18425 BURBANK BLVD., SUITE #102 TARZANA CA 91356
(818) 654-0520

Last Name: _____First Name: _____Middle Initial: _____

Address: _____City: _____ State: _____Zip Code: _____

Birth Date:_____ Gender: M / F Marital Status: S M D W SSN:_____

Name of Emergency Contact: _____Phone #: (_____) _____

Relationship to Patient: _____

Preferred Language:_____ Race: _____ Ethnicity: _____

Home Phone#: (_____) _____Alternate Phone#: (_____) _____

E-Mail Address: _____Referral Source: _____

Referring Physician: _____ Phone#: (_____) _____

Driver License #:_____

Employer: _____ Phone#: (_____) _____

Employer's Address: _____ City: _____ State: _____ Zip Code: _____

Primary Insurance Carrier: _____Phone Number: (_____) _____

Name of Insured: _____ Relationship to Patient: _____

Insured's SSN: _____ Date of Birth: _____

Primary ID Number: _____ Group Number: _____

Secondary Insurance Carrier: _____Phone#: (_____) _____

Name of Insured: _____Secondary ID # or SSN: _____

Payment is due from the patient at the time services are rendered. The patient is responsible for payment and not the insurance company. We will file claims for any insurance coverage for which we are a participating provider, however, copayments, deductibles and non-covered charges must be paid at the time that the services are rendered. If there are any questions regarding payment/insurance filing policies, please see one of the office staff at this time to make any necessary arrangements.

AGREEMENT TO PAY: The undersigned agrees to payment of all charges for services provided both before and after the date of this agreement and promises to pay said fee including the cost of collection, attorney fees, and court costs, if such be necessary, waiving now and forever the right to claim exemption under the laws of the state of California and any other state. The undersigned understands that accounts may be referred to an outside collection agency if the balance remains unpaid for sixty days unless alternate arrangements have been made and followed.

RELEASE OF RECORDS: I authorize Maged S. Mikhail, A Professional Corporation to request/release any medical information from or to another physician or medical institution as necessary for my medical care or for filing purposes.

SURGICAL/MEDICAL BENEFITS: I authorize payment directly to Maged S. Mikhail, A Professional Corporation for the surgical and/or medical benefits if any, otherwise payable to me for services rendered by Maged S. Mikhail, MD. I realize the insurance benefits may not pay the entire bill and I agree to pay the difference or the entire bill if necessary, excluding contractual allowances.

SIGNATURE OF PATIENT: _____ DATE_____

SIGNATURE OF RESPONSIBLE PARTY: _____ DATE_____

Los Angeles Varicose Vein Center

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ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

Assignment of Benefits:

I hereby assign all my medical and surgical insurance benefits for services rendered to the Los Angeles Varicose Vein Center and Maged S. Mikhail, A Professional Corporation. I also hereby authorize and direct my insurance carrier(s), including Medicare and other private insurance companies and other health benefits to issue payment directly to Maged S. Mikhail, A Professional Corporation.

Patient Signature: _____ Date: _____

Authorization to Release Information:

I hereby authorize Maged S. Mikhail, A Professional Corporation and Los Angeles Varicose Vein Center to (1) release any information necessary to insurance companies regarding my illness and treatments, (2) process insurance claims generated in the course of examination or treatment, and (3) allow photography of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

A photocopy of this Assignment of Benefit And Release of Information is to be considered as valid as the original.

Patient Name: _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

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STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that only a percentage of my treatment may be covered by my health insurance plan. I will be financially responsible for all services not covered by my insurance company.

_____Initial

I understand that I will be responsible for all co-payments, deductibles, and non-covered procedures on or before the day of the procedure.

_____Initial

I understand 24 hour cancellation notice is required for all procedures. Otherwise my insurance company and/or I will be responsible for all charges.

_____Initial

I agree to pay all financial obligations in a timely manner, and accept that all delinquent accounts will bear interest at the legal rate, but special financial arrangements may be made depending on certain circumstances.

_____Initial

It is my obligation to endorse and forward ALL checks that I receive from my health insurance company to the Los Angeles Varicose Vein Center and/or Maged S. Mikhail, A Professional Corporation, for the services rendered.

_____Initial

I have read the above information and by singing below, I agree to all the terms.

Patient Name: _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

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PHOTOGRAPHY RELEASE FORM

I, the undersigned hereby authorize the Los Angeles Varicose Vein Center (LAVVC) and Maged S. Mikhail, A Professional Corporation and his staff to take photos of me and use them as an aid in my treatment. I understand these photographs will help document the progress of my treatment. I hereby authorize and consent to the above-described photography.

Patient Signature_____ Date_____

I hereby authorize and consent to the above described photography being used by my practitioner for study reporting purposes and/or marketing and that any photographs taken will remain the property of the facility, if used for any of these purposes.

I understand that my identity will be kept strictly confidential. No name or other identifying information will appear on the photographs.

Patient Signature_____ Date_____

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Acknowledgement of Receipt of
Notice of (HIPPA) Privacy Practice

I hereby acknowledge receipt of a Notice of Privacy Practice from Los Angeles Varicose Vein Center and Maged S. Mikhail, A Professional Corporation.

_____ _____
Print Name of Patient Date

_____ _____
Signature of Patient/Authorized Representative Date

_____ _____
Signature of Witness Date

If signed as authorized representative, please specify relationship to patient:

_____

Unable to obtain acknowledgement of receipt of Notice of Privacy Practices because:

_____

_____

_____

_____ _____
Signature Date

Los Angeles Varicose Vein Center
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PATIENT QUESTIONNAIRE

PATIENT NAME: _____ **DATE:** _____

REFERRING DOCTOR: _____

AGE: _____ **WEIGHT:** _____ **HEIGHT:** _____

OCCUPATION_____ **PRIMARY LANGUAGE** _____

1. What problem brings you here? _____
_____

2. Which leg bothers you the most? ❑ Right ❑ Left ❑ Both

3. How long have you had abnormal veins? _____ years.

4. Check√ the types of veins that bother you on each leg.

Right Leg	Left Leg
❑ Bulging varicose veins	❑ Bulging varicose veins
❑ Large blue winding veins	❑ Large blue winding veins
❑ Small spider veins	❑ Small spider veins

5. Where are the abnormal veins located? Please check √ all that apply.

Right Side	Left Side
❑ Above knee	❑ Above knee
❑ Below knee	❑ Below knee
❑ Foot	❑ Foot
❑ Groin	❑ Groin
❑ Abdomen	❑ Abdomen

6. Check √ any symptoms that you have on the affected side?

	Right Leg	Left Leg
Pain	❑	❑
Tenderness to touch	❑	❑
Leg or ankle swelling	❑	❑
Leg heaviness or fatigue	❑	❑
Restless leg sensation	❑	❑
Leg itching	❑	❑
Cramping	❑	❑
Skin discoloration	❑	❑
Rash	❑	❑
Change in skin texture	❑	❑
Phlebitis	❑	❑
Rupture or bleeding from veins	❑	❑
Ulcer	❑	❑

7. How long have you had symptoms? _____ years.

8. Are <u>symptoms getting worse</u>? ❑ Yes ❑ No
If so, over what period of time? _____ years _____ months.

9. Do any of these <u>things make symptoms WORSE</u>?

Prolonged standing	❑ Yes	❑ No	
Prolonged sitting	❑ Yes	❑ No	
Warm weather	❑ Yes	❑ No	
Menstruation	❑ Yes	❑ No	❑ Not applicable

10. Do any of these <u>things make symptoms BETTER</u>?

Leg elevation	❑ Yes	❑ No
Sleep	❑ Yes	❑ No
Compression stockings	❑ Yes	❑ No
Walking	❑ Yes	❑ No

11. Please check √ conservative treatments that you have tried in the past?

- ❑ Compression stockings or hose
- ❑ Frequent leg elevation
- ❑ Pain medication
- ❑ Regular exercise
- ❑ Limit activities like avoid prolonged standing or sitting
- ❑ Take time off work
- ❑ Weight loss If so, how much? _____ pounds.

12. How long have you tried conservative treatments? _____ years _____ months.

13. Who prescribed conservative treatment? _____

14. Have you ever had <u>vein surgery</u> like <u>stripping</u> or <u>vein ablation</u>? ❑ Yes ❑ No
If yes, which side? ❑ Right leg ❑ Left leg When? _____

15. Have you ever had <u>vein sclerotherapy injections</u>? ❑ Yes ❑ No When? _____

16. Have you ever had a <u>deep vein thrombosis or thrombophlebitis</u>? ❑ Yes ❑ No
If yes, which side? ❑ Right leg ❑ Left leg When? _____

17. Do you or any close blood relatives have a known <u>clotting abnormality or tendency to bleed excessively</u> with surgery or medical procedures?
❑ No ❑ Yes Problem_____

18. Do you have <u>blood relatives with varicose veins</u>? Please check √.
❑ Mother ❑ Father ❑ Brother ❑ Sister

19. Have you ever had surgery or an injury to either leg that required a cast? ❑ Yes ❑ No

20. Obstetric History: Number of pregnancies _____ Number of deliveries _____

21. Did your vein problems start during pregnancy? ❑ Yes ❑ No ❑ Not applicable

22. Are you currently pregnant or trying to get pregnant? ❑ Yes ❑ No ❑ Not applicable
If yes, how far along are you? _____

23. Are you currently breastfeeding? ❑ Yes ❑ No ❑ Not applicable

24. Are you planning to get pregnant in the future? ❑ Yes ❑ No ❑ Not applicable

GENERAL MEDICAL QUESTIONNAIRE

25. Please list any drug allergies: _____
_____

26. Check√ any of the following medications you take:

❑ Coumadin ❑ Plavix ❑ Daily aspirin
❑ Steroids ❑ Topical skin medications ❑ Antibiotics
❑ Oral contraceptives ❑ Hormone replacement therapy(estrogens)

27. List any other medications that you currently take: _____
_____

28. Check√ the box next to any medical conditions that you have or have had before.

❑	Diabetes	❑	Seizures	❑	Heart disease
❑	Kidney disease	❑	Lung disease or asthma	❑	Hepatitis B or C
❑	High blood pressure	❑	HIV infection	❑	Arthritis
❑	Fainting	❑	Cancer	❑	Cirrhosis
❑	Sleep apnea	❑	Peripheral arterial disease	❑	Spinal stenosis
❑	Neuropathy	❑	Skin disorders	❑	Acid reflux/GERD
❑	Stroke	❑	Autoimmune disease or lupus	❑	Spinal disc disease
❑	Hip problem	❑	Knee problem	❑	Ankle problem

29. Please list any previous operations: _____
_____

30. Please check√ any of the following diseases you or any of your blood relatives have.

❑ Varicose veins ❑ Phlebitis ❑ Ulcer
❑ Peripheral arterial disease ❑ Coronary artery disease
❑ Heart attacks ❑ Other heart disease

31. Do you smoke? ❑ Yes ❑ No ❑ Smoked in the past ❑ Never smoked

32. Please check√ any of the symptoms you have.

❑	Visual problems	❑	Heartburn	❑	Depression
❑	Cough	❑	Abdominal pain	❑	Anxiety
❑	Snoring	❑	Nausea/Vomiting	❑	Weight loss
❑	Shortness of breath	❑	Rectal bleeding	❑	Numbness
❑	Wheezing	❑	Blood in urine	❑	Muscle weakness
❑	Chest pain	❑	Difficulty urinating	❑	Fatigue
❑	Can't lie flat	❑	Bleed easily	❑	Back pain
❑	Palpitations	❑	Panic attacks	❑	Joint pain
❑	Passing out	❑	Fever	❑	Rash