VIRGINIA VEIN CARE

8200 GREENSBORO DRIVE, SUITE 210 MCLEAN, VA 22102
850A EAST MAIN STREET PURCELLVILLE, VA 20132
2440 M ST NW SUITE 200 WASHINGTON DC 20037

FIRST NAME _____ MIDDLE INITIAL _____ LAST NAME _____ NICKNAME _____
GUARDIAN: _____ RELATIONSHIP TO PATIENT: _____
DATE OF BIRTH: _____ SEX: M F
ADDRESS: _____ CITY _____ STATE _____ ZIP CODE _____
PHONE-HOME _____ PHONE-CELL _____ PHONE-WORK _____
EMAIL : _____
EMERGENCY CONTACT: _____ EMERG PHONE: _____

PRIMARY CARE PHYSICIAN _____ OFFICE LOCATION CITY: _____ STATE: _____
REFERRING PHYSICIAN: _____ OFFICE LOCATION CITY: _____ STATE: _____

OCCUPATION: _____ EMPLOYER: _____

LANGUAGE: _____ NEEDS INTERPRETER Y N
ETHNICITY: Hispanic/Latino Non-Hispanic/Latino Decline to Answer
RACE: (circle one) Caucasion African Amer Hispanic Asian Indian Other Decline to Anser

INSURANCE COMPANY: _____ (PLEASE PRESENT CARD)
SUBSCRIBER: First Name: _____Last Name:_____DOB:_____

ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY

I, _____ certify that the above information is correct. Dr. Lawrence Markovitz and Dr. Christopher Rothstein are hereby authorized to furnish said information to insurance carriers concerning my illness and treatments, and to collect all payments for medical services rendered to myself or my dependents.

Submission of my insurance claims is a courtesy provided by Virginia Vein Care. I understand that I am responsible for my copay when services are rendered. After claims are processed, I understand that I am responsible for any deductible or coinsurance in accordance with my insurance policy's benefits.

Furthermore, I understand that in the event of a default on any payment obligation under this Agreement, that it is my responsibility to pay the entire balance of this agreement upon demand. I agree to pay any allowable interest, and if necessary, costs of collection including attorney's fees or collection agency fees. I also understand that a fee of $25.00 will be added for all returned or refused payments.

Signature: Patient / Parent / Guardian _____Date:_____

Witness _____Date:_____

VIRGINIA VEIN CARE

Patient Health History

Name: _____ Date: _____

Chief complaint:
Circle symptom and leg (s) if applicable

Pain - R L Both	Inflammation - R L Both	Spider Veins - R L Both
Swelling - R L Both	Skin Rash - R L Both	Reticular Veins - R L Both
Sock lines - R L Both	Discoloration - R L Both	Numbness or tingling in legs- R L Both
Varicose Veins - R L Both	Bleeding - R L Both	
Ulceration - R L Both	Hard Knot in vein - R L Both	Burning - R L Both
Restless Leg Synd - R L Both	Leg Cramps - R L Both	Heaviness - R L Both

Approximately how long have you had these symptoms? ____(# Months?) ____(# Years?)

Previous Treatments _____

Worse with: (circle)

Sitting	Walking	Menstrual Cycle
Standing	Working	Lying Down
Beginning of day	End of day	Pregnancy

Improved by: (circle)

Elevation	Compression Hose	Fluid Pills
Rest	Tylenol/Motrin Equivalent	Walking
Beginning of day	End of day	

Social History: Alcohol: Never ____ Rare ____ Social/Occasionally____ Daily____
Smoking: Never ____ Former ____ Current Occasionally ____ Current Daily ____

Past Surgeries: Coronary Artery Bypass ___ Angioplasty/Stent ___ Peripheral Vascular Surgery ___
Other: _____

Past History: Coronary Artery Disease ___ High Cholesterol ___ High Blood Pressure ___ Diabetes ___
Peripheral Vascular Disease___ Varicose Veins___
Other: _____

Family History: Coronary Artery Bypass , Who? _____
High Cholesterol Who? _____
High Blood Pressure Who? _____
Diabetes, Who? _____
Other _____

Allergies: ____ No known allergies OR: _____
_____

Current Medications: _____
_____

VIRGINIA VEIN CARE

Patient Health History
Review of Systems

Please check all that apply:

Skin
- _____ Itching
- _____ Hives
- _____ Bruising
- _____ Bleeding

Eyes
- _____ Vision changes
- _____ Vision loss
- _____ Double vision

Ears:
- _____ Hearing aids
- _____ Hearing loss
- _____ Pain
- _____ Discharge
- _____ Ringing
- _____ Infections

Nose:
- _____ Nosebleeds
- _____ Discharge
- _____ Pain
- _____ Infections

Mouth/Throat:
- _____ Cavities
- _____ Dentures
- _____ Bleeding Gums
- _____ Sores/Lesions
- _____ Hoarseness

Neck:
- _____ Goiter
- _____ Pain
- _____ Thyroid problems

Respiratory:
- _____ Cough
- _____ Blood
- _____ Shortness of Breath
- _____ Asthma
- _____ Emphysema
- _____ Pneumonia
- _____ Bronchitis
- _____ Tuberculosis

Cardiovascular
- _____ Chest Pain
- _____ Palpitations
- _____ Shortness of Breath:
  - _____ when sleeping
  - _____ when walking
- _____ legs swelling
- _____ leg cramps
- _____ varicose veins
- _____ color changes-legs
- _____ color changes-feet

Gastrointestinal
- _____ Vomiting
- _____ Constipation
- _____ Diarrhea
- _____ Heartburn
- _____ Blood in stool
- _____ Change in stool
- _____ Difficulty/pain in swallowing
- _____ Jaundice
- _____ Liver Disease
- _____ Gallbladder disease

Genitourinary
- _____ Excess urine frequency
- _____ Pain
- _____ Bloody urine
- _____ Incontinence

Hematology/Lymphatic
- _____ Anemia
- _____ Sickle Cell
- _____ Hemophilia
- _____ Swollen Glands
- _____ Night Sweats
- _____ Itching

Neurological
- _____ Headaches
- _____ Dizziness
- _____ Numbness
- _____ Falls
- _____ Tremors
- _____ Stroke/TIA
- _____ Loss of Memory
- _____ Problems w/gait

Psychiatric
- _____ Depression
- _____ Anxiety
- _____ Bipolar

Endocrine
- _____ Increased thirst
- _____ Increased urine
- _____ Intolerance to heat
- _____ Intolerance to cold
- _____ Diabetes
- _____ Hot flashes

Musculoskeletal
- _____ Weakness
- _____ Paralysis
- _____ Stiffness
- _____ Joint Pain
- _____ Swelling
- _____ Arthritis
- _____ Gout

Allergy/Immune
- _____ AIDS
- _____ Hepatitis B
- _____ Hepatitis C

Patient Signature: _____ Date: _____

Virginia Vein Care

8200 Greensboro Drive Suite 210 McLean VA 22102
850A East Main Street Purcellville VA 20132
2440 M Street NW Suite 200 Washington DC 20037

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSEDAND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

Effective Date: September 3, 2013

We are required by law to maintain the privacy of your protected health information("PHI") and to provide this Notice. This Notice informs you of our privacy practices, of our legal obligations, and of your rights regarding your PHI. We are required to abide by the terms of this Notice.

We reserve the right to change our privacy practices and this Notice at any time, provided such changes are permitted by law. We reserve the right to make the changes in our privacy practices and new provisions of our Notice effective for all PHI that we maintain, including PHI we created or received before we made the changes. Except when required by law, before we make a material change in our privacy practices or this Notice, we will change this Notice and provide a new Notice at our practice location, and we will distribute the new Notice 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 our contact information specified at the end of this Notice.

Your Authorization: In addition to our use of your PHI for the following purposes, you may give us written authorization to use your PHI or to disclose your PHI to anyone for any purpose. If you give us an authorization, you may revoke your authorization in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while your authorization was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI for any reasons except those described in this Notice.

We may use and disclose your PHI without your authorization for the following treatment, payment, and health care operations purposes:

Treatment: We use or disclose your PHI for your treatment. For example, we may disclose your PHI to a physician or other health care provider providing treatment to you.

Payment: We use and disclose your PHI to obtain payment for our services to you. For example, we may send claims to your health plan containing your PHI.

Health Care Operations: We use and disclose your PHI in connection with our health care operations. For example, our health care operations include quality assessment and improvement activities, reviewing the competence and qualifications of health care professionals, evaluating performance, conducting educational programs, and accreditation, certification, licensing, and credentialing activities.

Psychotherapy Notes: For most uses and disclosures of psychotherapy notes, we must seek your written authorization.

No Sale of PHI: Your PHI may not be sold without your written authorization.

To You or Your Personal Representative: We must disclose your PHI to you. We may disclose your PHI to your personal representative, but only if you agree that we may do so.

Persons Involved In Your Care: We use or disclose your PHI to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to any such uses or disclosures of your PHI, we will provide you with an opportunity to object to such uses or disclosures. In the event of your absence or incapacity or in emergency circumstances, we will disclose PHI based on a determination, using our professional judgment, regarding disclosing only PHI that directly is relevant to the person's involvement in your health care. We will also use our professional judgment and our experience to make reasonable inferences regarding your best interests in allowing a person to pick up filled prescriptions, medical supplies, x-rays, and other similar forms of your PHI.

Business Associates: Some of the services we provide involve our business associates. For example, we may use transcription services, outside billing services, consultants, and others to assist us. When these services are contracted, we disclose your PHI to our business associate so that they can perform their services. We require business associates appropriately to safeguard your PHI in accordance with the provisions of Business Associate Agreements.

Funeral Director or Coroner: Upon your death, we may disclose your PHI to a funeral director for burial purposes, as authorized by law. We may also disclose your PHI to a coroner or medical examiner for identification purposes, determining cause of death, or performing other duties authorized by law.

Disaster Relief: We use or disclose your PHI to assist in disaster relief efforts.

Marketing Health-Related Services: We will not use or disclose your PHI for marketing communications without your written authorization.

Fundraising: We will not use or disclose your PHI for charitable or similar fundraising without your written authorization.

Required by Law: We use or disclose your PHI when we are required to do so by law.

Public Health and Public Benefit: We may use or disclose your PHI to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the United States Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation and similar programs.

Decedents: We disclose PHI about a decedent as authorized or required by law.

National Security: We may disclose to military authorities the PHI of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials PHI required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution, or to a law enforcement official having lawful custody, the PHI of an inmate or patient under certain circumstances.

Appointment Reminders: We use or disclose your PHI to provide you with appointment reminders, including electronic mail messages, text messages, voicemail messages, postal cards, and letters.

Access: You have the right to see or obtain copies of your PHI, with limited exceptions. You may ask that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your PHI. You may obtain a form to request access by using the contact information specified below. You also may request access by sending a letter to our address specified below. We reserve the right to charge a reasonable fee for the cost of producing and mailing copies of your PHI.

Breach Notification: If an unauthorized use or disclosure of your unsecured PHI compromises the security or privacy of your PHI and thereby poses a significant risk of financial, reputational, or other harm to you, we will comply with legal requirements including notification and mitigation.

Access to Electronic Health Record: You have the right to access your electronic health record in an electronic format and to ask us to send your electronic health record directly to a third party.

Disclosure Accounting: You have the right to receive a list of instances in which we or our Business Associates disclosed your PHI, in the six years or a shorter period prior to written your request, for purposes other than treatment, payment, health care operations, and certain other activities. If you request an accounting more than once in a 12-month period, we may charge you a reasonable fee.

Restriction: You may request that we add certain restrictions regarding our use or disclosure of your PHI. In most instances we are not required to agree to such additional restrictions, but if we do agree we will abide by our agreement, except in certain circumstances where disclosure is required or permitted, such as in an emergency, for public health activities, or when disclosure is required by law. We must comply with a request to restrict the disclosure of PHI to a health plan for purposes of carrying out payment or health care operations if the PHI pertains solely to a health care item or service for which we have been paid privately in full.

Alternative Communications, Confidentiality: You may ask, in writing, that we communicate with you about your PHI by alternative means or at alternative locations. Your request must be reasonable and must specify the alternative means or location.

Amendment: You may ask, in writing, that we amend your PHI, but you must explain why an amendment is needed. We may deny your request under certain circumstances.

Electronic Notice: You may receive a paper copy of this Notice upon request, even if you agree to receive this Notice electronically on our Web site or via e-mail.

More Information: If you want more information about our privacy practices or have questions, concerns, or complaints, please inquire of our Chief Privacy Official by using our contact information specified below.

Violations: If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI or to have us communicate with you by alternative means or at alternative locations, you may complain to us by using our contact information specified below.

Chief Privacy Official
Virginia Vein Care, LLC
8200 Greensboro Drive
Suite 1015
McLean, Virginia 22102
Tel: (703) 664-1111

You also may submit a written complaint to the United States Department of Health and Human Services. Complaints may directed to:

Office for Civil Rights
U.S. Department of Health and Human Services
150 S. Independence Mall West
Suite 372
Public Ledger Building
Philadelphia, Pennsylvania 19106-9111
Voice: (800) 368-1019 - Fax: (215) 861-4431

No Retaliation: We support your right to the privacy of your PHI. We will not retaliate in any way if you file a complaint with us or with the United States Department of Health and Human Services.

I have been given the opportunity to read and acknowledge receipt of the Notice of Privacy Practices as presented by Virginia Vein Care.

Patient Signature: _____ Date: _____

Print Name: _____

Witness: _____

Emergency Contact:

Name: _____Relationship:_____Phone:_____

In addition, the physicians and staff of Virginia Vein Care may discuss my Protected Health Information with any of the following individuals as deemed necessary:

Name: Relationship:

I _____allow _____ do not allow: information mailed to my home

I _____allow _____ do not allow: calls to home phone or voice messages left on home phone

I _____allow _____ do not allow: calls to cell phone or voice messages left on cell phone. You may leave messages with : _____ me only _____ whoever answers ____other:_____

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the foregoing Notice of Privacy Practices because:
___An emergency existed and a signature was not possible at the time.
___The individual refused to sign.
___A copy was mailed with a request for a signature by return mail.
___We were unable to communicate with the individual because:
_____