Vein Center of North Georgia

5755 North Point Pkwy. Suite 214 Alpharetta, GA 30022
Phone: 770-664-5713 Fax: 770-663-0080

Patient Demographics

Last Name:_____ First Name:_____ M or F

Address:_____ City:_____ Zip:_____

Phone: Primary_____ Secondary_____

Email:_____ DOB:_____ Age:_____

Occupation:_____ Employer:_____

Emergency Contact:_____ Phone:_____

Referring Physician: _____

Primary Care Physician:_____
(Required for Medicare patients)
If referred by friend or family, please indicate name: _____

Financial Responsibility

(To be completed if you are not the primary policy holder)

Primary Insurance:

Policy Holder:

Date of Birth:

Secondary Insurance:

Policy Holder:

Date of Birth:

Consent

I consent to treatment for the care of the above named patient. I authorize the release of all medical records to the referring and family physicians and to my insurance company if applicable. I acknowledge full financial responsibility for services rendered by Vein Center of North Georgia, LLP. I understand that payment of charges incurred is due at time of service unless other financial arrangements have been made prior to treatment. I agree to pay all responsible attorney fees and collection costs in the event of default of payment of my charges. I further authorize and request that insurance payments be made directly to Vein Center of North Georgia. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization. Please be aware that Dr. Garvey is in solo practice. In the case of an emergency you should call 911 or go directly to the nearest emergency facility. Dr. Garvey is not on staff at the hospital for emergency care.

Signature:_____ Date:_____

Vein Center of North Georgia
Notice of Privacy Practices

The Health Insurance Portability & Accountability Act of 1966 (HIPPA) is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us are kept properly confidential. It is the policy of The Vein Center of North Georgia that any protected health information (PHI) will be held in strict confidence and will not be disclosed to other parties without the consent of the patient or as required or allowed by law. Patients are permitted to view and obtain a copy of their medical information.

1. The Vein Center of North Georgia may use and disclose your medical records for the purpose of treatment. This may include sending records to your primary care physician or to another specialist.
2. The Vein Center of North Georgia may use your medical records to obtain reimbursement for services, confirm insurance coverage, billing or collections activities, and utilization review. This may include sending records to your insurance company or verbally providing the insurance company with information from your medical records.
3. The Vein Center of North Georgia may disclose PHI where and when authorized by the patient.
4. PHI may be disclosed where specifically permitted or required by HIPAA or other federal or state law.

As a patient of The Vein Center of North Georgia, you have the following rights to your PHI:

1. The right to inspect and copy your PHI.
2. The right to amend your PHI.
3. The right to receive an accounting of your PHI.
4. The right to obtain a written copy of this notice from us upon request.
5. The right to be advised if your PHI is unintentionally disclosed.

I, as a patient of The Vein Center of North Georgia, acknowledge receipt of a copy of this Notice of Privacy Practices and consent to the disclosure of PHI under the circumstances set forth and herein.

This _____ day of _____ 20___.

Patient Signature: _____

Print: _____

Vein Center of North Georgia

Authorization for the Release of Information

Vein Center of North Georgia is authorized to release protected health information about the following patient to the entities selected below, for the purpose of informing the patient and/or others while remaining compliant with the patient's instructions.

Name of Patient: _____ Date of Birth: _____

Entity to receive information: Check each entity that you approve to receive information.	**Description of information to be released:** Check type of information to be released.
❑ Voice Mail	❑ Medical Information ❑ Financial Information ❑ Other:
❑ Spouse	❑ Medical Information ❑ Financial Information ❑ Other:
❑ Parent (Provide Name) _____	❑ Medical Information ❑ Financial Information ❑ Other: _____
❑ Other (Provide Name) _____	❑ Medical Information ❑ Financial Information ❑ Other: _____

Please read and sign below:

I understand that I have the right to revoke this authorization at any time. I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective going forward. This authorization shall be in effect until revoked by the patient.

I understand that the information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that treatment will not be conditioned on signing.

Patient Signature: _____ Date:_____

Vein Center of North Georgia

This information has been provided to clarify our policies concerning payment for professional services and to avoid any misunderstandings.

- Your insurance coverage is an agreement between you and your insurer. It is your responsibility to familiarize yourself with your plan benefits and to meet your referral requirements. Likewise, it is your responsibility to both ensure that your carrier remits payment for covered charges and to remit payment for charges not covered by your insurance plan. If a problem occurs with your claim, you will be required to establish written financial arrangements with our practice until your insurance problem is resolved.

Please initial here:_____

- It is our policy to file eligible charges to your insurance company for their responsibility and to collect your responsibility, including co-pays, deductibles, and coinsurance at the time services are rendered. In the event you have overpaid at the time of service, the overpayment will be refunded to you after a period of 90 days has passed from the receipt of the explanation of benefits. During those 90 days, your refund will be applied to any of your scheduled follow-up visits. Refunds will not be issued for credits in the amount of less than $10.00. Any credit for an amount of less than $10.00 will remain on your account to be applied to your next visit.

Please initial here:_____

- Each month you will receive a monthly statement of charges, which are due and payable within 30 days. If your payment is late, or if you have not previously made financial arrangements, we will mail a reminder notice indicating there is a problem with your account. If you are experiencing difficult circumstances, please call and we will be happy to work with you in making payment arrangements.

Please initial here:_____

- Your appointment times have been reserved exclusively for you and we would appreciate 24 hours notice if you are unable to keep an appointment to avoid charges for this time. The charge is $25 for a missed appointment without 24 hour notice. Please be aware that if you are late for your scheduled appointment time, it may be necessary to reschedule your appointment. We will try to be accommodating when possible but will not compromise the quality and timely care provided to our other patients.

Please initial here:_____

Vein Center of North Georgia

Most patients seeking treatment for spider veins and/or varicose veins will be recommended to receive sclerotherapy injections as part of their treatment plan. The following information has been provided to clarify our policies regarding pricing and payment for sclerotherapy. Please refer to the sclerotherapy handout for information regarding post-op instructions and follow-up care.

- Sclerotherapy used for the treatment of spider veins is considered by insurance companies to be a cosmetic procedure and is therefore not covered. It is also generally not covered for the treatment of varicose veins, even if those veins are symptomatic.

- Sclerotherapy may be covered by insurance when it is used as a follow-up treatment to varicose vein surgery. Please keep in mind that most insurance companies have strict guidelines regarding the number of sessions they will approve. In the event that your insurance company approves a session(s) of sclerotherapy, please remember that it is possible that you will need more than the number of sessions approved by your insurance company to complete your treatment. Any sessions beyond those approved by your insurance company are your responsibility and are subject to the fees outlined below.

- Our fees for sclerotherapy are as follows: $360 for a full session, $270 for ¾ of a session, $180 for a half session, $90 for ¼ of a session and $45 for a MTP (release of pressure) or post-op check. Please remember that payment is due in full at the time of service and is not eligible for billing.

- Please be aware that some veins may require more than one treatment before completely shutting down and fading away.

- I have received a copy of Vein Center of North Georgia's sclerotherapy handout, which includes important information regarding follow-up care and possible side effects.

Patient Signature: _____ Date: _____

Sclerotherapy

(Please keep for your records)

- The process of sclerotherapy is to inject a sclerosing agent into the vein, causing the vein to close down. Sometimes the vein will need more than one treatment to completely shut down and fade away. Please follow-up as Dr. Garvey indicates to achieve the optimum outcome from your sclerotherapy. Immediately after treatment your veins may look worse before they look better – this is normal.
- The blood that is in the vein when it is injected and starts to shut down can become trapped. This can cause lumpiness or small bumps along the course of the vein. This is normal and not dangerous. If the area is sore, Dr. Garvey can release some of the pressure. The time frame to follow-up is normally 4-6 weeks; however you can come in at 2 weeks if you have a sore area. Follow-up is important for the optimal cosmetic result.
- There is usually very minimal soreness following sclerotherapy injections. You can take over the counter medications such as Advil or Motrin if needed.
- You should wear your compression stockings for the recommended length of time following your injections. Wear them overnight the first night only, then as indicated – usually 4 days. The proper use of compression stockings will improve your overall results.
- You can work and perform all of your normal activities. Activities such as tennis, running, or weight lifting should be avoided during the time you are wearing your compression hose. Avoid hot tubs/pools/baths during the time you are wearing the compression hose.
- Avoid sun exposure or use 40-50 sun block on the areas treated for several weeks following sclerotherapy. Sun exposure can cause the skin over the treated areas to become stained.
- Possible side effects:
    1. Skin pigmentation (brown spots) – occasionally a freckling can occur at the site of the injection
    2. Skin ulcer – although this is rare, occasionally an injection is irritating enough to cause a small area of skin ulceration. If you notice any blistering or skin changes, please call our office.
    3. Flare – occasionally a new cluster of small veins can occur at the injection site. The flare usually will fade away within weeks/months but Dr. Garvey can usually retreat the area to hasten the healing.
    4. Failure of sclerotherapy – occasionally a patient is resistant to sclerotherapy. Dr. Garvey may treat the area with additional injections, use a different sclerosing agent or advise of another treatment method.
- All sclerotherapy is done by Dr. Garvey, a board certified vascular surgeon.
- If possible, please bring a pair of shorts to wear during the session.

Vein Center of North Georgia

Patient Name: _____

Reason for visit: _____

_____

Check all applicable symptoms:	Right leg	Left leg
Bulging or ropey veins present	_____	_____
Spider veins present	_____	_____
Pain or discomfort	_____	_____
Swelling	_____	_____
Fatigue or heaviness	_____	_____
Burning	_____	_____
Itching	_____	_____
Cramping	_____	_____
Discoloration	_____	_____
Bleeding from veins	_____	_____
Leg ulceration	_____	_____
Check if history of:		
Superficial phlebitis	_____	_____
DVT – deep vein thrombosis	_____	_____

Do you have a family history of varicose veins? _____

Do you have a bleeding or clotting disorder? _____

How long have you had varicose or spider veins? _____

Do your symptoms interfere with your daily activities? _____

Please indicate any conservative therapies you may have tried:

Compression stockings	_____
Leg rest/elevation	_____
Exercise/walking	_____
NSAIDS/OTC medications	_____

Have you had previous vein treatment? _____ If yes, please indicate type procedure and dates.

Current medications:

_____
_____
_____

Medication allergies: _____

Check all applicable medical conditions:

High blood pressure _____
Cardiac disease _____
Fainting/Syncope _____
Diabetes Mellitus _____
Kidney Disease _____
Arthritis _____
Cancer _____
HIV/AIDS _____
Hepatitis _____
Asthma _____
Auto-Immune Disorder _____
Spine/back problems _____

Do you smoke? _____ If yes, amount: _____
Do you drink alcohol? _____ If yes, amount: _____

Please list any significant health problems not listed above:

_____
_____
_____

Please list past surgical history:

_____
_____
_____