NEW PATIENT INFORMATION

Name: _____ Date of Birth: _____

Please answer the following questions about your symptoms as accurately as possible.

LOCATION: Where is your pain located? ___ Right Leg ___ Left Leg ___ Both Legs

QUALITY: How would you describe the pain?
___ Aching ___ Burning ___ Stabbing
___ Throbbing ___ Sharp ___ Dull
___ Occasional ___ Frequent ___ Constant

SYMPTOMS: ___ Worse during the day ___ Worse at night
___ Legs swell equally ___ Legs do not swell equally
(More in ___Right or ___Left)

SEVERITY: ___No pain ___Mild ___Moderate ___Severe ___Intermittent ___Constant

PAIN LEVEL: Today: ___/10 Worst Pain: ___/10

DURATION: How long have you had leg symptoms or varicose veins? _____

ONSET: Did the symptoms start ___ Suddenly or ___ Gradually?

TIMING: How often do you experience symptoms?
___Every day ___ 2-3 days per week ___4-6 days per week

HISTORY OF SYMPTOMS: ___ began after injury ___ began after clot ___ began after pregnancy
___ family history of blood clot ___ family history of varicose veins

ASSOCIATED SYMPTOMS: ___ Numbness ___ Tingling ___ Redness
___ Discoloration ___ Rash ___ Itching
___ Warmth ___ Heaviness ___ Bleeding from vein
___ Ulcer (date of onset: _____) ___ Recurrent Ulcers

ALLEVIATING FACTORS: ___ Walking ___ Elevation ___ Sitting
___ Lying down ___ Rest ___ Medication
___ Compression Socks

AGGRAVATING FACTORS: ___ Walking ___ Sitting ___ Stairs
___ Lying down ___ Standing for extended periods

Have you tried compression stockings? ___ Yes ___ No
If yes, for how long? _____

Do compression stockings improve your symptoms? ___ Yes ___ No

Have you had previous vein treatment? ___ Vein Stripping ___ Vein Injections ___ Vein Laser
Dates of treatment: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR PAST MEDICAL HISTORY

Please list your past medical conditions:

___ High blood pressure (requiring medication)
___ High cholesterol (requiring medication)
___ Peripheral Artery Disease
___ Stents
___ Skin ulcer
___ Allergic reaction to Latex
___ Allergic reaction to anesthesia
___ Other bleeding disorder
___ Other medical problems _____
_____
_____

___ Hemophilia
___ Factor 5 Leiden
___ Neuropathy
___ HIV/AIDS
___ Hepatitis
___ Deep Vein Thrombosis
___ Other heart problems

Please list any surgeries you have had:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____
6. _____ Date: _____

Are you allergic to any medications? NKDA □

_____
_____

Please list all of the medications you currently take:

Medicine	Dose	How many times daily?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you take any of the following?

Aspirin	____ No	____ Yes
Plavix	____ No	____ Yes
Warfarin (Coumadin)	____ No	____ Yes
Other blood thinner	____ No	____ Yes

What is your height? _____ Weight? _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR SOCIAL HISTORY

Is there a history in your family of spider or varicose veins? If yes, who? _____
_____
_____

Is there a history in your family of small or deep vein thrombosis, stroke, or clotting disorders?
If yes, who? _____
_____
_____

Do you currently smoke? ____ No ____ Yes
If yes, how many packs per day? _____
For how many years? _____

If you don't currently smoke, did you smoke in the past? ____ No ____ Yes
If yes, how long ago did you quit? _____
Before you quit, how many packs per day did you smoke? _____
Before you quit, how many years did you smoke? _____

Do you currently drink alcohol? ____ No ____ Yes
If yes, how many drinks per week? _____

Are you currently ____ Married ____ Single ____ Divorced
How many children do you have? _____

Do you currently work? ____ No ____ Yes, where? _____
What do you do? _____
For how long? _____

How did you hear about us? _____

I understand that for my doctor to provide me with the best possible care, I must provide complete and accurate information about my medical history. I certify the information I have provided is true and correct.

_____ _____/_____/_____
Patient Signature Date

Review of Systems

(Circle all that apply)

Constitutional: Fever, Chills, Night sweats

Eyes: Pain, Vision change

ENMT: Difficulty hearing, Ear pain, Vertigo, Tinnitus, Nose/Sinus problems, Oral abnormalities

Cardiovascular: Chest pain on exertion, Shortness of breath when walking, Shortness of breath when lying down, Palpitations, Known heart murmur

Respiratory: Cough, Wheezing, Shortness of breath, Bronchospasm

Gastrointestinal: Nausea, Vomiting, Frequent diarrhea, Constipation

Musculoskeletal: Leg muscle aches, Leg pain, Leg heaviness, Leg cramps, Ankle pain, Knee pain, Hip pain, Back pain

Skin in the legs: Dryness, Spider veins, Darkening, Rash, Ulcers, Redness

Neurologic: Leg weakness, Leg numbness, Leg tingling, Restless legs

Psychiatric: Depression, Anxiety, Panic attacks, Sleep disturbances

Endocrine: Fatigue, Cold intolerance, Heat intolerance, Hair loss on legs

Hematologic: Varicose veins in legs/feet, Swelling in legs/feet, Bleeding from varicose vein, Vein inflammation

Allergic: Itching in legs/feet, Hives

Insurance cards copied ❑
Date: _____

Patient Registration Information

Account # : _____
Insurance # : _____
Co-Payment: $ _____

Please PRINT AND complete ALL sections below!

Is your condition a result of a work injury? YES NO An auto accident? YES NO Date of Injury: _____

PATIENT'S PERSONAL INFORMATION Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed Sex: ❑ Male ❑ Female

Name: _____ (last name) _____ (first name) _____ (initial)
Street address: _____ (Apt. #____) City: _____ State: ____ Zip: _____
Home phone: (____) _____ Work phone: (____) _____ Cell phone: (____) _____
Date of Birth: ____/____/_____ Driver's Lic.: (State & #) _____ SSN _____-____-_____
How do you wish to be addressed? _____ E-mail: _____ Fax # (____) _____
Employer / Name of School: _____ ❑ Full Time ❑ Part Time
Spouse's Name: _____ (last first initial) Spouse's Work # (____) _____ SSN _____-____-_____

PATIENT'S / RESPONSIBLE PARTY INFORMATION

Responsible party: _____ Date of Birth: ____/____/_____
Relationship to Patient: ❑ Self ❑ Spouse ❑ Other _____ SSN _____-____-_____
Responsible party's home phone: (____) _____ Work phone: (____) _____
Address: _____ (Apt. #:____) City: _____ State: ____ Zip: _____
Employer's name: _____ Phone number: (____) _____
Address: _____ City: _____ State: ____ Zip: _____
Your occupation: _____
Spouse's Employer's name: _____ Spouse's Work phone: (____) _____
Address: _____ City: _____ State: ____ Zip: _____

PATIENT'S INSURANCE INFORMATION Please present insurance cards to receptionist.

PRIMARY insurance company's name: _____
Insurance address: _____ City: _____ State: ____ Zip: _____
Name of insured: _____ Date of Birth: ____/____/_____ Relationship to insured: ☐ Self ☐ Spouse ☐ Other ☐ Child
Insurance ID number: _____ Group number: _____
SECONDARY insurance company's name: _____
Insurance address: _____ City: _____ State: ____ Zip: _____
Name of insured: _____ Date of Birth: ____/____/_____ Relationship to insured: ☐ Self ☐ Spouse ☐ Other ☐ Child
Insurance ID number: _____ Group number: _____
Check if appropriate: ❑ Medigap policy ❑ Retiree coverage

PATIENT'S REFERRAL INFORMATION (please circle one)

Referred by: _____ If referred by a friend, may we thank him or her? YES NO
Name(s) of other physician(s) who care for you: _____

EMERGENCY CONTACT

Name of person not living with you: _____ Relationship: _____
Address: _____ City: _____ State: ____ Zip: _____
Phone number (home): (____) _____ Phone number (work): (____) _____

Assignment of Benefits • Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Steve Simmons, DO, PLLC, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____ Your Signature: _____

SOUTHWEST
VEIN & LEG CENTER

I_____ agree that in return for the services provided by Robert D. Menzies, MD, PLLC I will pay my/the account at the time service is rendered or will make financial arrangements satisfactory to Robert D. Menzies, MD, PLLC. If co-payments and/or deductibles are designated by my insurance company or health plan I agree to pay them to Robert D. Menzies, MD, PLLC. All co-payments and past due amounts are to be paid at the time of service. I understand and agree that if my account is delinquent, I may be turned over to a collection agency.

NON-COVERED SERVICES

I understand that Robert D. Menzies, MD, PLLC contracts with health care service plan(s) (i.e. HMO, PPO, etc.) that relate only to items and services which are "covered" by health care service plans. Accordingly, the undersigned accepts full personal responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include but are not limited to services not specified as being covered in the patient's contract with a health care service plan, or in the benefit summary the health care plan furnished to the patient.

HMO REFERRALS

If your insurance has designated a primary care physician (PCP) it is your responsibility and/or your PCP to provide an authorization to see a specialist. Therefore it is understood by you, the patient, that a prior authorization from your PCP for an office visit is required. If the authorization is not provided, whether by yourself or through your insurance carrier or your PCP, you will be asked to either reschedule your appointment or pay for the full visit at the time of service and you file to your insurance carrier.

SELF-PAY ACCOUNTS

Self-pay accounts are patients who are covered by carriers that the practice does not participate in or patients without an insurance plan at the time of service. The undersigned agrees that they are individually obligated to pay the full charges at the time of service. The undersigned agrees that they are individually obligated to pay the full charges at the time of service based on current charge schedule in effect.

NON-PARTICIPATING INSURANCE ACCOUNTS

The financial obligations of patients who are insured by carriers with which the practice does not participate are considered "out-of-network" plans and will be required to pay the co-pay and/or visit in full at the time of service.

IF YOU REQUIRE A PROCEDURE/SURGERY

If you require a procedure/surgery your physician/pre-cert staff will work with you to select a date that will accommodate your schedule. Also, one of our staff will review any anticipated financial responsibilities you will have. You may be asked to make a pre-payment to cover the amount of your deductible/percentage for surgical care and this payment will be due before the procedure/surgery is performed. Please feel free to talk to our staff about payment plans if you have a special financial situation. Allow our office to work with you to ensure you are able to be provided quality care.

RETURNED CHECKS

All returned checks will be assessed a $35.00 fee.

COPAYS & DEDUCTIBLES

All copays & deductibles are due at time of service. Your insurance requires you to pay your portion due, which is on your insurance card. If you cannot pay at the time of service you will be re-scheduled.

PATIENT PAYMENT PLANS

Robert D. Menzies, MD, PLLC has the ability to provide a payment agreement to any patient that is unable to pay their bill/balance in full. Please ask to speak with our Practice Manager to provide you with the terms and payment arrangements you may qualify to receive.

_____ _____

Signature of Patient or Authorized Representative Date

_____ _____ _____

Driver's License # of Responsible Party State SS# of Responsible Party

SOUTHWEST
VEIN & LEG CENTER

CONSENT TO TREAT

I consent to necessary medical treatment as recommended by my physician. I understand that I am personally responsible for payment for anything that insurance may not cover including all recommended medical services, such as preventative health exams, immunizations screening test, detailed phone consultations, copies of medical records, preparation of reports, forms and summaries.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical records information, and insurance authorization. These authorizations shall remain until written notice is given by me revoking said authorization.

Patient Signature: _____ Date: _____

PRIVACY NOTIFICATION

As permitted by the Health Insurance Portability and Accountability Act (HIPAA), I understand that my protected health information may be used and disclosed by the physician, office staff, and others outside of this office who are involved in my care and treatment for the purpose of providing health care services.

I acknowledge that I have been provided an opportunity to review the Notice of Privacy and Practices which explains how my medical information will be used and disclosed.

Patient Signature: _____ Date: _____

CONSENT TO CORRESPONDENCE

Consent to receive health notifications, appointment correspondence, announcements, and billing via email and portal access.

Patient Signature: _____ Date: _____

Steven Simmons, DO, PLLC

SOUTHWEST
VEIN & LEG CENTER

Robert D. Menzies, MD, PLLC

Dear Patient:

Our office has a fee for **No Show** and **No Call Appointments**. We require a 24-hour notice to our office to cancel or reschedule your appointment. A $50.00 fee will be required and needs to be paid in cash on your next office visit. This will be a separate payment from your normal office co-pay or coinsurance payment.

The purpose of this fee is to encourage our patients to be responsible and appreciate that this time is reserved for you and it is your responsibility to call and cancel or reschedule your appointment. We always have patients that need to come in for urgent visits and we need to keep available appointments open for these patients.

We understand that we all have emergency situations, and these will be considered based on the situation and a decision regarding the fee will be made by our office.

Thank you for your understanding and cooperation.

Patient Signature: _____ Date: _____

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: Steven Simmons, DO, PLLC and Robert D. Menzies, MD, PLLC

Address: 7148 Trail Lake Drive

City: Fort Worth State: Texas Zip Code: 76123-1969

Phone (817) 294-0934 Fax (817) 294-1488

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION example: attorney or attorney offices, family members, coach/training staff

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 _____

Please use next page to include additional individuals who can receive and use your health information.

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.

Initial _____

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**

ADDITIONAL INDIVIDUALS WHO CAN RECEIVE AND USE YOUR HEALTH INFORMATION:

Person/Organization Name ____

Address____

City____State________ Zip Code__________

Phone (_______)____________________Fax (_______)______________________________

Person/Organization Name ____

Address____

City____State________ Zip Code__________

Phone (_______)____________________Fax (_______)______________________________

Person/Organization Name ____

Address____

City____State________ Zip Code__________

Phone (_______)____________________Fax (_______)______________________________

Steven Simmons, DO, PLLC SOUTHWEST VEIN & LEG CENTER **Robert D. Menzies, MD, PLLC**

In order for Steven Simmons, DO, PLLC and Robert D. Menzies, MD, PLLC to provide me with healthcare, I consent and acknowledge that Steven Simmons, DO, PLLC and Robert D. Menzies, MD, PLLC may contact any current or prior physician, pharmacy or other provider who has prescribed to me or dispensed any controlled substance(s) within the last 12 months. Additionally, my primary care physician and referring physician will be provided with clinical notes on my treatments and office visits from Steven Simmons, DO, PLLC and Robert D. Menzies, MD, PLLC. As required, I consent to necessary medical treatment as recommended by my physician. I understand that I am personally responsible for payment for anything that insurance may not cover, including all recommended medical services, such as preventative health exams, immunizations screening tests, detailed phone consultations, copies of medical records, or preparation of reports, forms and summaries. From time to time, Dr. Simmons and Dr. Menzies need to communicate with me and as such I consent to receive health notifications, appointment correspondence, announcements and billing notifications, through email, text and website portal access.

As a new patient, submitting preliminary healthcare or insurance information and/or completing new patient paperwork or making a new patient appointment with Steven Simmons, DO, PLLC or Robert D. Menzies, MD, PLLC, does not establish a physician-patient relationship. That relationship is not established until Steven Simmons, DO, PLLC or Robert D. Menzies, MD, PLLC has completed a preliminary evaluation and then notifies the individual that he or she has been accepted as a patient.

As permitted by the Health Insurance Portability and Accountability Act, (HIPAA), I understand that my protected health information may be used and disclosed by Steven Simmons, DO, PLLC or Robert D. Menzies, MD, PLLC, office staff, and others outside of this office who are involved in my care and treatment for the purpose of providing health care services. I have been offered a copy of Dr. Simmons' and Dr. Menzies' *Notice of Privacy Practices*, which explains how my medical information may be used and disclosed.

Dr. Simmons and Dr. Menzies have ownership and/or management interest in certain facilities in which they may refer me to treatment and procedures. These facilities include USMD Fort Worth, Select Pain Procedure Center in Mansfield, DBC physical therapy and Sanitas Healthcare.

I have read the above consents, acknowledgements and disclosures related to Steven Simmons, DO, PLLC and Robert D. Menzies, MD, PLLC.

_____ _____ _____

Patient Name Signature Date