PREMIER MED GROUP

Date: _____

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

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Cell Phone: (___) ___ - _____ **Home Phone:** (___) ___ - _____ **Alternate Phone:** (___) ___ - _____ - _____

SSN#: _____ **Gender:** M / F / T **Marital Status:** _____ **Race:** _____

Primary Care Doctor: _____ **Referring Doctor:** _____

Emergency Contact Name: _____ **Phone:** _____ **Relationship:** _____

Language: English / Spanish / Other: _____ **How did you hear about us:** _____

Email Address: _____ **Contact Pref.:** Home Cell

Occupation: _____ **Employer:** _____

Pharmacy: _____

Insurance Information:

Primary Insurance: _____ **Policy #**_____ **Group#**_____

Policy owner: ☐ Self ☐ Spouse ☐ Other: _____

Policy Owner's Name & DOB: _____

Secondary insurance: _____ **Policy #**_____ **Group#** _____

Policy owner is your: ☐ Self ☐ Spouse ☐ Other: _____

Policy owner's name & DOB: _____

Worker's Compensation Case (OR) Motor Vehicle Accident Case:

Insurance Carrier: _____ **Date of Injury:** _____

Address: _____

Claim # _____ **Adjuster's Name:** _____

Phone# _____ **Fax#** _____

Where did the injury occur? _____

Attorney's Name: _____ **Phone #:** _____

Attorney's Address: _____

Are you currently working? (Please circle) YES / NO Full-time / Part-time

If NO, date you last worked? _____

What is your current: Height _____Feet _____ Inches / Weight _____ Lbs.

Where on your body is your main pain? (Check all that apply)
☐ Head Arm: ☐ Right ☐ Left Hand: ☐ Right ☐ Left Leg ☐ Right ☐ Left
☐ Neck Chest ☐ Right ☐ Left Abdomen: ☐ Right ☐ Left Back: ☐ Right ☐ Left

Pick a number for your pain: Least 1 2 3 4 5 6 7 8 9 10 Worst

How long have you had this Pain? _____months _____years

Is there another area on your body that you have pain? _____

Describe the quality of the pain: ☐ Knife Like ☐ Burning ☐ Electric Shock ☐ Throbbing ☐ Dull Ache

Describe the duration of the pain: ☐ Constant ☐ Comes & Goes ☐ Always present but gets worse at times

Describe the intensity of the pain: ☐ Mild ☐ Discomforting ☐ Distressing ☐ Horrible ☐ Excruciating

What makes the pain worse: ☐ Sitting ☐ Walking ☐ Damp Weather ☐ Other: _____

What makes the pain better: ☐ Rest ☐ Hot Shower ☐ Other: _____

What treatments have you received: ☐ Physical Therapy ☐ Injections ☐ None ☐ Other (specify): _____

What medications do you take for pain? _____

Do you take Aspirin/Baby Aspirin or Blood Thinning Medications? ☐ Yes ☐ No

How do you sleep at night? ☐ Poor ☐ Fair ☐ Normal

Have you had to cut down on normal activities because of our pain? ☐ Yes ☐ No

If YES, how much? ☐ Mildly ☐ Moderately ☐ Severely

Have you had any of these medical conditions?
☐ Heart problems ☐ Asthma ☐ Kidney problems ☐ Liver problems ☐ Arthritis ☐ Stomach Ulcers
☐ Diabetes ☐ Stroke ☐ High Blood Pressure ☐ Blood Disorders ☐ Easy bruising ☐ Psychiatric problems

List ALL surgeries you have had in the past with dates:

_____

_____

List ALL medication with dosage:

_____ _____ _____

_____ _____ _____

List any medications you are allergic to:

_____

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day do you smoke? _____

Do you drink alcohol? ☐ Yes ☐ No ☐ Socially

Do you use any recreational drugs like marijuana, cocaine, etc.? ☐ Yes ☐ No

Are you experiencing any of the following? If so, please circle.

Constitutional
Fever
Chills
Sweats
Loss of appetite
Weight Loss
Fatigue

Eyes
Vision Loss
Double vision
Blurred vision
Eye irritation
Eye pain
Discharge
Light sensitivity
Swelling around the eye
Redness in both eyes
Glasses
Contact Lenses

ENMT
Earache
Ear discharge
Ringing in the ears
Decreased hearing
Frequent colds
Nasal congestion
Nosebleeds
Bleeding gums
Difficulty swallowing
Hoarseness
Sore throat
Red and dry lips
Red and swollen tongue

Gastrointestinal
Change in appetite
Indigestion
Heartburn
Nausea
Vomiting
Excessive gas
Abdominal pain
Abdominal bleeding
Hemorrhoids
Diarrhea
Change in bowel habits
Constipation
Black or tarry stools
Bloody stools
Swelling in the abdominal area
Enlarged liver
Bloating of the abdomen with fluid

Cardiovascular
Difficulty breathing at night
Chest pain or discomfort
Irregular heart beats
Fatigue
Lightheadedness
Shortness of breath with exertion
Palpitations
Swelling of hands or feet
Difficulty breathing while lying down
Leg cramps with exertion
Discoloration of lips/nails
Recent weight gain
Anxiety
Diaphoresis
Tachycardia
Bradycardia
Built-up fluid in the heart

Respiratory
Sleep disturbances due to breathing
Cough
Coughing up blood
Shortness of breath
Chest discomfort
Wheezing
Excessive sputum
Excessive snoring
Built-up fluid in the lungs
Dry or persistent cough

Genitourinary Male
Frequent urination
Blood in urine
Foul urinary discharge
Kidney pain
Urinary urgency
Trouble starting urinary stream
Inability to empty bladder
Burning or pain on urination
Genital rashes or sores
Testicular pain or masses

Genitourinary Female
Inability to control bladder
Unusual urinary color
Missed periods
Excessively heavy periods
Lumps or sores
Pelvic pain

Musculoskeletal
Knee pain
Joint stiffness
Joint swelling
Muscle cramps
Muscle weakness
Muscle aches
Loss of strength
Upper body pain
Pain in upper hips-sides of hips
Upper chest pain
Pain between shoulder blades
Neck pain
Lumbar spine pain
Thoracic spine pain
Shoulder pain
Arm pain
Elbow pain
Wrist pain
Ankle pain
Leg pain
Leg swelling
Facial pain
Jaw pain
Finger pain
Toe pain
Heel pain
Foot pain
Hip pain
Thigh pain
Calf pain
Skull pain
Hand pain

Skin
Suspicious lesions
Night sweats
Excessive perspiration

Poor wound healing
Dryness
Itching
Rash
Flushing
Changes in hair or nails
Changes in color of skin
Pale gray or blue skin color Cyanosis
Clammy skin
Peeling of the skin on the hands and feet

Neurologic
Headache
Poor balance
Difficulty with speaking
Difficulty with concentration
Disturbances in coordination
Weakness or numbness
Brief paralysis
Tingling
Visual disturbances
Faints or blackouts
Seizures
Tremors
Sensation of room spinning
Memory loss
Excessive daytime sleeping
Dizziness

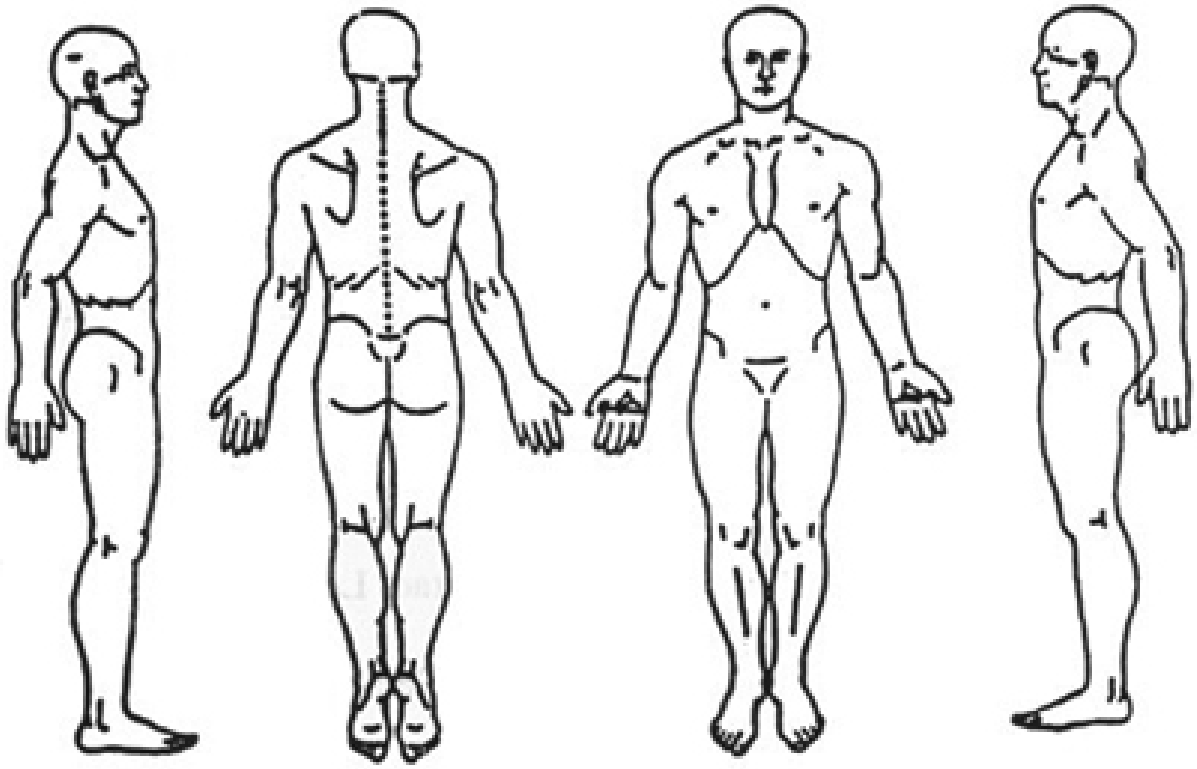
Psychiatric
Anxiety
Nervousness
Depression
Memory change
Frightening visions or sounds
Thoughts of suicide or violence
Impending sense of doom
Anger
Loneliness

Endocrine
Heat or cold intolerance
Weight change
Excessive thirst or hunger
Excessive sweating or urination

Hematologic-Lymphatic
Skin discoloration
Bleeding
Enlarged lymph nodes
Fevers
Abnormal bruising

Allergic-Immunologic
Seasonal allergies
Hives or rash
Persistent infections
HIV exposure

On the drawing below please shade in the areas in which you are experiencing pain:



Right Side Backside Front Left Side

Initials: _____

Pain Management Narcotic Administration Contract

This agreement is between patient and the pain management physician. It is agreed that narcotic medications will be given by the physicians ONLY if the following terms are met:

1. Pain Management Physician discusses the uses of narcotic medications with the patient, including realistic goals for pain relief, proper methods of taking the medications, risks of side effects and specific issues of developing tolerance, dependence, habitation, addiction and withdrawal problems due to these medications and the need for co-prescribing of Narcan (or) Evzio.
2. The patient has a chance to ask questions regarding the use of narcotic medications.
3. By signing a special consent form for chronic narcotic administration, the patient indicated that he/she has understood the discussion about the use of narcotic medications, including all the side effects, and is agreeable to start this treatment under the terms set by Pain Management Physician.
4. Pain Management Physician should be the one and only source of narcotic medications unless written permission is given by Pain Management Physician for the patient to get narcotic prescriptions from another physician. Any breach will call for immediate discharge.
5. Only one pharmacy will be used for filling narcotic prescriptions. The name, address and telephone number will be given to Pain Management Physician.
6. The patient agrees to have urine tests (screening for medications) done randomly at the physician's request.
7. The patient must agree to allow the Pain Management Physician to communicate with the referring physician and any pharmacists regarding the patient's use of controlled substances.
8. The patient understands that Pain Management Physician will not replace any lost or inaccessible narcotic prescriptions or narcotic medications for ANY REASON. Any lost or stolen medication should immediately be reported to the local authorities and the report should be presented to the office.
9. The patient must take the narcotic medications exactly as instructed by the Pain Management Physician.
10. Any unauthorized increase in the dose of narcotic medication may be viewed as a cause for discontinuation of the treatment with narcotic medications.
11. If the patient demonstrates unacceptable behavior patterns, the Pain Management Physician may discontinue prescribing the narcotic medications for the patient.
12. The patient must keep all regular follow up appointments as recommended by the Pain Management Physician. Failure to comply may cause discontinuation of narcotic prescriptions.
13. All triplicate prescriptions must be picked up by the patient themselves. If the patient is too debilitated or sick, an exception may be allowed.
14. No triplicate (narcotic) prescriptions will be refilled on weekends or over the phone. Narcotic prescriptions cannot be refilled over the phone – refills will only be issued at the time of your follow up visit. If your prescription does not last until your next visit, that indicates a problem. Please schedule an appointment at your earliest convenience in order to discuss the reasons why you ran out of medication and whether we can refill your narcotic prescription.
15. The patient understands that the benefit of the narcotic medications will be evaluated periodically using the following criteria of pain relief, increase in general functions, increase in exercise, completion of Rehabilitation, return to work, maintenance of a job, etc.
16. The patient understands that narcotic medications can be discontinued immediately, at the treating physician's discretion, if the patient does not fulfill the terms of this agreement. Medication can also be

Initials: _____

discontinued if there is evidence of rapid tolerance, loss of effectiveness or if significant side effects develop.

17. The patient certifies or agrees to the following:
    a. That he/she is not currently abusing illicit or prescription drugs, and that he/she is not undergoing treatment for substance dependence or abuse.
    b. That he/she has never been involved in the sale, illegal possession, diversion or transport of controlled substances (narcotics, sleeping pills, nerve pills, or pain killers).
    c. That she is not pregnant and that she will use appropriate contraception during her course of treatment.
    d. Sharing your narcotics is STRICTLY prohibited. Any sharing will result in the immediate cancellation of your prescription refills.
18. Evidence of medication hoarding, increasing the amount of medication without communication to your Pain Management Physician, refilling your prescription too frequently, getting the medication from multiple physicians, increasing the amount of the medication despite significant side effects, altering prescriptions, medication sales, unapproved use of other drugs (alcohol, sedatives, or using non-prescription medications inconsistent with the drug labeling) during narcotic analgesic treatment or other inacceptable behavior will result in tapering and discontinuing of narcotic maintenance therapy.

This form has been fully explained to me, I have read it or have had it read to me, and I understand and agree to the terms of this contract.

_____	_____	_____
(Patient's Name)	**(Patient Signature)**	**(Date)**
_____	_____	_____
(Witness Name)	**(Witness Signature)**	**(Date)**

Authorization for Release of Medical Records

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

I hereby authorize PREMIER SPINE AND PAIN MANAGEMENT and it's associates to release or request from other Doctors or Hospitals, any and all information which they possess or require relating to my examinations and illness, which may be part of the medical record, including psychiatric/psychological, alcohol, drug abuse, AIDS, ARC, or HIV related diagnosis, treatments and rehabilitation for the following period:

_____

_____

_____

_____

PHYSICIAN, HOSPITAL, AGENCY

Full Name: _____

Address: _____

City, State, Zip: _____

Information is being released or requested for the following reasons:

- ☐ To a Physician for continued medical care
- ☐ Insurance
- ☐ Attorney
- ☐ Other: _____

Signature of patient or other legal representative: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

ASSIGNMENT OF BENEFITS & AUTHORIZATION

TO PURSUE APPEAL AND / OR LITIGATION OF HEALTH CARE BENEFITS

In consideration of the professional services rendered by Premier Spine and Pain Management and its affiliate healthcare providers, ("Health Care Providers"), I hereby irrevocably direct, authorize, assign and consent to the following:

1. The assignment of my rights to bill, collect, appeal and/or arbitrate my claims for health insurance benefits with regard to the above-captioned claim to healthcare providers, including but not limited to surgical facility fees, supplies, primary physician, assistant, anesthesia and any other fees related to my claims, pursuant to my rights under state and/or federal law including but not limited to the federal ERISA statues, Health Claims Authorization, Processing and Payment Act (HCAPPA), and HealthCare Quality Act (HCAA).
2. The authorization of Health care providers to act as my agent-in-fact with regard to all aspects regarding the above-captioned claim and to receive any and all communications regarding the claim any appeals or arbitration of the denial of my claim as a substitute beneficiary under my policy of health insurance whether fully founded or self-funded.
3. The authorization of healthcare providers to initiate, prosecute, and resolve any and all appeals and/or arbitrations and/or legal actions on the denial of my claim, including but not limited to internal appeals with the insurer, outside reviewing entities or agencies as well as arbitrations and litigations matters in state or federal court including but not limited to claims under the federal ERISA statutes, Health Claims Authorization, Processing and Payment Act (HCAPPA), and HealthCare Quality Act (HCQA).
4. The authorization of Health care providers to obtain and/or disclose any Private health information as contemplated by HIPAA limited to my claim for insurance benefits and any appeal there from. I have signed a separate HIPAA authorization in this regard.
5. The authorization of healthcare providers to file a complaint with regard to any denial of my claims(s) with the Department of Health and Senior Services, the Department of Banking and Insurance, the federal department of labor as it relates to ERISA plans, as well as any other governmental agency with jurisdiction over my claim and/or the insurer.
6. The authorization for payment of any and all insurance benefits directly to HealthCare providers to which I might be entitled under the above-captioned claim.

_____	_____	_____
(PATIENT NAME)	(WITNESS NAME)	(DATE)
_____	_____	_____
(PATIENT SIGNATURE)	(WITNESS SIGNATURE)	(DATE)

ASSIGNMENT OF BENEFITS & AUTHORIZATION

TO PURSUE APPEAL AND / OR LITIGATION OF HEALTH CARE BENEFITS

In consideration of the professional services rendered by Northeast Pain Associates, LLC and its affiliate healthcare providers, ("Health Care Providers"), I hereby irrevocably direct, authorize, assign and consent to the following:

1. The assignment of my rights to bill, collect, appeal and/or arbitrate my claims for health insurance benefits with regard to the above-captioned claim to healthcare providers, including but not limited to surgical facility fees, supplies, primary physician, assistant, anesthesia and any other fees related to my claims, pursuant to my rights under state and/or federal law including but not limited to the federal ERISA statues, Health Claims Authorization, Processing and Payment Act (HCAPPA), and HealthCare Quality Act (HCAA).
2. The authorization of Health care providers to act as my agent-in-fact with regard to all aspects regarding the above-captioned claim and to receive any and all communications regarding the claim any appeals or arbitration of the denial of my claim as a substitute beneficiary under my policy of health insurance whether fully founded or self-funded.
3. The authorization of healthcare providers to initiate, prosecute, and resolve any and all appeals and/or arbitrations and/or legal actions on the denial of my claim, including but not limited to internal appeals with the insurer, outside reviewing entities or agencies as well as arbitrations and litigations matters in state or federal court including but not limited to claims under the federal ERISA statutes, Health Claims Authorization, Processing and Payment Act (HCAPPA), and HealthCare Quality Act (HCQA).
4. The authorization of Health care providers to obtain and/or disclose any Private health information as contemplated by HIPAA limited to my claim for insurance benefits and any appeal there from. I have signed a separate HIPAA authorization in this regard.
5. The authorization of healthcare providers to file a complaint with regard to any denial of my claims(s) with the Department of Health and Senior Services, the Department of Banking and Insurance, the federal department of labor as it relates to ERISA plans, as well as any other governmental agency with jurisdiction over my claim and/or the insurer.
6. The authorization for payment of any and all insurance benefits directly to HealthCare providers to which I might be entitled under the above-captioned claim.

_____	_____	_____
(PATIENT NAME)	(WITNESS NAME)	(DATE)
_____	_____	_____
(PATIENT SIGNATURE)	(WITNESS SIGNATURE)	(DATE)

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and al full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or sent a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed: _____

_____

_____ _____ _____

(PRINT PATIENT NAME) **(PATIENT SIGNATURE)** **(DATE)**

PATIET PROTECTION AND ADVOCACY POLICY

AFFORDABLE CARE ACT DISCLOSURE

Dear Patient:

1. As your patient advocate (PA), we offer the highest quality care and safety possible at the most affordable cost to you, regardless of whether you are covered by an in-network or out-of-network health plan.
2. We offer an Affordable Care Act Discount (ACA Discount) under our Corporate Compliance policy to anyone who qualifies, on a case by case basis. You only pay what you can afford or are willing to pay for your deductible and co-insurance, as outlines in your plan cost-sharing obligations, based on your medical need. Most people may qualify and your satisfaction is guaranteed.
3. Our affordable care act (ACA) discount is similar to or even much better than all PPO discounts, as our ACA discount is available for both in-network and out-of-network providers and facilities.
4. Once you qualify, you will NOT receive any unexpected invoices, bills or collection letters FROM US, even if your insurance denies your claims.
5. As your patient advocate and authorized representative, and under federal health reform law PPACA (patient Protection and Affordable Care Act or ACA), we may appeal all of the claims denials or delays on your behalf, which is strictly in compliance with the federal health reform law, PPACA
6. As your patient advocate, your best interest is our best interest. To ensure that you also get this of ACA Discount from other providers known to us or affiliated with us, we will inform you of these facilities and/or providers, so you may also receive the best care possible along with the ACA discounts and savings.
7. With your informed choice, we will refer you to a provider who may also offer a compliant ACA discount and ensure that you are always protected from any unexpected costs and bills under the federal health reform law (PPACA).
8. As your patient advocate, we want you to be fully protected from any unexpected costs and bills from any providers, unless otherwise authorized by you.
9. You always have freedom of choice to receive healthcare from any provider you choose. However, we cannot speak for, or guarantee anything on behalf of other providers we don't know or are not affiliated with, regarding their discount or collection policies. You are advised to contact them directly before scheduling your net appointment(s) or medical procedures(s).
10. If you are willing to be protected from any unexpected costs and bills, feel free to apply for our Affordable Care Act discount under our corporate PPACA Indigency policy. "Once indigency is determined, collection is no longer undertaken with regard to the patient for the forgiven amount". Your satisfaction is guaranteed.

I have read and fully understand this Patient Protection & Advocacy Policy. My questions are fully answered.

_____	_____	_____
(PRINT PATIENT NAME)	**(PATIENT SIGNATURE)**	**(DATE)**

New Jersey Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act ("Act") Disclosure and Acknowledgement Form

WE, DR. VIVEK DAS, DR. ARUN KANDRA, & DR. SHANTI EPPANAPALLY ("Provider"), hereby notify you of the following: I. Dr. Vivek Das is in-network with respect to the following health benefit plans:

HORIZON BCBS, CIGNA & TRADITIONAL MEDICARE

Dr. Shanti Eppanapally is in-network with respect to the following health benefit plans: TRADITIONAL MEDICARE

Dr. Arun Kandra is in-network with respect to the following health benefits plans:

TRADITIONAL MEDICARE; HORIZON NJ HEALTH; GATEWAY HEALTH OF PA

Dr. Kyle Mele is in-network with respect to the following health benefits plans:

TRADITIONAL MEDICARE

Dr. Andrew Levy is in-network with respect to the following health benefit plans: HORIZON BCBS.

Dr. Rachid Assina is in-network with respect to the following health benefit plans: TRADITIONAL MEDICARE

II. Provider is out-of-network with respect to all health benefits plans not listed in I above.

III. Providers are affiliated with the following facilities: ROBERTWOOD JOHNSON UNIVERSITY HOSPITAL SOMERSET, EASTON HOSPITAL PA, SOMERSET AMBULATORY SURGICAL CENTER, WEST MORRIS SURGERY CENTER, UNIVERSITY CENTER FOR AMBULATORY SURGERY, TEAM MD SURGERY CENTER

IV. You have the right to request from the Provider the amount or estimated amount the Provider will bill you for the services is available to you upon your request.

V. You have the right to request that Provider provide you, in writing, with a list of the services and CPT Codes associated with those services, absent any unforeseen medical circumstances which may arise during the course of your treatment, as well as the amount or estimated amount that Provider will bill you for such services.

VI. You should be aware that, with respect to a Provider who is out-of-network with your health benefits plan:

a. You will have a financial responsibility applicable to the health care services provided by the Provider in excess of your copayment, deductible, or coinsurance, and you may be responsible for any costs in excess of those allowed by your health benefits plan; and you should contact your carrier for further additional information those costs.

VII. Other Providers:

a. Please note that it's your responsibility to check your insurance participation and benefits for

services provided by facilities we refer you to coordinate your care such as but not limited to: "Referred to" Specialist Physicians; Physical Therapy; Urine Drug Screen Laboratories, Radiology Imaging facilities, and/or other specialists or surgeons

b. You can determine the health plans in which the foregoing healthcare provider(s) participate

by contacting them at their respective phone number. You should contact your carrier for further consultation on costs associated with this/these provider's/providers' services mentioned above.

VIII. The receipt an acknowledgment of this disclosure shall not waive or otherwise affect any protection you may have under existing statutes or regulations regarding in-network health benefits plan coverage available to you or created under the Act.

IX. If between the time of you were notified of Provider's network status and the time of your

procedure, the network status of Provider changes, then Provider shall promptly notify you of the same.

I HEREBY ACKNOWLEDGE THAT, PRIOR TO THE SCHEDULING OF MY APPOINTMENT, I HAVE RECEIVED THE FOREGOING DISCLOSURES. I HAVE READ THE FOREGOING, UNDERSTAND ITS CONTENTS, AND HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS REGARDING THE SAME, AS WELL AS CONSULT WITH MY HEALTH BENEFITS PLAN IN CONNECTION WITH THE DISCLOSURES PROVIDED IN THIS DOCUMENT.
BEING FULLY AWARE OF THE OUT-OF-NETWORK STATUS OF THE PROVIDER, I HEREBY KNOWINGLY, VOLUNTARILY AND SPECIFICALLY SELECT PROVIDER FOR THE PERFORMANCE OF SERVICES/MY PROCEDURE AND RELATED ANCILLARY SERVICES. I CERTIFY THAT I AM AT LEAST 18 YEARS OF AGE, COMPETENT, NOT UNDER THE INFLUENCE OF ANY DRUG, ALCOHOL OR OTHER SUBSTANCE THAT WOULD IMPAIR MY ABILITY TO UNDERSTAND THESE DISCLOSURES, AM NOT BEING COERCED TO SIGN THIS DISCLOSURE, AND DO SO UPON MY OWN FREE WILL.

Patient Signature: _____

Patient Name: _____

Date: _____

I. VASCULAR HISTORY

Do you have or have you ever been diagnosed with:

Varicose vein problems Y / N Leg: Right / Left
Phlebitis (vein redness/tenderness) Y / N Leg: Right / Left
Blood clots Y / N Leg: Right / Left
Deep vein thrombosis (DVT) Y / N Leg: Right / Left
Saphenous Vein Reflux Y / N Leg: Right / Left

Do you experience any of the following in your legs(s):

Aching/pain Y / N Leg: Right / Left
Heaviness Y / N Leg: Right / Left
Tiredness/fatigue Y / N Leg: Right / Left
Itching/burning Y / N Leg: Right / Left
Swelling Y / N Leg: Right / Left
Diabetes Y / N Leg: Right / Left
Restless legs Y / N Leg: Right / Left
Throbbing Y / N Leg: Right / Left
Skin or Ulcer problems Y / N Leg: Right / Left
HTN Y / N Leg: Right / Left
Lupus Y / N Leg: Right / Left
High Cholesterol Y / N Leg: Right / Left
Connective Tissue Disorders Y / N Leg: Right / Left
Other:

Which of the following do you currently do to improve your leg vein symptoms:

Medication for pain Y / N What? _____
Elevation of legs Y / N What? _____
Wear support hose Y / N What? _____

II. FAMILY HISTORY (List family members)

Have any of your family members had

Varicose veins :_____
Vein stripping :_____
Blood coagulation disorder : _____
Blood clots :_____
Stroke, heart attacks or
Pulmonary emboli : _____

III. VEIN TREATMENT HISTORY

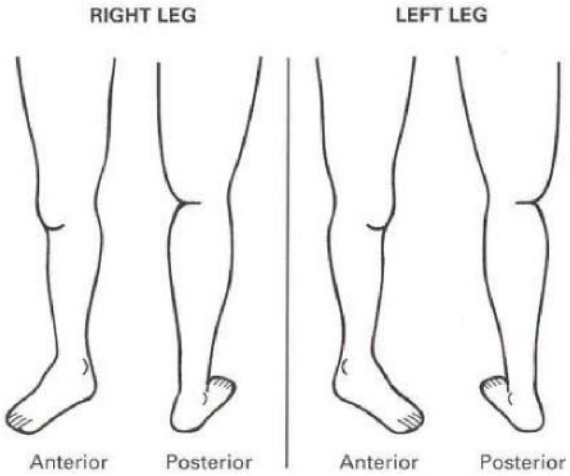
Have you ever been treated for varicose veins with:

Sclerotherapy Y / N Leg: Right / Left Laser
Therapy Y / N Leg: Right / Left
Phlebectomy Y / N Leg: Right / Left
Vein stripping surgery Y / N Leg: Right / Left
RF ablation (VNUS Closure) Y / N Leg: Right / Left

IV. Personal Activities List

Does your work require: YES / NO
Prolonged standing periods YES / NO
Prolonged sitting periods YES / NO
Do you exercise regularly? YES / NO
Do you smoke? YES / NO
Pregnancies YES / NO How many___

V. VEIN SCREENING



PHYSICAL EXAM:

CEAP Clinical Signs:

RIGHT LEG (check all that apply)

___ No signs of venous disease ___Spider veins
___ Visible varicose veins ___ Edema
___ Pigmentation ___ Healed ulcers ___ Active Ulcers

LEFT LEG (check all that apply)

___ No signs of venous disease ___Spider veins ___
Visible varicose veins ___ Edema ___
Pigmentation ___ Healed ulcers ___ Active Ulcers

TREATMENT PLAN:
(Check all that apply)

___ Duplex Ultrasound Leg: Right / Left
___ Sclerotherapy Leg: Right / Left
___ Medical compression stockings Leg: Right / Left
___ Other: _____ Leg: Right / Left

Screening Provider Signature: _____

FOLLOW-UP APPOINTMENT

Date: _____ Time :_____
Physician: _____

Initials:
_____