Reset Form

TEXAS VASCULAR INSTITUTE™
Get your Legs Back. Get your Life Back.

**DALLAS**
8330 Meadow Rd., # 100
Dallas, TX 75231

**PLANO**
4716 Alliance Blvd | Suite 180
Plano, TX 75093 (Pavilion II, first floor)

**HURST**
809 W. Harwood Rd., Suite 101
Hurst, TX 76054

**REFERRAL COORDINATOR:** 972-338-9974 **PHONE:** 972-646-8346 **FAX:** 972-597-4880 **TEXASVASCULAR.COM**

## PATIENT INFORMATION

Name (First): _____ (MI): _____ (Last): _____
Address _____ City _____ State _____ Zip Code _____
Home Phone _____ Cell Phone _____ Email _____
DOB __ / __ /__ [redacted] Sex ☐ Male ☐ Female Marital Status ☐ S ☐ M ☐ D ☐ W
Occupation _____ Employer _____
Work Phone _____ City _____ State _____

**Insurance Information:** ☐ Patient ☐ Spouse
Primary _____ Group _____ ID# _____ Insured's Name _____
Secondary _____ Group _____ ID# _____ Insured's Name _____

**Spouse Information:**
Name _____ DOB ___ / _____ / ____
Occupation _____ Employer _____ City/State _____

**How did you find out about us?**
☐ Referral from Physician _____ ☐ Friend/Family Member _____
☐ Internet _____ ☐ Other _____

**Referring Physician**
Name _____ Specialty _____ Phone _____
Address _____ City _____ State _____ Zip _____

**Primary Care Physician (if other than referring physician)**
Name _____ Specialty _____ Phone _____
Address _____ City _____ State _____ Zip _____

**OB/GYN Physician (if other than referring physician)**
Name _____ Phone _____
Address _____ City _____ State _____ Zip _____

**In Case of Emergency: Contact** _____ **Phone** _____
I authorize Premier Endovascular PLLC (Texas Vascular Institute and Dallas Vein Institute)
_____
To send an appointment reminder to my Cell phone as text messages and phone calls.
***Preferred way of Communication*** ☐ Email ☐ Phone Call ☐ Text Message

Signature _____ Date _____

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| **Symptoms (please check if yes)** | **R** | **L** |
|---|---|---|
| • Aching / Pain in legs | ☐ | ☐ |
| • Heaviness | ☐ | ☐ |
| • Tiredness / Fatigue | ☐ | ☐ |
| • Itching / Burning / Warmth | ☐ | ☐ |
| • Leg cramping | ☐ | ☐ |
| • Leg restlessness | ☐ | ☐ |
| • Throbbing | ☐ | ☐ |
| • Swelling | ☐ | ☐ |

Do your symptoms interfere with your sleep? ☐
Are your symptoms worse later in the day? ☐
Are your symptoms worse with or after activity? ☐
Do your symptoms keep you from doing anything? ☐

**Check if you've had any of the following:**

- Heart Disease ☐
- Peripheral Arterial Disease ☐
- HIV ☐
- Hepatitis ☐
- Diabetes ☐
- Cancer ☐
- Leg Trauma/Surgery ☐
- Asthma/COPD ☐
- Major Surgery/Hospitalizations:

_____

_____

_____

Do you have an Advanced Directive? Yes ☐ No ☐

**Do you have any Peripheral Arterial Disease (PAD) Symptoms? Check all that apply:**

☐ Was diagnosed with PAD in the past

☐ Have/Had cramping leg pain that worsened with walking

☐ Feet/Toes become pale and painful with exercise or when elevating them

☐ Have/Had ulcers on feet or toes

**Conservative measures used currently or previously: (please check those measures that you have tried)**

☐ Pain medication ☐ Weight loss ☐ Leg elevation ☐ Job change

☐ Exercise ☐ Compression stockings or leg wraps? ☐ Strength of stockings: _____ mmHg

Please list your Weight: _____ lbs Height: ____ ft ____ in

**Restless Leg Syndrome: (please check box if yes)**

- Do you find the need to move your leg(s) to relieve an uncomfortable feeling? ☐
- Do(es) your leg(s) feel better when moving it (them) or walking? ☐
- Are your leg symptoms worse when sitting or resting, without elevating your leg(s)? ☐
- Are your leg symptoms worse later in the day or night? ☐

**Please check below if you have had any of the following**:

☐ Prior evaluation for your veins: _____ (yr)

☐ Previous vein surgery or laser treatments: _____ (yr) ____ R ____ L

☐ A family history of vein disease

☐ A family history leg ulcerations

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☐ Previous vein injections: _____ (yr) ____ R ____ L

☐ Bleeding from a vein: _____ (yr) ____ R ____ L

☐ Leg ulceration: _____ (yr) ____ R ____ L

☐ Superficial thrombophlebitis or inflammation of a vein: _____ (yr) ____ R ____ L _____(Location)

☐ Any type of blood clot: _____ (yr) ____ R ____ L _____ (Diagnosis)

☐ Any type of clotting disorder: _____ (yr) _____ (Diagnosis)

☐ Migraines with aura

☐ Diagnosed with PFO (Patent Foramen Ovale)

☐ A family history of blood clots

☐ A family history of clotting disorder

**Women Only:**

- Are you pregnant of considering a pregnancy in the future? ☐
- Are you breastfeeding? ☐
- Are your legs more painful associated with menstruation? ☐
- Have you been diagnosed with Pelvic Congestion Syndrome and/or had bulging veins during pregnancy? ☐
- Number of pregnancies: ____ Deliveries: _____ Miscarriages: _____
  Children's Age(s): _____

| What is your **"reminder preference"** for communication: SELECT BEST ONE BELOW:<br>Home phone: ☐ May leave voicemail<br>Work phone: ☐ May leave voicemail<br>Cell phone: ☐ May leave voicemail<br><br>Email: _____<br><br>Preferred primary language<br>☐ English ☐ Other: _____ | **Race:**<br>☐ American Indian or Alaska Native<br>☐ Asian<br>☐ Black or African American<br>☐ Native Hawaiian or Pacific<br>☐ Islander<br>☐ White<br>☐ Decline to state | **Ethnicity**<br>☐ Hispanic<br><br>☐ Not Hispanic<br><br>☐ Decline to State |
|---|---|---|

**Annual Influenza Immunization:** Did you receive a flu shot during the "Flu Season" (August - March)? Date of last flu shot ___ / ___ ☐ No refused ☐ Decline for medical reason ☐ Allergy ☐ Other medical reason

**Social History:**

**Tobacco use history** ☐ Never smoked ☐ Former smoker but quit on: _____ (approx. date)
☐ Current smoker – Started: _____ (approx. date) number of cigarettes: _____ per day
☐ Use of tobacco in other forms: _____ Amount: _____ Per day

**Alcohol use history**: Did you have a drink containing alcohol in the past year? ☐ No ☐ Yes
**If Yes:** How often? ☐ Monthly or less ____ Drinks per month ____ Drinks per week _____ Drinks per day

**How often >6 drinks on one occasion in the past year?** ☐ Never ☐ Less than monthly ☐ Weekly ☐ Daily

**Allergies and your Allergic Response:** Or ☐ No Known Allergies

_____ ☐ Rash ☐ Nausea/Vomiting ☐ Diarrhea ☐ Shortness of breath ☐ Anaphylaxis ☐ Other: _____
_____ ☐ Rash ☐ Nausea/Vomiting ☐ Diarrhea ☐ Shortness of breath ☐ Anaphylaxis ☐ Other: _____
_____ ☐ Rash ☐ Nausea/Vomiting ☐ Diarrhea ☐ Shortness of breath ☐ Anaphylaxis ☐ Other: _____

**Current medications:** Include prescription drugs, over the counter drugs, vitamins, minerals, herbals, dietary (nutritional) supplements
☐ NONE

| # | Medication Name | Dose | Frequency |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |

Patient Signature:_____ Date:_____

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# Authorization for Communication of Protected Health Information

It is frequently necessary for personnel at this practice to communicate information about treatment, instructions, payment, and other items of protected health information with our patients. It is not always possible to speak personally with the patient, therefore we may need to leave this information. In the event that our personnel are not able to speak with you (the patient) directly, please give us instructions about communicating it to you.

**How may we contact you? (Tick ✓ ALL that apply)**

☐ Text Cell Phone ☐ Call Cell Phone ☐ Call Home Phone ☐ Call Work Phone ☐ Email

**Which Communication method is your preferred:**

☐ Text ☐ Call Cell ☐ Call Home ☐ Call Work ☐ Email

**Voicemails containing Medical Information can be left on: (Tick ✓ e ALL that apply)**

☐ Cell Phone ☐ Home Phone ☐ Work Phone

**Other person(s) authorized to receive messages on my behalf:**

1. Name _____@_____

2. Name _____ @ _____

I hereby release, discharge and agree to hold harmless all parties to whom this consent is given from any liability that may arise from the release of information authorized above. I understand that I may revoke this consent in writing at any time. This consent is valid for one year from the date of signature unless otherwise revoked in writing.

Patient name _____

Patient signature _____

Date _____

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## Photograph / Video and Personal Testimony Release Form

I hereby grant Premier Endovascular (Dallas Vein Institute and Texas Vascular Institute) permission to use my photographs and personal testimony or likeness in any and all of their media publications including but not limited to print, website entries, video without payment or any other compensation or considerations. I understand and agree that these materials will become the property of Premier Endovascular (Dallas Vein Institute and Texas Vascular Institute) and will not be returned. I hereby irrevocably authorize Dallas Vein Institute to edit, alter, copy, exhibit, publish, or distribute the photographs and personal testimony or likeness for purposes of publicizing Dallas Vein Institute or for any other lawful purpose. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my photographs and personal testimony or likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of photographs and personal testimony or likeness. I hereby hold harmless and release and forever discharge Dallas Vein Institute or any future entities they create from all claims, demands, and cause of action which, I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have reason of this authorization.

_____ _____

**Print Name** **Email Address**

_____ _____

**Signature Name** **Date**

**For Parents or Guardians of a Participant of Minor Age**

If the person signing is under the age of 18 at the time of release, there must be consent by a parent or guardian, as follows:

I hereby certify that I am the parent or legal guardian of _____, named above, and I hereby give my consent without reservation to the foregoing on behalf of this person.

_____ _____ _____

**Print Name** **Signature** **Date**

## Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW HEALTH AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH AND MEDICAL INFORMATION IS IMPORTANT TO US.**

### OUR RESPONSIBILITIES

We at Premier Endovascular, PPLC (Texas Vascular Institute) understand that medical information about you and your health is personal. Applicable federal and state law requires us to maintain the privacy of our health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect This Notice takes effect 04/1/2020, and will remain in effect until we replace it. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

### USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**To Treat You:** We can use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Billing and Payment for Services:** We can use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We can use and disclose your health information in connection with our healthcare operations which include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time; your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member,

friend or another person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for PCIHIPAA.com Page 1 of 3 your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information.
**Marketing Health-Related Services:** We will not use your health information for marketing purposes without your written permission.
**Required by Law:** We may use or disclose your health information when we are required to do so by state or federal law, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.
**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.
**Respond to organ and tissue donation requests:** We can share health information about you with organ procurement organizations. Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual die.
**Address workers' compensation, law enforcement, and other government requests:** We can use or share health information about you: For workers' compensation claims For law enforcement purposes or with a law enforcement official With health oversight agencies for activities authorized by law For special government functions such as military, national security, and presidential protective services Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.
**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, text messages or letters).

**PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies, mailing, and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end PCIHIPAA.com Page 2 of 3 of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

**QUESTIONS AND COMPLAINTS** If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact our office. You also may submit a written complaint to the U.S. Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1- 877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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## Texas Vascular Institute – Clinic Policy and Rules

Thank you for choosing Texas Vascular Institute. To ensure a smooth experience, please review and adhere to the following policies:

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**Appointment Reminder Notification**
- A reminder call will be made two days in advance of your scheduled appointment. A text message will be sent one day prior to your scheduled appointment.

**Appointment Confirmation**
- Confirm your appointment at least 48 hours prior to your scheduled time by phone or email. Unconfirmed appointments may be canceled or rescheduled.

**Insurance Information**
- Provide accurate and up-to-date insurance information at scheduling and at each visit.
- Report any changes to your insurance coverage immediately.
- Failure to provide valid insurance details may result in delays or personal responsibility for payment.

**Compression Stockings Policy**
- Compression stockings are not covered by insurance.
- Texas Vascular Institute will provide one pair free with your treatment.
- Additional pairs may be purchased for $35 each.

**Payment Policy**
- Co-payments, deductibles, and non-covered charges are due at the time of service.
- For non-covered services, payment plans may be discussed with our staff.

**Late Arrivals**
- Arriving more than 15 minutes late may result in rescheduling to avoid disruptions.

**Respectful Environment**
- We maintain a respectful and professional atmosphere. Disruptive or inappropriate behavior will not be tolerated.

**Contact Information**
- Ensure we have your current phone number, email, and mailing address to communicate important updates.

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**Consent for Treatment**
By signing below, I consent to Texas Vascular Institute to:

1. **Treat and diagnose** my medical conditions.

2. **Notify my referring provider** of all results and relevant healthcare communications related to my care.

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**Acknowledgment of Receipt and Agreement**
I confirm that I have received and reviewed the Texas Vascular Institute Clinic Privacy, Policy and Rules. I agree to comply with these policies and provide my consent for treatment and healthcare communication.

Patient Name (Print): _____

Signature: _____

Date: _____

For questions or assistance, contact us at 972-646-8346.

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# Patient Financial Responsibility Release

Your signature below forms a binding agreement between Premier Endovascular PLLC (DBA: Texas Vascular Institute) and the Patient who is receiving medical services or the Responsible Party. The Responsible Party is the individual who is financially responsible for payment of medical care.

Patients are required to notify our office immediately of any insurance changes. An insurance change can affect coverage and payment by the insurance provider. Most services require prior authorization through insurance, and failure to notify our office of changes may result in non coverage by your insurance provider. In such cases, the Patient will be held financially responsible for all incurred charges.

**General Responsibilities:**

- Premier Endovascular will assist you by billing to our contracted insurance providers. However, the Patient is required to provide us with the most correct and updated information about their insurance, phone numbers, and address changes. Patients must notify the practice within 30 days of any updates. Failure to do so may result in denial of claims, and the Patient will be held financially responsible for any charges incurred.
- Patients are responsible for the payment of their specialist co-pays for each office visit, coinsurance, deductibles, and all out-of-pocket expenses, as determined by their insurance plan.

**Additional Charges:**

Patients may incur, and are responsible for, the payment of additional charges at the discretion of Texas Vascular Institute, which may include but are not limited to:

- Compression stockings: $35.00
- Missed appointments without 24-hour notice: $100.00 fee
- Release of medical records (print and mail only): $25.00 fee
- Visually Guided Sclerotherapy/Spider Vein Treatment: $400.00
- Returned check fee for insufficient funds: $35.00
- Costs associated with the collection of patient balances: Fee varies
- Any additional treatment needed after the initial stages of treatment (e.g., subsequent development of varicose veins): Cost determined by insurance benefits.

**Fee Adjustment:**

Premier Endovascular reserves the right to update and adjust fees periodically. Patients will be notified of changes to the fee structure in writing.

**Patient Authorizations:**

- By my signature below, I hereby authorize Premier Endovascular (DBA: Texas Vascular Institute) to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies and other third-party payers to obtain authorization for my treatment plan.
- I understand that it is ultimately my responsibility to ensure that proper authorization has been granted by my insurance company prior to my procedures. If I am treated without authorization and the services are denied by my insurance company, I will be held financially responsible for that date of service and treatment cost.
- I consent to receive both E-Statements (electronic paperless statements) and paper statements. I also consent to pay through the Harlow payment portal and to receive notifications from the eClinicalWorks system. These notifications may be sent via phone call, SMS text, mail, and/or email regarding appointments, balances, or other practice-related communications.

**Payment and Collections Policy:**

- Deductibles and Co-insurance: All deductibles, co-pays, and coinsurance amounts will be collected at the time of service, where applicable.
- Pretreatment Estimates: A pretreatment breakdown will be provided to assist in planning for upcoming procedures.
- Payment Deadlines: Patient balances are expected to be paid within 30 days of billing.
- Collections Process: If payment is not received within the specified time, Premier Endovascular (DBA: Texas Vascular Institute) reserves the right to disclose relevant account information to an outside collection agency. The Patient or Responsible Party is liable for all costs associated with collections, including transfer fees.

**Payment Methods Accepted:** Cash, checks, MasterCard, Visa, Discover, Care Credit, and online payments via our statement portal.

**Refund Policy:** If an overpayment occurs, the patient will be refunded after all outstanding claims have been resolved, and the patient's account reflects a credit. Refunds will be issued within 30 days of account resolution.

**Non-Covered Services:** Patients are responsible for the payment of all services not covered by their insurance. It is the Patient's responsibility to verify coverage with their insurance provider before services are rendered.

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**Communication Opt-Out:**
If you prefer not to receive electronic communications (E-statements or payment reminders), you may opt out by notifying the practice in writing.

**Acknowledgment of Financial Responsibility:** By signing below, you agree to accept full financial responsibility as a Patient who is receiving medical services or as a Responsible Party. You also acknowledge that it is your responsibility to understand the terms of your insurance and ensure timely updates to all personal information.

Patient Signature: _____ Date: _____

Responsible Party Signature (if applicable): _____ Date: _____

Staff/Witness Signature: _____ Date: _____