Finesse Surgical Solutions
GENERAL • VASCULAR • COSMETIC
James W. Schlotter, MD, FACS
1347 Thorpe Lane, San Marcos, TX 78666
Office: (512) 395-8770 Fax: (512) 395-8772

Varicose Vein Patient Form

Patient Name: ____ Date: _______________

Years with Varicose or Spider Veins: ______ Referred by: ____________________________

Leg Veins
Check all that apply

Vein/Skin Conditions

_ None	_ Purple Vein Networks	_ Facial Veins
_ Small Red "Spider" Veins	_ Flat, Blue-Green Veins	_ Ankle Sores
_ Diagnosed Vein Disease	_ Abdominal Veins	_ Bulging Veins
_ Skin Discoloration	_ Vaginal Veins	_ Other: ___________________
_ Purple Veins	_ Chest or Breast Veins	

Leg & Ankle Problems

_ Aches	_ Fatigue	_ Cramps
_ Pain	_ Heaviness	_ Restlessness
_ Swelling	_ Itching	_ Other: ___________________

Please explanation any "yes" answers ____

Methods Used to Relieve Leg Discomfort

_ No Discomfort	_ Warm Soaks	_ Tylenol
_ Leg Elevation	_ Aspirin Packs	_ Exercise
_ Flexion/Extension of Feet	_ Wraps	_ Cold
_ Walking	_ Ibuprofen	_ Other: ___________________

Compression Stockings

Do you wear compression stockings?		_ Yes	_ No		
If yes, the stockings were bought		_ Prescribed		_ Over the Counter	
What type of compression stockings?	_ Knee High 20-30	_ Knee High 30-40	_ Thigh High 20-30	_ Thigh High 30-40	_ I don't know
Did the stockings resolve your symptoms?		_ Yes	_ No		

Family History
Select all family members that have/had these conditions

Spider or Varicose Veins			Deep Thrombosis, Stroke, or Clot Disorder		
_I don't know	_ Child	_ Aunt/Uncle	_I don't know	_ Child	_ Aunt/Uncle
_ None	_Grandparent	_ Parent	_ None	_Grandparent	_ Parent
_ Sibling	_ Other		_ Sibling	_ Other	

Patient Medical History
Check all that apply

Conditions Patient Had / Has

_ None	_ Crohn's Disease/IBS	_ HIV / AIDS	_ Pulmonary Embolus
_ Anemia	_ Deep Vein Thrombosis	_ Hypertension	_ Rupture/Bleeding Vein
_ Ankle Skin Changes	_ Diabetes *with insulin*	_ Kidney Disease	_ Stroke
_ Atherosclerosis	_ Diabetes *No insulin*	_ Leg Ulcers	_ Superficial
_ Bleeding Blood Disorder	_ Easy Bruising	_ Liver Disease	_ Superficial Thrombophlebitis
	_ Heart Disease	_ Lupus	
_ Chest Pain/Discomfort	_ Hepatitis	_ Migraine Headaches	_ Trauma to Leg
_ Constipation	_ High Cholesterol	_ Mitral Valve Prolapse	

Conditions Patient Had / Has

Do you have any allergy to medications or substances? _Yes _ No Please List__________________

Do you have any current illnesses? _ Yes _ No If yes, please describe ____________________________

Please list any current medications, vitamins, or herbal supplements that you are taking:

____

____

Female Patients Only

Are you now, or are planning to be pregnant? _ Yes _ No Are you breast feeding? _ Yes _ No

How many pregnancies have you had? ___________ Miscarriages? _________ Live Births? ___________

Social History

Occupation: ________________ Long time on your feet? _ Yes _ No Explain___________________

Does walking [increase, decrease, stay the same] the discomfort? __________________________________

Do you smoke? _ Yes _ No How many packs per day? __________

Do you drink alcohol? _ Yes _ No How many drinks per day? __________

Past Surgeries

Check those that apply and explain

Surgery	Date	Type of Surgery
_ Abdominal	________________	____
_ Heart	________________	____
_ Head/Neck	________________	____
_ OB/GYN	________________	____
_ Breast	________________	____
_ Orthopedic	________________	____
_ Other	________________	____

Past Vein Treatment(s)

Check those that apply and explain

Procedure	Leg			Date	Provider
_ Stab Phlebectomy	_ Left	_Right	_Both	___________	________________________
_ Varicose Vein Injections	_ Left	_Right	_Both	___________	________________________
_ Endovenous Laser Ablation	_ Left	_Right	_Both	___________	________________________
_ Ligation and/or Stripping	_ Left	_Right	_Both	___________	________________________
_ Radio-Frequency Ablation	_ Left	_Right	_Both	___________	________________________
_ Spider Vein Injections	_ Left	_Right	_Both	___________	________________________
_ Spider Vein Laser Therapy	_ Left	_Right	_Both	___________	________________________

What were the results of the above treatments? ____

____

What would you most like to correct about your legs? ____

____

For Office Use Only

Reviewed by: ______________________________________ Date: __________________________

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Patient Name: *Last*_________________ First _______________ __Male __Female
Patients' Mailing Address: ____
City: _______________ State: ________________ Zip: _____________________
Date of Birth: ______/_______/_______ Social Security Number: _____-____-_____
Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed
Is the patient a full-time student? __ Yes __No If yes, where? ________________
Patient's Employer: ________________ Work Phone: ________________________
Home Telephone: __________________ Cell Phone: __________________________
Email Address: _________________________ @ ________________________ . COM

Name of person who carries this insurance policy: _____________________________
Mailing Address: ____
City: ________________ State: _________________ Zip: _____________________
Date of Birth: ____/____/____ __ Male __Female SSN: _______-_______-_______
Employer: ________________________ Cell/Home Phone : _____________________
Relationship to Patient: ___ Self ___ Spouse ___ Child ___ Other
Name of Insurance: ____
Policy #: __________________________ Group #: ____________________________

Emergency Contact: ________________ Relationship: ________________________
Home/Cell Phone: _________________ Work Phone: ________________________

Pharmacy Name: __________________ Location of Pharmacy: _________________

By signing below I attest that the above is correct and true. Also I have read and seen Finesse Surgical Solutions' HIPPA policy:

Signature: ___________________________________ Date: ____________________

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Financial Policies

Our office has contracts with most (local) insurance companies. We will be glad to file your claim minus any deductibles owed and/or copay. We will file your claim to your primary and secondary carriers but not a third policy. Our office does **not** file any claims for **Worker's Compensation or Motor Vehicle Accidents**. You must pay for any charges related to these two carriers. We will provide you with an itemized statement to present to your insurance company so that you may be reimbursed.

Our office accepts assignment on Medicare, Medicaid, and Tricare claims. This means that we will file your claim for all covered services and they will reimburse us directly. Every Medicare patient has a deductible each year. Medicare patients pay 20% of the allowed charges ***after*** any deductible has been met at the time of service. Our office will file a secondary claim once. **If your secondary insurance does not respond to the claim within 60 days we will forward the claim to you for payment.**

If your insurance requires a predetermination prior to any procedure our office will do the necessary paper work to obtain their approval. Prior to your procedure an attempt will be made to verify your benefits and ***estimate* the dollar amount that you will need to bring on the day of your surgery/procedure. We will file the claim to your insurance company. We will provide them with any medical documentation that they may request so that your claim will be paid. By law insurance carriers have 45 days to process clean claims. Occasionally we encounter problems with insurance companies that delay payment on our patient's claims. If this happens to your claim, we ask that you contact your carrier and find out what information they need and inform our office. **If after 90 days the claim has not been paid we will forward a bill to you for payment.** ____________ **Initial**

Since many of our services are done in "staged procedures" (over multiple dates), we will send refunds for overpayment(s) to patients once all treatment is completed and all claims have been paid by insurance companies. _____________**Initial**

If you do not have insurance we require payment in full at the time of service. We except cash, check, Care Credit, Master Card, Visa, and Discover Card. _____________**Initial**

Due to the large block of time that most of the vein procedures require, our clinic requires a $300.00 deposit when scheduling a surgery. This deposit will be applied towards the cost of your procedure. **We require 72 (business days) hour notice of cancellation to receive a deposit refund. _____________**Initial**

Failure to keep office appointments charges: 1st $25, 2nd $50 and 3rd $100 **Cosmetic Appointments require $100 to reserve initial consultation. The patient will forfeit the $100 if they fail to cancel appointment or reschedule 24 (business) hours prior to scheduled time.** _____________**Initial**

I hereby assign medical and or surgical benefits, to include major medical benefits, to which I am entitled, (Medicare, Medicaid, HMO, PPO, Private Insurance) payable to James W. Schlotter, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered valid as an original. **I understand that I am financially responsible for all charges whether or not paid by said insurance.** I hereby authorize said assignee to release all medical information necessary to secure the payment. **I have read, understand and agree to the above policy.**

Signature of insured/patient:____ **Date:** _________________

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PF-100

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can have access to this information. Please review it carefully.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Heath care operations. Your health information may be used as necessary to support the day-to-day activities and management of **James W. Schlotter, M.D, F.A.C.S**. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information. Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights. You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information (a charge for copies will apply).
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

The practice of James W. Schlotter, M.D., F.A.C.S. duties. We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also required to abide by the privacy polices and practices that are outlined in this notice.

Right to Revise Privacy Practices. As permitted by law, we reserve the right to amend or modify our privacy polices and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information. You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our Receptionist or Office Manager. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints. If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Office Manager
James W. Schlotter, M.D.
1347 Thorpe Lane
San Marcos, TX 78666

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person. The name and address of the person you may contact for further information concerning our privacy practices is: **Michelle Schlotter**

This notice is effective on or after April 3, 2003.

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Office Policy for Failure to Cancel Appointments

Office visits and surgeries need to be cancelled 48 (business) hours prior to scheduled appointment. Failure to speak directly with our office staff to reschedule or cancel will result in a fee of:

$25 for 1st failure to cancel

$50 for 2nd failure to cancel

$100 for 3rd failure to cancel

The above fee will need to be paid when rescheduling your appointment.

While most of our patients are very good at keeping their scheduled appointments we do have patients who fail to notify us that they will not be coming in. Many of our procedures and appointments are anywhere from 45 minutes to 2 hours long. When a patient fails to cancel at least 48 hours prior to their appointment it leaves a large block of empty time that could have been given to another patient. This causes financial and schedule disruptions to our practice.

We appreciate your understanding while we implement this policy into our practice.