerotherapy or endovenous procedures etc. Such fees can be avoided by giving more than 48 hours' notice by calling Practice at (855) 798-3467 or emailing to info@bostonveincare.org

RETURNED CHECK: If payment is made by check and it is returned or declined for any reason, the Practice charges a $50.00 fee, in addition to any costs assessed or charged by any depository institution. This fee becomes part of the Patient Responsible Amount and will be invoiced and charged accordingly.

Patient signature: _____Date: _____

COLLECTION POLICIEIS: I understand that any and all unpaid balances assigned as Patient Responsibility may be subject to both internal and external collection efforts, as well as credit reporting to three major credit bureaus if not paid in a timely manner. If after default my account is placed in the hands of an attorney or collection agency, the undersigned agrees to pay for any unpaid balance and all attorney and/or collection agency charges.

KNOW YOUR DEDUCTIBLES, COINSURANCE & IF YOU NEED PCP REFERRAL: I understand it is patient responsibility to know their deductibles, coinsurance, copays, any other out of pocket expenses and whether patient will need a referral from primary care provider (PCP) to see a specialist in Boston Vein Care. I understand that Practice will submit claim on my behalf to my insurance. If it gets denied due to lack of PCP referral or any other reason, it will become my responsibility.

ASSIGNMENT OF BENEFITS: I hereby assign to Boston vein care and/or associated physicians, the right to all health insurance benefits otherwise payable to me, and I authorize Medicare and/or medical insurance benefits to be paid directly to Boston Vein Care and/or associated physicians. I agree to cooperate and provide information as needed to establish my eligibility for such benefits. A copy of this assignment and authorization may be used in place of the original.

FINANCIAL RESPONSIBILITY: I understand that insurance may not pay a full amount of all my charges for my medical care and related professional charges and I acknowledge that I am financially responsible and agreed to pay my bills for non-covered services, as well as deductibles, coinsurance and any amount in excess of insurance benefits. If I am uninsured, I agree to assume full financial responsibility for the payment of all charges.
SIGNATURE: My signature below constitutes my acknowledgment that I have read and understand the above information, that any questions I have asked have been satisfactorily answered, and that I agree to this consent of treatment as described herein.

Patient signature: _____Date: _____

NOTICE OF PRIVACY RIGHTS AND PRACTICES ACKNOWLEDGMENT STATEMENT:
I acknowledge that I have received a copy of Boston wound care notice of privacy practices & I can access it using web link www.bostonveincare.org/patientprivacy. I understand that notice of privacy practices describes the way in which Boston Vein Care may use and disclose my healthcare information for treatment, payment, and healthcare operations. I understand that I may contact privacy officer identified in the notice of privacy practices, if I have question or complaint.

Patient signature: _____Date: _____

CREDIT/DEBIT CARD ON FILE AGREEMENT:
Boston Vein Care PC implements a credit/debit card retention policy. At check in, your credit or debit card information may be obtained and stored securely until your insurance(s) have paid their portion and notified us of the balance. At that time, you will be called or mailed a statement. You will have 15 days to pay, after 15 days, if bill remains unpaid, Boston Vein Care will bill your credit/debit card on file. Payments to your credit/debit card are processed only for payments not covered by your insurance and only after the claim has been filed and processed by your insurance and the insurance portion of the claim has been paid and posted to the account. Additionally, if the credit card that I gave today, changes, expires or is denied for any reason, I agree to immediately give Boston Care a new, valid credit or debit card which I will allow them to charge over the telephone. Even though Boston Vein Care will not be processing the new card in person, I agree the new card to be stored securely and used with same authorization as the original card I presented.
By signing below, I authorize Boston Vein Care, PC to keep my signature and credit card information securely on-file. I also authorize Boston Vein Care to charge my credit/debit card today and an in future date for the portion of my bill is my financial responsibility.

Patient signature: _____Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entitles that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include surgeries, follow-up care, administering medication, etc.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your medical health plan for your medical services.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities. Auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care who assist in taking care of you. We will use and disclose your protected health information when we are required to do so by federal, state or local law. We may disclose your protected health information to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your protected health information if requested by a law enforcement official for any circumstance required by law. We may release your protected health information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directions to perform their jobs. We may release protected health information to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your protected health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your protected health information if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your protected health information to federal officials for intelligence and national security activities authorized by law. We may disclose protected health information to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose protected health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official. Disclosure for these purposes

would be necessary: (a) for the Institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your protected health information for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspects and copy your protected health information.
- The right to request and amendment to your protected health information.
- The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:
Name: Tanzila Aslam or Office Manager at Boston Vein Care
Address: 1 Courthouse Ln #9, Chelmsford, MA 01824
Phone: (978) 666-4200

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)