THANK YOU FOR PRINTING CLEARLY WITH BLACK OR BLUE INK

McQUAID Vein Care

Patient Registration Form

Last Name:_____ First Name: _____ Middle Initial: ____ Date of Birth:____/____/____

Age: ____ Sex: ☐Male ☐Female Marital Status: _____

Address:_____ City, State, and Zip: _____

Home Phone: _____ Cell Phone: _____ Primary phone: Home / Cell

Soc. Sec. #:_____-____-_____ Email: _____

Referred by:_____ Primary Care Dr.: _____

Dr. Phone #:_____ Dr. Phone #: _____

Primary Insurance:_____ Phone: _____

Insured's name:_____ Date of Birth:____/____/____ Soc. Sec. #: _____

Relationship to patient: Self / Spouse / Parent

Member ID#:_____ Group #: _____

Secondary Insurance:_____ Phone: _____

Insured's name:_____ Date of Birth:____/____/____ Soc. Sec. # _____

Relationship to patient: Self / Spouse / Parent

Member ID#:_____ Group #: _____

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship:_____ Phone: _____

FINANCIAL POLICY

Charges for medical services are due and payable at the time the services are rendered. As a courtesy to you, we will file your insurance claims. You are responsible for the payment of your bill regardless of the status of your insurance claim. If unusual circumstances should make it impossible for you to meet our credit terms we invite you to call or personally discuss the matter with the Office Manager. Charges for medical care rendered by this office will be through this office and should not be confused with charges of care received in the hospital.

RELEASE

I authorize assignment of benefits to Southlake Vein Care/North Texas Vascular & Varicose Veins, PA. I also permit the release of any information from my medical record to my insurance company as may be required to facilitate payment of services rendered. I understand I am responsible for all charges.

Signature:_____ **Date:** _____

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NEW PATIENT MEDICAL HISTORY

Name: _____ **Date of Birth:** _____ **Sex: M / F**

This section for women only:	
Date of Last Menstrual Cycle:	Currently Nursing: ☐ Yes ☐ No
Currently Pregnant: ☐ Yes ☐ No	Total Number of Pregnancies:
Live Births:	Total Number of Miscarriages:

Tobacco Use:		
Smoke Cigarettes? ☐ Yes ☐ No	Other Tobacco ☐ Cigar ☐ Snuff ☐ Chew	
Current: Packs/day _____ # of Years _____	**Past:** Quit Date _____ Packs/day _____	
Alcohol Use:		
Do you drink alcohol? ☐ Yes ☐ No	☐ Beer ☐ Wine ☐ Liquor	# of drinks per week _____
Drug Use:		
Do you use marijuana? ☐ Yes ☐ No	Do you use any other recreational drugs? ☐ Yes ☐ No	

Are you allergic to:

- ☐ Latex
- ☐ Iodine
- ☐ Adhesives/Medical Tape
- ☐ Medications: _____

Review of systems (Check all that apply)

GENERAL
☐ Fever
☐ Fatigue
☐ Weight Loss
☐ Weight Gain
☐Other_____

HEAD / EYES / EARS
☐ Frequent Headaches
☐ Migraines
☐ Dizziness
☐ Ringing in Ears
☐ Change in Hearing
☐ Sinus Issues
☐ Sore Throat
☐ Nosebleeds
☐ Glaucoma
☐ Cataracts
☐Other_____

CARDIOVASCULAR
☐ Chest Pain
☐ High Blood Pressure
☐ Palpitations
☐ Use Oxygen at home
☐ Pacemaker/Defibrillator
☐ Swelling in Ankles/Legs
☐Other_____

RESPIRATORY
☐ Shortness of Breath
☐ Wheezing
☐ Asthma
☐ Frequent Colds
☐ Other _____

BLADDER/ KIDNEY / LIVER
☐ Burning with Urination
☐ Blood in Urine
☐ Difficulty Urinating
☐ Prostate/Testicular Problems
☐ Cirrhosis of the Liver
☐ Hepatitis
☐ Hemophilia
☐Other_____

MUSCULOSKELETAL
☐ Leg pain at rest
☐ Leg pain with exertion
☐ Back pain
☐ Muscle pain
☐ Joint pain
☐ Joint Swelling
☐ Decreased range of motion
☐ Trouble with Balance
☐ Other_____

HEMATOLOGIC
☐ Unusual bruising
☐ Anemia

DIGESTIVE
☐ Heartburn
☐ Vomiting
☐ Vomiting Blood
☐ Constipation
☐ Diarrhea
☐ Black Stools
☐Other_____

NEUROLOGICAL
☐ Memory Problems
☐ Speech Problems
☐ Weakness
☐ Numbness
☐ Seizures
☐Other_____

PSYCHIATRIC
☐ Depression
☐ Anxiety
☐Other_____

SKIN
☐ Skin Cancer
☐ New Growths/Lumps
☐ Color change in mole(s)
☐ Rash
☐ Itching
☐ Other_____

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NEW PATIENT MEDICAL HISTORY

Name:_____ **Date of Birth:** _____

Do you need to take antibiotics before all surgical or dental procedures? ☐ Yes ☐ No

Disease/Condition	Personal	Family Member (Please list relationship)
Varicose Veins/Chronic Venous Disease		
Bleeding Disorder ("thin blood")		
Blood Clotting Disorder ("thick blood")		
Small vein blood clots (Phlebitis)		
Deep vein blood clots (DVT)		
Blood clots in the lungs (PE)		
Diabetes (Type I or Type II)		
Heart Disease/Heart Attack		
High Blood Pressure		
Migraine Headaches		
Hyperthyroidism		
Hypothyroidism		
Lupus		
Auto-immune disease		
HIV		

Please list any other medical conditions that are not listed above:

Please list your current medications (including prescription, non-prescription, herbal, vitamins and home remedies)

Please list any previous surgeries:

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.

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PATIENT PHOTOGRAPHIC AND TESTIMONIAL AUTHORIZATION AND RELEASE

I,_____, authorize Southlake Vein Care/ McQuaid Vein Care/ North Texas Vascular & Varicose Veins, PA and/or Mark A. McQuaid, MD, J. Andrew Skiendzielewski, DO, and/or representative(s), to collect and use testimonials, photographs, slides, videotapes of me or parts of my body for the following procedure(s), program(s) and for medical purposes to be used for my care, medical presentations and/or articles.

In addition, I authorize the use of these words or images, without compensation to me, for the following specific purposes: (Please initial and circle Yes or No for each item)

____ Yes No In the office photo album for prospective or current patients.
____ Yes No In office seminars for prospective or current patients.
____ Yes No On our website for prospective or current patients.
____ Yes No On social media accounts, including Facebook, Instagram and Twitter.
____ Yes No In printed material or advertisements.
____ Yes No On television.

Additional Comments:

I understand that:

1. Such testimonials, photographs, slides or videotapes may be published by Southlake Vein Care/ McQuaid Vein Care / North Texas Vascular & Varicose Veins, PA and/or Mark A. McQuaid, MD, and/or J. Andrew Skiendzielewski, DO, in any print, visual, or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, for the purpose of informing the medical profession or the general public about general and vascular surgery methods or weight loss or wellness programs. I understand that such uses may also include marketing on behalf of Southlake Vein Care/ McQuaid Vein Care / North Texas Vascular & Varicose Veins, PA and/or Mark A. McQuaid, MD, for which Dr. McQuaid may or may not receive direct or indirect remuneration.

2. I will not be identified by name in any of the imagery media described above; however, I also understand that testimonials may identify me by first name and last initial.

3. I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to Southlake Vein Care at 1518 Legacy Drive, Ste 120, Frisco, TX 75034 or by email at info@ SouthlakeVeinCare.com. A revocation shall not affect any release of information made prior to revocation in reliance upon this Authorization. Any revocation may take up to 60 days to become effective. If I do not revoke this authorization, it shall not expire, except to the extent action has been taken thereon.

Patient Signature: _____ **Date:** _____

Printed Name: _____

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OFFICE FINANCIAL POLICY

We strive to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve that goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

INSURANCE

1. **Upon arrival, please check in at the front desk and present your current insurance card and official identification**. If you do not notify us at that time of a change in insurance, we will assume all the information on file is current and accurate. You will be required to sign and date the file copy of the chart cover sheet. This is your verification of the correct insurance and consent to bill them on your behalf. IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU MAY BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND YOU ALSO MAY NEED TO SUBMIT THE CHARGES TO THE CORRECT PLAN.
2. Although we try to get current and accurate benefits from your insurance company, it is ultimately your responsibility to understand your benefit plan. It is your responsibility to know if a written authorization or preauthorization is required prior to a procedure, and what services are covered. We try to keep you informed on the status of any authorizations/denials but you should also take an active role in understanding your insurance status, as you are responsible for any balances as a result of not meeting their criteria.

MANAGED CARE

3. If your insurance company requires you to obtain a referral from your primary care physician to see a specialist, you are responsible for providing our office with this information. Any claims denied as a result of not getting a referral may be billed to you directly.

REFUNDS

4. Overpayments will be refunded to the appropriate party, normally the insurance company or guarantor. Patients' refunds will not be processed until all active or past due accounts are paid in full. Refunds of less than $20 will be retained for future services unless requested in writing from the patient or guarantor.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

5. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances for all services determined to be medically necessary. Failure to fulfill your obligations will require our office to report this to your insurance company (may result in termination of your policy) and the IRS (you would be required to report any fees as income on your taxes).
6. Co-payments are due at time of service. If you owe toward your deductible/co-insurance for your visit, you will be asked to pay these fees based on an estimated charge by your insurance company's contracted rate.
7. If our physician does not participate in your insurance plan or you do not have insurance, payment in full is expected from you at the time of your office visit unless other agreements are in place. For scheduled appointments, all existing balances must either be paid prior to the visit.
8. We are not a Medicaid provider. Therefore, we do not bill Medicaid as primary or secondary and you will be responsible for all charges.
9. Not all services provided by our office are covered by every plan. **Any service determined to be non- covered or not medically necessary by your plan will be your responsibility.**

PROCEDURES

PLEASE UNDERSTAND THAT GETTING AUTHORIZATION, AND THE PROCESS FOR SCHEDULING ANY PROCEDURES, TAKES CONSIDERABLE TIME AND EFFORT FROM OUR STAFF. WE UNDERSTAND THAT THERE MAY BE CIRCUMSTANCES THAT REQUIRE YOU TO RESCHEDULE OR POSTPONE YOUR TREATMENTS WITH US. HOWEVER, **IF WEHAVE TO CANCEL, RESCHEDULE, OR POSTPONE YOUR TREATMENTS MORE THAN ONCE FOR NON- MEDICAL/INSURANCE ISSUES YOU MAY BE ASKED TO PAY A $75 FEE.**

10. For all procedures requiring sedation, you need to arrive 45 minutes before your scheduled appointment time.

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11. Failure to do so may result in your procedure (and subsequently scheduled appointments) being rescheduled and will be considered a "late cancellation" subject to applicable fees.

12. We provide treatment plan estimates upon request with the understanding that they are subject to change as your policy, benefits, and information provided by your insurance company changes.

APPOINTMENT FEES

WE REALIZE THERE ARE UNEXPECTED CIRCUMSTANCES THAT ARISE WHICH MAY CAUSE YOU TO BE LATE OR NOT CANCEL YOUR APPOINTMENT WITHIN THE REQUESTED TIME FRAME. HOWEVER, WE HAVE TO MAINTAIN A STANDARD POLICY FOR ALL PATIENTS AND BE CONSISTENT IN ITS ENFORCEMENT.

If you are more than 15 minutes late checking in for an appointment you may be charged a $25 late fee and may be asked to reschedule your appointment.

13. We require 24-hour notice for canceling any non-procedure appointments. There is **a $25 charge for appointments if they are not canceled OR if 24-hour notice is not given**.

14. We require 48- hour notice for cancelling any procedures (ablations, phlebectomy, ultrasound guided sclerotherapy, mass removal, general surgeries/procedures, etc.). **Failure to notify our office within 48- hours of a cancellation may result in a non-negotiable $75 fee.**

OTHER FEES

15. A **$25 fee will be charged for any checks returned for insufficient funds**, plus any bank fees incurred.

16. **We charge $25 to copy or transfer medical records (each time)**. You must provide written consent to send this information and our turnaround time is 48-72 hours for completion.

17. **If you have any disability, FMLA, or any other paperwork/forms that need to be filled out by our clinical staff for work or insurance, there is a $25 charge.** Payment is due when the forms are dropped off. We have a 48-72 hour turnaround time for forms.

I,_____, have been given the Office Financial Policy of Southlake Vein Care/ McQuaid Vein Care / North Texas Vascular & Varicose Veins, PA.

I have read and understand this Office Financial Policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

_____	_____	_____
Signature of Patient/Responsible Party	**Printed Name (First Last)**	**Date**
_____	_____	_____
Witness	**Patient Name (If Different Than Above)**	**Date**

*Should you decline this portion of the agreement, there is an alternative form that may be signed. **Initial**_____