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: _____

Please update for any additions/deletions/changes

Review of Systems

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 update for any additions/deletions/changes

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**

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

PHARMACY NAME: _____

Address: _____ **Phone**: _____

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:** _____

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:_____

SURGICAL HISTORY: (IT TRULY MATTERS- (please report ANY/ALL here) (IF NOT APPLICABLE, PLEASE PUT N/A)

Surgery:_____ Date: _____

Surgery:_____ Date: _____

Surgery:_____ Date: _____

Surgery:_____ Date: _____

Surgery:_____ Date: _____

Surgery:_____ Date: _____

Surgery:_____ Date: _____

_____ _____

Signature of Patient/Guarantor **Date**

_____

Printed name of Patient or Guarantor