VEIN SPECIALISTS OF ILLINOIS

Patient Registration Form

Expert Care. Healthier Legs

Dr. Stephen C. Sorenson, MD, RVT, RPVI
Thomas A. Lutz, MD, RVT, RPVI

CURRENT PATIENT INFORMATION

Last Name: _____ **First Name:** _____

Preferred Name: _____ **Middle Name:** _____

Date of Birth: _____ **Sex:** **Male** **Female**

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Work Phone:** _____

Mobile Phone: _____ **Consent to text?** Yes No

Email: _____ **Consent to Email?** Yes No

Preferred method of contact: Home Phone / Mobile / Phone / Email / Work Phone / Patient Portal

Primary Care Provider: _____ **PCP Phone:** _____

PCP Address: _____

Preferred pharmacy: _____

How did you hear about us? _____

Referring physician name **(if applicable)**: _____

Required by government mandate [You may refuse to answer]

Language: _____ **Race:** _____

Ethnicity: _____ **Marital Status:** _____

EMERGENCY CONTACT

Name: _____

Relationship: _____ **Phone:** _____

EMPLOYER INFORMATION

Occupation: _____ **Employer Name:** _____

Employer Address: _____

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GUARANTOR INFORMATION (to whom statements are sent)

_____ **Self** _____**Other** (please complete below information)

Name: _____

DOB: _____ **Relationship to pt:** _____ **Phone:** _____

PRIVACY INFORMATION

Consent to download a list of your medications from the pharmacy you have provided? Yes No

Please list the names of any people that you authorize us to release your protected health information (PHI) to (this may include clinical information, results, billing information, appointment information):

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Please indicate how you'd like to be contacted for each of the following categories: (circle all that apply):

Appointment reminders: Email Text Phone **Announcements:** Email Text Phone

Billing Reminders: Email Text Phone **Health Notifications**: Email Text Phone

INSURANCE INFORMATION

Primary Ins Company: _____

Pt Relationship to Policy Holder: _____

Last Name: _____

First Name: _____

Middle Initial: _____ DOB: _____ Sex: M F

Address: _____

City: _____ State: _____ Zip: _____

Employer Name: _____

Secondary Ins Company: _____

Relationship to Policy Holder: _____

Last Name: _____

First Name: _____

Middle Initial: _____ DOB: _____ Sex: M F

Address: _____

City: _____ State: _____ Zip: _____

Employer Name: _____

To the best of my knowledge, the above information is complete and accurate.

Signed: _____ **Date:** _____

VEIN SPECIALISTS OF ILLINOIS

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Patient Health History

Dr. Stephen C. Sorenson, MD, RVT, RPVI
Thomas A. Lutz, MD, RVT, RPVI

CURRENT PATIENT INFORMATION

Last Name: _____ **First Name:** _____

Middle Initial: ____ **Date of Birth:** _____ **Sex:** M F **Height:** _____ **Weight:** _____lbs

Allergies: Yes / No (if yes, please list below)

_____ **Reaction:** _____ **Severity:** _____

_____ **Reaction:** _____ **Severity:** _____

_____ **Reaction:** _____ **Severity:** _____

Current Medications: _____ See attached list or list below:

_____

_____

_____

_____

RECENT VACCINATIONS (please check all that apply)

☐ **Flu** (Date) _____ ☐ **Shingles** (Date) _____ ☐ **Pneumonia** (Date) _____

☐ **Tdap (tetanus)** (Date) _____ ☐ **Other** (please list)_____ (Date) _____

FAMILY HISTORY (please check all that apply)

___ Varicose Veins (Relative) _____ ___ Leg Ulcers (Relative) _____

___ Pulmonary Embolism (PE) (Relative) _____ ___ Cancer (Relative) _____

___ Blood clotting disorders (Relative) _____

___ Deep Vein Thrombosis (DVT) (Relative) _____

Other: _____

GYNECOLOGICAL HISTORY (FOR WOMEN ONLY)

Are you currently pregnant? Yes or No **Are you currently breastfeeding?** Yes or No

Date of LMP: _____ **# of pregnancies:** _____ **# of live births:** _____

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SOCIAL HISTORY

Do you have an Advanced Directive? Yes / No

Smoking Status: Current / Former / Never **If current/former pack per day:** _____

Alcohol Intake: None / Occasional / Moderate / Heavy

Illicit drugs used: _____

Lives alone: Yes / No **Limited mobility:** Yes / No **Frequent air travel:** Yes / No

Exercise level: None / Occasional / Moderate / Heavy

SURGICAL HISTORY

_____ **Date** _____ _____ **Date** _____

_____ **Date** _____ _____ **Date** _____

_____ **Date** _____ _____ **Date** _____

PAST MEDICAL HISTORY (please check all that apply)

___ **Previous tx of varicose veins** (please list type of tx and dates below)

_____

___ **Previous tx of spider veins** (please list type of tx and dates below)

_____

Do you routinely wear prescribed compression stockings: Yes / No

___ Venous leg ulcers	___ Bleeding/Clotting Disorder	___ Kidney Disease
___ Superficial thrombophlebitis	___ Anti-coagulant therapy	___ Asthma/Lung Disease
___ History of deep vein thrombosis (DVT)	___ Cancer	___ Neurological Disease
___ History of pulmonary embolism (PE)	___ Diabetes	___ Autoimmune Disease
___ May-Thurner Syndrome	___ Heart Disease	___ Dermatological Disease
___ Klippel-Trenaunay Syndrome	___ High Blood Pressure	___ HIV / AIDS
___ Restless legs	___ Stroke	___ Hepatitis

Other: _____

_____

_____

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Patient Health History

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REVIEW OF SYMPTOMS
(please circle all symptoms that you are currently or recently experiencing)

Constitutional:
Fever, Chills, Night sweats, Weight gain, Weight loss, Exercise Intolerance, Decrease in appetite, Insomnia

Eyes:
Dry eyes, Irritation, Pain in eyes, Vision change, Floaters, Photophobia, Double vision, Discharge

ENMT:
Difficulty hearing, Ear pain, Vertigo, Tinnitus, Difficulty smelling, Frequent Nosebleeds, Nose/sinus problems, Sore throat, Difficulty swallowing, Unusual taste, Bleeding gums, Snoring, Dry mouth, Oral abnormalities, Mouth ulcers, Teeth problems, Mouth breathing

Cardiovascular:
Chest pain, Arm pain on exertion, Palpitations, Shortness of breath w/walking, Known heart murmur, Lightheadedness, Calf or jaw pain, Ankle swelling, Shortness of breath w/lying down

Respiratory:
Cough, Wheezing, Shortness of breath, Rapid breathing, Coughing up sputum, Coughing up blood, Sleep Apnea

Gastrointestinal:
Nausea, Vomiting, Vomiting blood, Abdominal pain, Abnormal appetite, Black/Tarry Stools, Diarrhea, Constipation, Heartburn

Genitourinary:
Pain w/urination, Incontinence, Difficulty urinating, Blood in urine, Increased frequency, Feelings of urgency, Incomplete emptying, Flank pain, Urinary tract infections

____ ALL NORMAL

Musculoskeletal:
Muscle aches, Muscle weakness, Muscle cramps, Arthralgia/joint pain, Back pain, Swelling in the extremities, Difficulty walking, Leg pain

Integumentary:
Dry skin, Abnormal mole, Jaundice, Rash, Discoloration, Itching, Ulcers, Growth/lesion, Excessive sweating

Neurologic:
Loss of consciousness, Slurred speech, Weakness, Numbness, Tingling, Tremors, Seizures, Dizziness, Headaches, Restless Legs, Memory lapse/change, Difficulty finding desired words, Loss of balance/falls

Psychiatric:
Irritability, Depression, Anxiety, Panic attacks, Sleep disturbances, Feel unsafe in relationship, Thoughts of suicide, Paranoia

Endocrine:
Fatigue, Increased thirst, Hair loss, Increased hair growth, Cold intolerance, Heat intolerance, Unusual body odor, Erectile dysfunction, Irregular/problematic menstrual cycle

Hematologic/Lymphatic:
Swollen glands, Easy bruising, Excessive bleeding

Allergic/Immunologic:
Runny nose, Sinus pressure, Itching/hives, Frequent Sneezing

Other: _____

_____

To the best of my knowledge, the above information is complete and accurate.

Signed: _____ **Date:** _____

Vein Specialists of Illinois
1670 Capital St. Ste 500 Elgin, IL 60124 T: 847-468-9900 F: 847-468-9901
795 Ela Rd Ste 115 Lake Zurich, IL 60047 T: 847-550-4984 F: 847-847-7289

Updated 1/9/19

VSI VEIN SPECIALISTS OF ILLINOIS
Expert Care. Healthier Legs

Dr. Stephen C. Sorenson, MD, RVT, RPVI
Dr. Thomas A. Lutz, MD, RVT, RPVI

PATIENT FINANCIAL POLICY

Thank you for choosing Vein Specialists of Illinois (VSI) as your health care provider. We are dedicated to providing the best possible care for you and building a successful physician-patient relationship. VSI believes that part of good health care practice is to establish and communicate a financial policy to our patients. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities.

CANCELLATION POLICY

Your appointment is time that we have set aside for you alone as we do not double book our appointments. We understand that sometimes things can come up or emergencies arise. Should you need to cancel or reschedule your appointment we would greatly appreciate at least 24-hour's notice. This allows us adequate time to possibly refill the appointment as well as reschedule your appointment for a time that will better fit your needs. Repeated no-shows or late cancellations will result in a $50.00 cancellation fee.

Initials_____

PATIENTS WITH INSURANCE

If you have medical insurance, we wish to help you receive your maximum allowable benefits. To achieve this, it is necessary for you to understand how we interact with your insurance and what your responsibilities are as the insured party. Insurance is a contract between you and your insurance company and **ultimately you are responsible for payment in full**. As a courtesy to our patients we will file all primary and secondary insurance claims.

Network Participation

Our staff will attempt to provide you with the most accurate information possible in regards to our participation with your insurance plan, however, due to the many different insurance plans and products within each company, our staff cannot guarantee the accuracy of this information. **It is ultimately your responsibility to contact your insurance company to verify that we are listed as participating providers within your particular plan**.

If our doctor is NOT listed in your plan's network (we are "out-of-network") our services may not be covered at all or may be covered at a lower rate than services provided by an in-network provider.

Initials_____

Eligibility, Coverage and Benefits

Our medical records system will electronically verify your eligibility prior to each appointment if your insurance plan has enabled this functionality. For those plans that have not enabled this functionality, our staff will manually verify your eligibility at you first appointment and at the start of each new calendar year. Due to limited staff resources, **we will not manually verify your eligibility prior to each appointment**. It is YOUR responsibility to keep us updated with your correct insurance information. **Inaccurate or untimely information given to the staff that results in denial or non-coverage by your insurance company results in the guarantor being responsible for payment.**

As a courtesy, our staff will provide you with an overview of your benefits including deductible, co-pay and co-insurance amounts and exclusions after your consultation and/or mapping. Please understand that due to the complicated nature and wide range of insurance plans, it is ultimately YOUR responsibility to fully understand the

benefits of your specific plan. Please also be aware that we are sometimes given incorrect information by representatives from the insurance company. In these cases, we will do our best to appeal your case, but you are ultimately responsible for the charges your insurance company designates as patient responsibility.

Not all insurance plans cover all services or products so it is very important that you understand the provisions of your individual policy. Coverage of a service does NOT mean that you will not have any financial responsibility for the service; you may still have to pay a deductible, co-pay or co-insurance amount for the covered service. **In the event your insurance plan determines a service or product to be "not covered" for any reason, you will be responsible for the charges.**

Initials_____

Prior Authorization of Procedures

During the initial review of your insurance benefits, we will ask your insurance company if the procedures we perform require prior authorization, prior notification or pre-certification. If prior authorization is required, we will submit any forms and/or medical records necessary to obtain the authorization.

Prior authorization, pre-certification or pre-determination of a service DOES NOT GUARANTEE THAT YOUR INSURANCE COMPANY WILL PAY THE SERVICE ONCE IT IS BILLED. If the insurance company does not pay a claim for a prior-authorized service, we will appeal the claim, but you are still financially responsible for the charges if the appeal is denied.

Initials_____

Billing Procedures

You will be billed separately for each appointment. There are no follow-up appointments that are considered part of the prior procedure performed and not-billable.

Co-pays will be due at the time of service without exception. The co-pay cannot be waived by our practice as it is a requirement of our contract with the insurer to collect this fee.

You will be sent a statement for charges after your insurance company has processed a claim and has sent us an EOB stating what your financial responsibility is for the billed services. Please understand that most appointments involve billing multiple different codes for that day's services. Your insurance company may choose to process these codes separately, at different times, which can result in charges from a single date of service being billed to you on separate statements.

Your balance represents any deductible, co-insurance, unpaid co-pays and non-covered charge amounts that are your responsibility after the insurance has made any payments or contractual discounts against the original billed amount. We are contractually obligated to collect these amounts from you if we are in-network with your insurer and you are contractually obligated to pay these amounts by accepting coverage from your insurer.

Unless prior arrangements have been made with our office, payment in full is due within **10** business days of your receipt of your bill.

Initials_____

VEIN SPECIALISTS OF ILLINOIS
Expert Care. Healthier Legs

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Dr. Thomas A. Lutz, MD, RVT, RPVI

SELF-PAY PATIENTS

In order to address the needs of our patients without insurance and patients with coverage limitations, we offer a discount from our standard fees for any non-cosmetic procedures. This discount acknowledges the lower cost involved in billing and collections when a claim does not need to be submitted to a third-party payer. A further 10% discount is available if charges are paid in full at the time of service. All self-pay patients will be provided with a cost estimate for their treatment plan. If you are unable to pay your balance in full, you will need to make prior arrangements with our Practice Administrator.

Initials_____

PAYMENT AND FINANCIAL RESPONSIBILITY

We accept payment in the form of cash, check, money order, Care Credit or credit card (Visa, MasterCard, Discover and American Express). If you are unable to pay your balance in full please ask our staff about payment arrangements.

A cost estimate for the proposed treatment plan will be provided to you after the initial consultation and before the time of your first procedure. **We strive to be as accurate as possible in calculating your responsibility but, with so many variations in policies and fee schedules, we are not always exact. You are ultimately responsible for all balances incurred during your treatment.**

All patients are required to sign the Cost Estimate and the Payment Agreement forms prior to beginning treatment

A down payment of half your deductible amount due (capped at $500.00) will be required prior to your first treatment.

Payment and credits are applied to the oldest charges first, except for co-pays and insurance payments which are applied to the corresponding dates of service.

Returned checks will incur a $25.00 service charge. Stop payments constitute a breach of payment and are subject to the $25.00 fee and collections action.

Initials_____

PAST DUE ACCOUNTS

If your account reaches 120 days past due and no payment arrangements have been made, your account will be forwarded to an outside agency for collection efforts. If your account is forwarded to a collection agency, we will continue to see you on an emergency basis only for the next 30 days, giving you time to find a new source of medical care. Any fees incurred by the practice that are the results of these collection efforts will be your responsibility and will be added to the total amount due. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

Initials_____

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign, transfer, and set over directly to Stephen Sorenson, MD/Thomas Lutz, MD/Illinois Vein Specialists, Elgin - S.C. sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said practice. I authorize Stephen Sorenson, MD/Thomas Lutz, MD/Illinois Vein Specialists, Elgin - S.C. to contact my insurance company or health plan administrator and obtain all pertinent

financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Stephen Sorenson, MD/Thomas Lutz, MD/Illinois Vein Specialists - Elgin, S.C. I authorize Stephen Sorenson, MD/Thomas Lutz, MD/Illinois Vein Specialists - Elgin, S.C to release all medical information requested by my health insurance carrier, Medicare, other physicians or providers, and any third-party payers.

Initials_____

RELEASE OF INFORMATION: I hereby authorize and direct Stephen Sorenson, MD/Thomas Lutz, MD/Illinois Vein Specialists - Elgin, S.C to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

Initials_____

REPSONSIBILITY FOR PAYMENT: I understand that I, personally, am financially responsible to Stephen Sorenson, MD/Thomas Lutz, MD/Illinois Vein Specialists - Elgin, S.C for charges not covered by the assignment of insurance benefits.

Initials_____

ACKNOWLEDGEMENT

I acknowledge that I have received and read a copy of the Vein Specialists of Illinois Patient Financial Policy and agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____
Signature of Patient (or Guarantor, if applicable) Date

_____
Print the name of the patient

_____ _____
Authorized Practice Representative Date

VEIN SPECIALISTS OF ILLINOIS
Expert Care. Healthier Legs

Dr. Stephen C Sorenson, MD, RVT
Dr. Thomas A. Lutz, MD, RVT

NOTICE OF PRIVACY PRACTICES

In accordance with the Health Insurance Portability and Accountability Act of 1996, as of April 14, 2003 all health care providers are required to provide their patients with a "Notice of Privacy Practice' statement.

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

The health provider named above is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

1. We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.
2. On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with the healthcare provider named above.
3. It is our policy to provide a substitute health care provider, authorized by the healthcare provider named above to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation.

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to us for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received.

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings.

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Change of Ownership

In the event that the health care provider named above is sold or merged with another organization, your health information/record will become the property of the new owner.

Marketing

We may contact you for marketing purposes or fundraising purposes, as described below.

1. As a courtesy to our patients, we may call your home prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.
2. It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc . During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Health Care provider sponsored fund-raising events. If we conduct fundraising and we use communications like the U.S. Postal Service or electronic email for fundraising, you have the right to opt-out of receiving such communications from us.
3. We also provide educational and informative newsletters. We use communications like the U.S. Postal Service or electronic email for our newsletters--you have the right to opt-out of receiving such communications from us.

Your Health Information Rights

1. You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that the healthcare provider named above is not required to agree to the restriction that you requested.
2. You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
3. You have the right to inspect and copy your health information.
4. You have a right to request that the healthcare provider named above amend your protected health information. Please be advised, however, that the healthcare provider named above is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
5. You have a right to receive an accounting of disclosures of your protected health information made by the healthcare provider named above.
6. You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

1. The healthcare provider named above reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, the healthcare provider named above is required by law to comply with this Notice.
2. The healthcare provider named above is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please call the office number listed at the top of this page.

Complaints

Complaints about your Privacy rights, or how the healthcare provider named above has handled your health information should be directed to Practice Privacy Officer by calling this office at the number noted at the top of this page. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:
DHHS, Office of Civil Rights, 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, DC 20201**.**

Right to a Copy of This Notice

You have a right to have a paper copy of our Notice of Privacy Practices at any time. In addition, a copy of this Notice will always be posted in our waiting area. If you would like to have a copy of our Notice, ask the receptionist for a copy or contact our Privacy Officer at (**847) 468-9900**.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide the healthcare provider named above with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient's Name (print) _____

Patient's Signature _____ Date_____

Authorized Facility Signature _____ Date_____