Dr. Ronnie G. Smalling, MD, FACC, FSCAI
Smalling Vascular Institute – INVEIN

11025 Metcalf Ave
Overland Park, KS 66210
(913) 912-3624

Welcome to IN VEIN by Smalling Vascular Institute. We are glad that you have chosen to receive vascular care within our office. Thank you for your trust. We are committed to your LEG HEALTH.

Office Policies:

Hours:

Monday- Friday 9:00 am to 4:30 pm
If communicating with the office after hours, please leave a message and someone will respond to you as soon as possible. If it is an emergency, please visit your local Emergency Department.

Contact Information:

Phone- 913.912.3624 / Fax- 913.717.6362 / Email: info@inveinmd.com

Test Results:

Please allow **5 to 10 days minimum** for the physician to receive and review your test results or submit your insurance paperwork.

Finance/Insurance:

Each patient is responsible for payment of his/her medical bills unless otherwise stated in your new patient paperwork. Co-pays are due at the time services are rendered. We CAN NOT mediate disputes or resolves differences between you and your insurance company. Please keep in mind that it is your responsibility to advise our office immediately of any change in your insurance and contact information to ensure accuracy of care and to continue coverage so neither party is left with a bill being denied by your insurance provider.

Appointment/Procedure Cancellation:

When scheduled for a procedure, be aware that the time of your appointment may be later than initially scheduled. Please try to keep a clear schedule after your appointment on procedure days. The doctor will have procedures that will take longer than previously expected because people are complex beings, and the Doctor will make sure all patients get proper care. Always feel free to call and check how the schedule is flowing on the day of your procedure.

If you find yourself unable to keep any scheduled office appointment, please notify our office **before 24 hours prior** to the scheduled appointment **or you will be charged a $50 fee.**

If you find yourself unable to keep a scheduled procedure, please notify our office **before 24 hours prior** to the scheduled procedure or **you will be charged a $250 fee.**

****Please note that these fees are not covered by your insurance company and payment is expected prior to scheduling any future appointments/procedures.**

I have reviewed all office notifications regarding terms/cancellation information and fees. INITIAL: _______

NOTICE: I also understand that, IF for ANY reason, we cannot access the vein on the day of my procedure after 60 minutes, SVI has the right to RESCHEDULE the appointment. This is due to comfortability of the patient and the Doctor, and sometimes rescheduling can make for a more successful procedure the next time.
At any time during treatment, a venous ulcer may become active. This can happen due to the hydrostatic pressure from the procedures and will heal after diseased veins are closed.

Patient Signature: ____ Date: ______________

PLEASE COMPLETE ALL QUESTIONS

PATIENT DEMOGRAPHICS:

Last Name:________________________________ First Name ______________________________________

Nickname:_______________________ MI:_____ DOB: ______________ Sex: **M or F** Age: _________

Address: ____ Assisted Living **Y or N**

City: ____ State:_______ Zip code: _________________

Phone: (C)____________________________ (H):______________________ (W):_______________________

Employed **Y or N** On Active Military Duty **Y or N** Retired **Y or N**

Employed: ☐ Full Time ☐ Part Time ☐ Self Employed

Employer/Previous Employer/School:______________________________ Marital Status: _______________

Email Address: ____

Preferred methods of contact: (please mark one) ☐ Text Message, ☐ Email,

Phone call: ☐ Cell ☐ Home ☐ Work, or ☐ E-message through Patient Portal

EMERGENCY CONTACTS: (Spouse's information first if applicable)

Name:____ Relationship:_______________________

Phone: (C)__________________________ (H)__________________________ Live with **Y or N**

Name:____ Relationship:_______________________

Phone: (C)__________________________ (H)__________________________ Live with **Y or N**

INSURANCE INFORMATION:

Primary:___________________________________ Secondary: _________________________________

Policy Holder:______________________________ Policy Holder: _____________________________

DOB:______________________________________ DOB:______________________________________

ID #:_____________________________________ ID#: _______________________________________

Group #:__________________________________ Group #: ___________________________________

COPAY: Y or N **DEDUCTIBLE: Y or N** **Coinsurance: Y or N**

BILLING INFORMATION: (Complete if information is **different** from "patient demographics")

Last Name: ____________________________ First Name: ______________________________ MI: _____

Address: ____

City: ____ State: _______ Zip Code: ______________

Relationship to Patient: ____

PRIMARY CARE PROVIDER:

Name: ____ Phone: ________________

Address: ____ Fax: __________________

*Have you seen your Primary Care Physician within a year? **Y or N**

*Date of Last Primary Care Appointment ____

REFERRING Physician or Provider, if any:

Name: ______________________________________ Phone: _______________ Fax: _________________

Address:____ Specialty: _________________

Ambulation/Mobility:

Need Assistance : **Y or N** ☐ Cane ☐ Walker ☐ Wheelchair Other: _______________________

HOW DID YOU HEAR ABOUT US?
Source: ________________ or Referring Provider: ________________

QUESTIONAIRE: Have you ever experienced any of the following?

Ultrasound to check for Venous Insufficiency: **Y or N** If yes, when: ______where: __________results: ____________

Venous Ablation: **Y or N** If yes, when:____________what method: Radiofrequency or Laser or ___________

Varicose Vein Procedure: **Y or N** If yes, when: ________________ what method: ________________

Sclerotherapy/Foam Injections: **Y or N** If yes, when:______________ where: ________________

CIRCLE ALL THAT APPLY: Right Leg Left Leg Both Legs

Vein Stripping: **Y or N** If yes, when: ________________ where: ________________

CIRCLE ALL THAT APPLY: Right Leg Left Leg Both Legs

***History of any blood disorders? **Y or N**

***History of blood clot: **Y or N** If yes, when: ________________

CIRCLE ALL THAT APPLY: Right Leg Calf or Thigh Left Leg Calf or Thigh Both Legs Calf or Thigh

History of phlebitis (inflammation of the vein): **Y or N** If yes, when: ________________

CIRCLE ALL THAT APPLY: Right Leg Left Leg Both Legs

Do you experience any of the following symptoms in your legs? (***<u>CIRCLE ALL THAT APPLY</u>***)

Symptom				
Pain/Aching	**Y or N**	Right Leg	Left Leg	Both Legs
Heaviness:	**Y or N**	Right Leg	Left Leg	Both Legs
Fatigue:	**Y or N**	Right Leg	Left Leg	Both Legs
Itching:	**Y or N**	Right Leg	Left Leg	Both Legs
Burning:	**Y or N**	Right Leg	Left Leg	Both Legs
Swelling:	**Y or N**	Right Leg	Left Leg	Both Legs
Cramping:	**Y or N**	Right Leg	Left Leg	Both Legs
Throbbing:	**Y or N**	Right Leg	Left Leg	Both Legs
Restless Legs:	**Y or N**	Right Leg	Left Leg	Both Legs
Leg Ulcers:	**Y or N**	Right Leg	Left Leg	Both Legs
Bleeding varicose veins:	**Y or N**	Right Leg	Left Leg	Both Legs
Lymphedema:	**Y or N**	Right Leg	Left Leg	Both Legs

Other: ________________

*Do you elevate your legs to relieve discomfort of symptoms? **Y or N**
If yes, how long per day: ________________

*Do you exercise on a regular basis? **Y or N**
If yes, what kind of exercise: ________________ How often: ________________

*Do you wear light support or prescription compression stockings? **Y or N**
If yes, what type and gradient: ____________ How long have you worn them? ________________

Why did you start compression socks/hose? ________________

Have you had recent testing for your symptoms within the last 6 months? **Y or N**
If yes, when: ______________ Facility: ______________ Type of testing if known: ______________

Did the test reveal Venous Insufficiency: **Y or N or Unknown**

Do you have trouble walking? **Y or N**
If yes, please mark if you use: ☐ Cane ☐ Walker ☐ Wheelchair

*Is there any improvement in symptoms after taking Aspirin, Advil, Naproxen, or any anti-inflammatories? **Y or N**

Which over-the-counter occasional pain relievers have you tried from above? ________________

When are your symptoms **at their worst?** ________________

*Do you take specific supplements for Vascular Support? **Y or N**

*Do your leg issues impair your life? **Y or N** Explain: ________________

PLEASE COMPLETE ALL QUESTIONS

YOUR MEDICAL HISTORY:(PLEASE CIRCLE ACCORDINGLY)

Condition	Response	Details
Aneurysm	**Y or N**	
Angina	**Y or N**	
*Artificial Implant	**Y or N**	If yes, please list: ____
*Asthma	**Y or N**	If yes, is it controlled? ____
Bipolar Disorder	**Y or N**	
*Birth Control Hormone	**Y or N**	If yes, What kind? ____
*Blood Clot/DVT:	**Y or N**	If yes, please explain with date(s): ____
*Blood Disorders:	**Y or N**	If yes, please explain: ____
*Cancer:	**Y or N**	If yes, what type: ____ Remission: **Y or N**
Cardiac:	**Y or N**	If yes, circle each, (for example: heart attacks, stents, bypass, PAD, replacement valves, ICD's, Pacemakers, heart valve replacement, Coumadin/Anticoagulation Therapy, etc.)
Contacts/Glasses:	**Y or N**	If yes, which: ____
Dercum's Disease:	**Y or N**	
Dermatitis:	**Y or N**	
Dysrhythmia:	**Y or N**	
Gastrointestinal:	**Y or N**	If yes, please describe: ____
Gout:	**Y or N**	
Hallucinations/Delusions:	**Y or N**	If yes, last occurrence: ____
Head Trauma:	**Y or N**	
Hiatal Hernia:	**Y or N**	
*High blood pressure:	**Y or N**	If past history, please explain: ____ Medication: ____
HIV:	**Y or N**	
Hyperlipidemia:	**Y or N**	
*Incontinence (bowel or urine):	**Y or N**	If yes, is it controlled with medication and what type? ____
Kidney Disease:	**Y or N**	
Leg Skin Changes:	**Y or N**	If yes, which (staining, rashes, wounds, etc.): ____
Lung Disease (COPD):	**Y or N**	
*Lymphedema: *	**Y or N**	
Murmur (heart):	**Y or N**	
Psoriasis:	**Y or N**	
Thyroid Disease:	**Y or N**	
Type 1 Diabetes:	**Y or N**	Do you take oral medication **Y or N** Insulin? **Y or N** Controlled? **Y or N**
Type 2 Diabetes:	**Y or N**	Do you take oral medication **Y or N** Insulin? **Y or N** Controlled? **Y or N**
Skin conditions:	**Y or N**	
Stomach Ulcer:	**Y or N**	
*Stroke/CVA/TIA:	**Y or N**	
*Suicidal ideations or attempts:	**Y or N**	If yes, last occurrence? ____
Tuberculosis:	**Y or N**	
***Experienced Anaphylaxis:**	**Y or N**	If yes, did you use an: **Epi-Pen ____ Epinephrine Injection ____ Unsure ____**
High Cholesterol:	**Y or N**	
*Heart Failure or CHF:	**Y or N**	If yes, Is it current? **Y or N** Are you taking Water Pills? **Y or N**
*Neuropathy:	**Y or N**	If yes, who diagnosed?____When?____
Varicose Veins:	**Y or N**	Other (please specify): ____
*Needle Phobia:	**Y or N**	

Do you currently see a podiatrist? **Y or N** If yes, where: ____

*Do you have a wound? **Y or N** If yes, how long have you had it: ____

*Do you currently go to a wound care? **Y or N** If yes, where: ____

*Do you receive wound care supplies at home? **Y or N**

Do you currently (or recently) go to physical therapy? **Y or N** If yes, where: ____

☐ **I cannot complete this list of my medical history**

Review of Systems

PLEASE COMPLETE ALL QUESTIONS

General/Constitutional:	Yes	No
High-grade fever		
Low-grade Fever		
Night sweats		
Increased energy levels		
Decreased energy levels		
Unexpected weight gain		
Unexpected weight loss		
ENT:	**Yes**	**No**
Headache		
Ringing in ears		
Nosebleeds		
Hoarseness		
Eye redness		
Decreased vision		
Spots in vision		
Eye dryness		
Loss of smell		
Sinusitis		
Bleeding gums		
Mouth sores		
Pulmonary:	**Yes**	**No**
Wheezing		
Cough		
Shortness of breath on exertion		
Coughing up blood		
Asthma		
Pneumonia		
Chest pain w/breathing		
Cardiovascular:	**Yes**	**No**
Chest Pain		
Palpations		
Heart murmurs		
Racing heart		
High blood pressure		
HIV		
Cramping in legs		
Pain in legs w/walking		
Passing out spells		

Gastrointestinal	Yes	No
Nausea		
Vomiting		
Heartburn		
Regurgitation/wet burp		
Belching		
Diarrhea		
Constipation		
Excessive gas		
Blood in stool		
Hemorrhoids		
Abdominal pain		
Gastrourinary (GU)	**Yes**	**No**
Trouble urinating		
Pain with urination		
Cloudy urine		
Frequent urination in the night		
Incontinence		
Kidney stones		
Rash in genitals		
Sexual problems		
Sexually transmitted disease		
Genital Varicosities		
Hematology:	**Yes**	**No**
Anemia		
Enlarged lymph nodes		
Clotting issues		
Easily bleeding		
Neurological	**Yes**	**No**
Chronic headache		
Dizziness		
Numbness of hands		
Numbness of feet		
Memory loss		
Tremors		
Balance problems		
New areas of weakness		

Endocrine:	Yes	No
Cold Intolerance		
Heat Intolerance		
Excessive thirst		
Decreased sex drive		
Increased sex drive		
Infectious Diseases:	Yes	No
Endocarditis		
Chronic hepatitis B		
Chronic hepatitis C		
Immune compromised state		
Acute infection		
Chronic infection		
Fever		
Chills		
Sweats		
Musculoskeletal:	**Yes**	**No**
Calf pain		
Joint pain		
Muscle pain		
Neck pain		
Back pain		
Fractures		
Mental Health:	**Yes**	**No**
Anxiety		
Depression symptoms		
Hearing voices		
Suicidal ideations		
Obsessive compulsive habits		
Problems concentrating		
History of abuse		
Skin/Integument:	**Yes**	**No**
Rashes		
Jaundice		
Abnormal		
Skin lesions		
Bruising		
Itching		

PLEASE COMPLETE ALL QUESTIONS

PLEASE LIST LOCAL PHARMACY YOU PREFER ON FILE (no E-scripts)

PHARMACY: Name: ____ Phone: ______________________________

Address: ____

MEDICATIONS/ VITAMINS & SUPPLEMENTS: (Please attach list if needed)
(IF NOT APPLICABLE PUT N/A)

Type:______________________________ Dosage:________ How often:_____________ Reason:____________

Type:______________________________ Dosage:________ How often:_____________ Reason:____________

Type:______________________________ Dosage:________ How often:_____________ Reason:____________

Type:______________________________ Dosage:________ How often:_____________ Reason:____________

Type:______________________________ Dosage:________ How often:_____________ Reason:____________

Type:______________________________ Dosage:________ How often:_____________ Reason:____________

Type:______________________________ Dosage:________ How often:_____________ Reason:____________

Type:______________________________ Dosage:________ How often:_____________ Reason:____________

*__PLEASE SPECIFY__ **if you are currently taking:** (please circle if applicable) **Isotretinoin** or **Minocycline**

ALLERGIES, SENSITIVITIES, INTOLERANCE Reactions: If not applicable (circle N/A) **N/A**

Do you have confirmed allergies to: (Circle each) Latex Eggs Pollens Shellfish

Animals Soap Adhesive Glue Artificial Nails Anesthesia

Chemical Household items: ____

DRUG, FOOD, AND ANY OTHER INTOLERANCES: ____

Have you ever had an allergy skin/ patch test performed? Y or N

If yes, when: ____________________________________ Were foods tested: **Y or N or Unsure**

where: ____________________________________ Is this your Allergist? **Y or N**

Results: ____

* Any listed allergies, please **explain your reactions when exposed:** ______________________________

IMMUNIZATIONS:

Are your immunizations up to date: **Y or N** Height:______________ Weight: ______________

SOCIAL HISTORY:

Do you drink - Alcohol? **Y or N** If yes, how often? ____

Caffeine? **Y or N** How much? ____

Have you ever smoked? **Y or N** If Yes, how long? ____

Did you quit? **Y or N** When: ____

PLEASE COMPLETE ALL QUESTIONS THAT APPLY

SURGICAL HISTORY: **(IT TRULY MATTERS- When in doubt to report, please report here)**

(IF NOT APPLICABLE, PLEASE PUT N/A)

Surgery:______________________________ Date: ______________

Surgery:______________________________ Date: ______________

Surgery:______________________________ Date: ______________

Surgery:______________________________ Date: ______________

Surgery:______________________________ Date: ______________

Surgery:______________________________ Date: ______________

Surgery:______________________________ Date: ______________

FAMILY HISTORY: (Circle all that apply)

Mother: Cancer High blood pressure Heart attack Stroke Varicose veins Swelling (legs) Ulcers (legs)

Father: Cancer High blood pressure Heart attack Stroke Varicose veins Swelling (legs) Ulcers (legs)

Brother: Cancer High blood pressure Heart attack Stroke Varicose veins Swelling (legs) Ulcers (legs)

Sister: Cancer High blood pressure Heart attack Stroke Varicose veins Swelling (legs) Ulcers (legs)

Other: Cancer High blood pressure Heart attack Stroke Varicose veins Swelling (legs) Ulcers (legs)

*Any immediate family members experience **AMPUTATION OF LEG, FOOT, TOES**? **Y or N**

If yes, please provide more information here: ______________________________

____

____

____

____

____

____

In Order to Coordinate your Care (Please provide your other doctors):

Cardiologist: ____

Chiropractor: ____

Dermatologist: ____

Endocrinologist: ____

Homeopathic: ____

Internist: ____

Obstetrician/ OBGYN: ____

Oncologist: ____

Organ Transplant Doctor: ____

Physical Therapist: ____

Podiatrist: ____

Wound Doctor/Clinic: ____

Other Providers/Doctors:

____

____

____

HIPAA Privacy Authorization for Release of Records to IN VEIN Smalling Vascular Institute L.L.C

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164.)

Authorizations:

I authorize **IN VEIN Smalling Vascular Institute L.L.C.** to **obtain** and **disclose** my health information from sources herein. Specifically, as well the following facilities, providers, or individuals *(**INCLUDE ALL MAIN PROVIDERS AND ANY RECENT HOSPITALIZATIONS IN ORDER FOR US TO PROVIDE CARE FOR YOU**):*

CHECK ALL THAT APPLY:

☐ Any records from any/all physicians, ER's, hospitals which pertain to my current health information Dr. Smalling and I discuss.

☐ Any/All physicians I have listed above **ON THIS FORM ONLY**

Effective Period:

This authorization is only valid for information from:

☐ Date: _________________ to Date: __________________

OR

☐ All past, present and future records

Information Directives:

☐ I authorize for all of my health records (including mental health, communicable diseases, HIV or AIDs and treatment of alcohol or drug abuse records)

OR

☐ I authorize for all of my health records EXCEPT:

________ Mental health records

________ Communicable diseases (including HIV or AIDS)

________ Alcohol/Drug abuse

________ Other: ____

- This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
- This authorization shall be in force and effect until I AM DISCHARGED FROM SVI at which time this authorization expires.
- I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if it was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

____ ____________________

Signature of Patient/Guarantor **Date**

____ ____________________

Printed name of Patient/Guarantor **Patient's date of birth**

HIPAA Notice of Privacy Practices

IN VEIN Smalling Vascular Institute L.L.C.
11025 Metcalf Ave.
Overland Park, KS 66210
Phone: 913.912.3624 **Fax:** 913.717.6362

This notice describes how medical information about you may be used, disclosed and how you can get access to this information. Please read carefully and sign the correlating section.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes yours rights to access and control your protected health information. “Protected Health Information” is information about you, including demographic information, that may identify you and that relates to your past, present or future health and mental health care services.

Uses and Disclosures of Protected Health Information

Your Protected Health Information may be used and disclosed by your physician, our office staff and other offices that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice and any other use required by the law.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This is including the coordination or management of your health care with a third party. For example:
We would disclose your protected health information, as necessary, to a home health agency that provides care to you. Your protected health information may be provided to a physician to whom you have been referred to, to ensure the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example: Obtaining prior authorization, approval or predetermination for an in office surgical procedure may require that your relevant health information be disclosed to the insurance agency for them to review and provide the facility with an approval or denial.

Healthcare Operations: We may use or disclose, as needed, your protected health information, including any photographs obtained, in order to support the business activities of your physician’s practice or educational purposes which may be used on the internet. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students if applicable, licensing or conducting and arranging for other business activities. For example:
We may disclose your protected health information to a medical resident that cares for patients at our facility. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate the name of your provider. We may also call you by your name in the waiting room when your provider is ready to visit with you. We may use or disclose your protected health information, as necessary, to contact you for reminders regarding upcoming appointments.

Your information is handled via HIPAA compliant technical pathways. It is to be understood, regarding potential breeches, we work with many HIPAA compliant, third party IT vendors and some of the safeguards in place are beyond our control as technology evolves. We will take every precaution possible and attempt to update HIPAA requirements as technology evolves, compliancy guidelines change and ensure the informational forms to you as a patient, are instituted to the best of our abilities as medical providers.

We may use or disclose your protected health information in the following situations without your authorization. These situations, as required by law, include public health issues, communicable disease, health oversight, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donors, research,

approval

criminal activity, military activity, national security, Worker's Compensation, inmates, required uses and disclosures. Under the law we must make disclosers to you and, when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of Sections 164.500.
Other Payment and Required Uses and Disclosures will be made, when possible or required with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice have taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

-Following is a statement of your rights with the respect to your protected health information:
-You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes: information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.
-You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
-Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to select a different healthcare professional.
-You have the right to request confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from our practice, upon request, even if you have agreed to accept this notice alternatively (i.e., electronically).
-You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
-You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
-We reserve the right to change terms on this notice and will inform you of any changes. You then have the right to object or withdraw as provided in the notice.

Complaints

-We make every effort to communicate our interest and concern in your procedure outcomes and request you reach out to one of our staff, in regard to any concerns or complaints, so we have the opportunity to assess properly atypical outcomes or concerns. Every patient is unique, and we cannot assist patients, who neglect in contacting our offices. Our goal is for you to be satisfied with your outcomes, while knowing the possibilities of side effects, but that we invite you to communicate any and all concerning potential side effects. We would like the ability to address these concerns directly, in an attempt to resolve unique issues post procedure, for a satisfactory outcome.
-You may also file a complaint to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us also by simply notifying the front desk.
-We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with the respect to protected health information. If you have any objections or questions about this, please ask to speak with our Private Practice Operations Officer in person, or by phone, at our main phone number, 913-912-3624.

approval

MEDICAL RELEASE RECORDS:
I hereby authorize the use or disclosure of my personal health record information to the following individuals. Please understand that if ANY person is not listed below, by law, we cannot communicate or release any information regarding your personal health records. Note, that this authorization is completely voluntary and can be altered at any time in writing or via email at INFO@inveinmd.com.

Signature: ______________________________ **Date:** ______________

Name **Relationship**

____

____

HIPAA NOTICE OF PRIVACY PRACTICES:
By signing this form, you acknowledge that you have been given a Notice of Privacy Practices and comprehend the information which explains our privacy practices, and you give consent to use your protected health information as described. You have the right to revoke this consent, in writing, except where we have already made your information available in reliance on your previous consent. I understand that IN VEIN Smalling Vascular Institute. L.L.C. will not discuss my protected health information unless I have directed otherwise.

Signature: ______________________________ **Date:** ______________

CONTACT PHARMACY TO UPLOAD PRESCRIPTIONS:
I hereby authorize IN VEIN Smalling Vascular Institute L.L.C to electronically contact my pharmacy in order to ensure all medicines prescribed are populated in my chart.

Signature: ______________________________ **Date:** ______________

MEDICARE: (**patients who have Medicare, must sign this portion**)
I request that payment of authorized Medicare benefits be made either to me or on my behalf to the treating provider for any services rendered. I authorize any holder of health records regarding myself be released to the Health Care Financing Administration and its agents if needed to determine these benefits are payable for related services.

Signature: ______________________________ **Date:** ______________

PATIENT ANUTHORIZATION FOR CLAIMS:
I hereby authorize IN VEIN Smalling Vascular Institute L.L.C to have permission to work with any and all Commercial self-funded or government payer to settle any and all claims which might be denied for reimbursement.

Signature: ______________________________ **Date:** ______________

PATIENT AUTHORIZATION CONSENT:
I hereby authorize IN VEIN Smalling Vascular Institute L.L.C. to furnish collected information to my insurance carrier and referring physician regarding my conditions and treatment. I understand that I am responsible for payment of my bills and bills accrued by dependents. If the patient is a minor, I have authority to authorize treatment.

Signature: ______________________________ **Date:** ______________

approval

Patient Insurance Coverage Responsibility:
I understand that it is my responsibility to know whether IN VEIN, Smalling Vascular Institute, L.L.C. is currently an authorized provider according to my insurance contract. If, for any reason, my insurance is not valid or any fees are not covered by my insurance agency, I am responsible for payment of all charges. I also understand that IN VEIN, Smalling Vascular Institute, L.L.C. is required by law and contract to collect from me any present co-pay amount, on the date of service, required by my insurance agency.

I understand that I am responsible to know which lab and outside facilities my insurance agency is contracted with for all lab work, diagnostic testing, or specialist providers. If prior authorizations are required by my insurance agency for diagnostic testing and specialist appointments, I realize that it is my responsibility to request a referral authorization from my provider. Failure to obtain authorization may result in denial of payment from my insurance agency and leave me responsible for any outstanding balances.

I understand and agree that, if my employer, workman's compensation carrier, or my insurance plan does not pay in full, I will be responsible for payment of all charges. I also agree that, in the event of collection, I will pay all outstanding charges and costs of collection including reasonable attorney's fees. I authorize my insurance company to pay all benefits directly to IN VEIN, Smalling Vascular Institute, L.L.C. and agree to the release of relevant medical information to insurance carriers. The listed directives will remain in effect until revised by myself in writing. A copy within my records serves as the original document. I understand and agree to the financial policies as described.

Initial: _______________

Authorization and Consent for Medical Treatment:
During scheduled office visits or any procedures, I permit the physician, staff and all other persons providing care for me to treat me in ways they judge are beneficial to me. I understand that the nature of my condition will be explained to me along with the recommendations of treatment options and any associated risks from treatment. I also understand the care received may include diagnostic testing, examinations, medical and/or surgical treatment, and that guarantees have not been made to me about the outcome of the care. I give consent for general treatment, medical procedures, and to receive any medications prescribed as needed.

Initial: _______________

Calls/Text:
I give IN VEIN Smalling Vascular Institute, L.L.C. permission to contact me via home or cellular telephone and leave messages regarding medical information and information regarding upcoming appointments if I am not available.

Please check one of the following:

☐ **DO NOT CONTACT ME**

OR

☐ **CONTACT ME VIA (CIRCLE ONE) CALLS, EMAIL, TEXT, OR LETTER VIA POST**

____ _______________
Signature of Patient/Guarantor **Date**

____
Printed name of Patient or Guarantor

approval

Smalling Vascular Institute
11025 METCALF AVENUE | OVERLAND PARK KS, 66210 | (913) 912 -3624

Written Financial Policy

Thank you for choosing IN VEIN, Smalling Vascular Institute L.L.C. Our primary mission is to deliver the best and most comprehensive care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Visa®, MasterCard®, American Express® or DiscoverCard®

  or

- Convenient Monthly Payment Plans[1] from CareCredit®
  - Allows you to pay over time
  - No annual fees or pre-payment penalties

Please note:

IN VEIN, Smalling Vascular Institute L.L.C. requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.

Smalling Vascular Institute charges $35.00 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the treatment and care you want and need.

Patient or Guardian Signature **Date**

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

approval