



## RESTORATION VEIN CARE

Welcome to Restoration Vein Care (RVC). We are a collaborative practice with board certified vascular surgeons and board certified interventional radiologists. Our combination of physicians offers unparalleled comprehensive expertise in vein care with many treatment options. Our combination of treatments include a variety of minimally invasive procedures that provide beneficial medical and cosmetic results.

We believe that every patient deserves the best possible care. Your consultation includes a careful and thorough evaluation; our doctor will recommend the treatment or combination of treatments that are appropriate for your care. Diagnostic evaluation includes physical examination and, when indicated, thorough assessment by ultrasound.

Enclosed are several items that will acquaint you with the practice and provide information about your upcoming appointment. We encourage you to take a few moments to look through this packet. If you have any questions or concerns, please feel free to call a member of our staff. We also have a website, [www.restorationveincare.com](http://www.restorationveincare.com), designed to assist patients with frequently asked questions and directions. **If you use mapping software or GPS to locate our office, use our street address of 5333 McAuley Dr., Ypsilanti, MI 48197.** If you use the PO Box address, it will give you incorrect directions.

At Restoration Vein Care, we understand your time is valuable. Our goal is to provide quality healthcare in a timely manner. If this is your first appointment in our office, please complete the enclosed forms, both front and back, and bring them with you to your appointment. Please arrive 10 minutes before your scheduled appointment to allow time for the check-in process.

1. Please complete the enclosed Patient Information Form and Health Questionnaire and bring the completed forms with you to your appointment.
2. Please read and sign the Patient Financial Information Form and the Notice of Privacy Practices Form and bring these forms with you to your appointment.
3. If you have records from another physician's office, it is important that you bring those with you to your appointment.
4. Bring all insurance cards and your driver's license with you.
5. If you are a member of an HMO, check that your referral has been sent.

Restoration Vein Care participates with Medicare, Priority Health, HAP, Blue Care Network, and Blue Cross Blue Shield plans. Insurance benefits are complex and we ask that you carefully review the benefits and guidelines of your policy before your appointment. Although your insurance coverage may provide payment for your medical care, please remember that you are ultimately responsible for all charges incurred.

**\*Patient payments are due at the time of service\***

If a procedure is recommended for you, our office staff can provide general guidelines whether a particular insurance carrier usually covers a procedure, but we cannot tell you if they will pay for your specific case. It is important for each patient to verify their own coverage because not all policies issued by each insurance carrier have the same coverage. For example, some policies require pre-certification and many require a trial period of wearing compression stockings before any other treatment will be covered. You are fully responsible for knowing your policy's coverage and all charges not paid by your insurance carrier.

Located in the Reichert Health Building on the campus of St. Joseph Mercy Hospital  
5333 McAuley Drive • Suite 4016 • Ypsilanti, Michigan 48197  
734.712.4310 [www.restorationveincare.com](http://www.restorationveincare.com)

## Patient Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: F M

Preferred Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Home address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Contact #s Home: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse name: \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_

Relation to patient: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Referring physician (if any): \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Primary care physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

## Health Insurance Information

Primary Insurance: \_\_\_\_\_ State: \_\_\_\_\_ Policy # \_\_\_\_\_

Policy holder's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ State: \_\_\_\_\_ Policy \_\_\_\_\_

Policy holder's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Other Insurance: \_\_\_\_\_ State: \_\_\_\_\_ Policy \_\_\_\_\_

Policy holder's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

<p><i>How did you hear of our practice?</i> <input type="checkbox"/> Referring Doctor <input type="checkbox"/> Friend/Family Member <input type="checkbox"/> Internet <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Newspaper _____ <input type="checkbox"/> SJMH Employee <input type="checkbox"/> Magazine <input type="checkbox"/> Other</p>
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**Authorization** (for Medicare, Priority Health, HAP, Blue Care Network, and Blue Cross/Blue Shield plans)  
I hereby authorize my insurance carriers to pay benefits directly to Restoration Vein Care, PLC. I understand that I am responsible to pay for any services not covered by my insurance. I also authorize release of pertinent medical information to my insurances carriers and the above-named physicians.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# Health Questionnaire

Name: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

## Medical History

Do you now or have you had:

- |                                 |                                    |                                   |             |
|---------------------------------|------------------------------------|-----------------------------------|-------------|
| Varicose vein problems          | <input type="checkbox"/> Right leg | <input type="checkbox"/> Left leg | When? _____ |
| Redness or tenderness of a vein | <input type="checkbox"/> Right leg | <input type="checkbox"/> Left leg | When? _____ |
| Superficial Vein Thrombosis     | <input type="checkbox"/> Right leg | <input type="checkbox"/> Left leg | When? _____ |
| Deep Vein Thrombosis (DVT)      | <input type="checkbox"/> Right leg | <input type="checkbox"/> Left leg | When? _____ |
| Leg/ankle/foot fracture         | <input type="checkbox"/> Right leg | <input type="checkbox"/> Left leg | When? _____ |

If you have ever been treated for these conditions, please describe: \_\_\_\_\_

How do the veins bother you?

- sharp pain  aches/discomfort  congestion/pressure  swelling  itching  appearance

Have you had previous injection sclerotherapy of your veins?  No  Yes When? \_\_\_\_\_

Have you tried previous treatment for your varicose veins, such as:

- Compression stockings  Weight loss  Leg elevation  No  Yes When? \_\_\_\_\_

Do you now, or have you ever had any of the following?

- |  |                             |                              |             |
|--|-----------------------------|------------------------------|-------------|
| Diabetes                                       | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Thyroid disease                                | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| High blood pressure                            | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Heart disease or heart attack                  | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Jaundice or hepatitis                          | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Cancer   | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Weight change of more than 10 lbs in last 6 mo | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Easy bruising or bleeding                      | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Leg pain caused by walking                     | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Major injury or surgery of legs                | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |

Number of pregnancies: \_\_\_\_\_ Number of deliveries: \_\_\_\_\_ Dates: \_\_\_\_\_

Are you now pregnant?  No  Yes Breast feeding?  No  Yes

List hormones you have taken (including birth control pills): \_\_\_\_\_

Dates used: \_\_\_\_\_

List current medications you are taking and dosages: \_\_\_\_\_

List previous surgeries/dates: \_\_\_\_\_

Smoking history:  Never  Yes- What, when and how much? \_\_\_\_\_

List all drug allergies:  None  Latex  Iodine/X-ray dye  Other \_\_\_\_\_

Please describe allergic reaction: \_\_\_\_\_

## Family History

Has a member of your family had any of the following:

- |                            |                             |                              |            |
|----------------------------|-----------------------------|------------------------------|------------|
| Blood clots                | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who? _____ |
| Blood coagulation disorder | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who? _____ |
| Stroke or heart attack     | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who? _____ |
| Pulmonary embolism         | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who? _____ |
| Varicose veins             | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Who? _____ |

\_\_\_\_\_  
Your signature

\_\_\_\_\_  
Today's date

**RESTORATION VEIN CARE, PLC**  
**Notice of Privacy Practices**

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

This notice applies to all of the records of your care generated by the practice, whether made by the practice or an associated facility. This notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA).

**HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION**

We will routinely use your medical information inside our office for these purposes without any special permission:

**Treatment.** Our practice may use and disclose your medical information to treat you.

**Payment.** We may use and disclose your medical information in order to bill and collect payment for services.

**Health care operations.** Our practice may use and disclose your medical information to operate our business.

In addition, we may use or disclose your medical information for the following reasons:

**Appointment reminders-** Our practice may use and disclose your medical information to contact you and remind you of an appointment.

**Treatment options and health-related benefits.** To inform you of potential treatment options or services that may be of interest to you.

**Disclosures required by law.** Our practice may use and disclose your medical information when we are required to do so by federal, state, or local law.

**Health oversight activities.** Oversight activities can include investigations, inspections, audits, surveys, licensure and disciplinary actions, civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

**Lawsuits and similar proceedings.** If you are involved in a lawsuit or similar proceeding, we may use and disclose your medical information in response to a court or administrative order or to defend the office.

**Serious threat to health/safety.** We may use or disclose your medical information when it is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

**Involvement in individual's care.** We may disclose your medical information to a family member, close personal friend or other person identified by. Please list person(s) that RVC may disclose your medical information to: \_\_\_\_\_

**YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION**

Your rights include but are not limited to the following:

**Confidential communications.** You have the right to request that we communicate with you in certain ways. RVC will accommodate reasonable requests.

**Inspection and copies of records.** With limited exceptions, you may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. This request must be made in writing and you may be charged a fee for the costs of copying, mailing, and other costs incurred by us in complying with your request.

**The right to request amendments to your information.** You may request an amendment of protected health information about you as long as we maintain this information. Requests must be made in writing and must be directed to the office manager.

**Disclosures.** You have the right to a detailed list of all disclosures our practice has made of your medical records.

**Paper copy or complaints.** You have the right to a paper copy of this notice and the right to file a complaint with the office manager if you feel that your privacy rights have been violated at any time.

I have received a copy of Restoration Vein Care's Notice of Privacy Practices.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Patient Financial Information

### **Billing Information:**

Patients treated in this practice are responsible for the fees associated with their tests, treatments and office visits.

Patients seek medical attention for a variety of venous conditions and problems. Medicare and health insurance plans consider some conditions and treatments to be '*medically necessary*' and others to be '*cosmetic*' or '*elective*'.

Cosmetic or elective procedures are usually not covered by insurance plans. Fees for initial office visits and cosmetic services must be paid at the time service is provided. Fees for office consultations may vary, depending on the complexity of the consultation required.

Medically necessary procedures are often covered in part by insurance plans. Restoration Vein Care (RVC) bills insurance for medically necessary procedures performed on patients covered by Medicare, Priority Health, HAP, Blue Care Network and Blue Cross/Blue Shield plans. Patients covered by other insurance plans must pay at the time of service. RVC will provide the information needed to submit their claims directly to their insurance carrier. Collection of insurance benefits will be the responsibility of the patient.

You may be referred to a St. Joseph Mercy Health System (SJMHS) facility for additional laboratory or diagnostic testing such as duplex ultrasound exams. Charges for these procedures will be billed directly to you by SJMHS. Patients must consult with their insurance plans to determine if this testing is a covered benefit.

### **Payment for services:**

Should your RVC physician recommend a procedure to be performed in a SJMHS operating room facility or Imaging Center, you will receive a bill from SJMHS (facility fee). Facility fees incurred for procedures performed for medical necessity will usually be covered in part by your insurance carrier. Questions regarding your facility bill should be directed to the SJMHS Billing Department.

You will also receive a separate bill from RVC (professional fee). All patients except those insured through Medicare, Priority Health, HAP, Blue Care Network and Blue Cross/Blue Shield plans, or those whose services are not a covered benefit, are responsible for the direct full payment of our professional fees for medically necessary procedures. If you have another form of medical insurance, you will be furnished with an itemized statement for professional services rendered for the operative or interventional procedure, and you should submit the charges to your insurance company for reimbursement. Payment for professional services provided in the SJMH Imaging Center or operating room facilities is due one week prior to your procedure.

Patients are encouraged to consult their insurance company to determine or confirm specific coverage.

My signature below confirms: I have received a copy and understand Restoration Vein Care's patient financial information.

I understand that it is my responsibility to know what the terms of my insurance coverage are, and in compliance with those terms, agree to pay all applicable co-pays and outstanding patient balances as described in the provided document.

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Patient/Guarantor Signature

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Today's date