1230 Bald Ridge Marina Rd. Suite 500 Cumming, GA 30041
100 Liberty Blvd, Suite 110 Canton, GA 30114
12655 Birmingham Hwy. Suite 304 Milton, GA 30004
Office: 678-513-1600
Fax: 470-695-7217

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Sex: _____

SSN: _____ Email: _____

Address: _____ City/State/ZIP: _____

Home Phone: _____ Cell: _____ Work: _____

Employer Name/ Address: _____

Marital Status: ____ Married ____ Single ____ Divorced ____ Widowed

Spouse Name: _____ Spouse Phone: _____

Primary Care MD: _____ Pharmacy: _____

Person Responsible for Account: _____ Relationship: _____

Emergency Contact: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance Holder: _____Self _____Spouse _____Mother ____Father

Name of Insured: _____ DOB: _____ SSN: _____

Name of Insurance Company: _____ Phone: _____

Group Number: _____ Member ID: _____

Employer of Policy Holder: _____

Billing Address: _____ City/State/ZIP: _____

SECONDARY INSURANCE (If Applicable)

Name of Insured: _____ DOB: _____ SSN: _____

Name of Insurance Company: _____ Phone: _____

Group Number: _____ Member ID: _____

Employer of Policy Holder: _____

Billing Address: _____ City/State/ZIP: _____

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FINANCIAL POLICY

Payment is due at the time of service. We accept cash, personal checks, Visa and MasterCard. If you are a new patient, we require that your first visit be paid by cash, Visa or MasterCard.

Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim in you assign the benefits to the doctor, in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of your benefits. We will bill them, and you are required to pay a copayment or percentage at the time of your visit.

If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you. Our charges to you are due at the time of service. If the insurance carrier sends the office a check, we will in return send you a refund check.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be “not covered”, you will be responsible for the complete charges. Payment is due upon receipt of a statement from our office.

I have read and understand the practice’s financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____

Patient Signature Date

_____

Patient Name (Print)

If you miss an appointment and fail to call 24 hours in advance to cancel or reschedule your appointment, you will be charged a $50 no-show fee.
All return checks will have a $25 return fee.

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RECORDS RELEASE

Patient Name: _____ Date of Birth: _____

SSN: _____ Phone: _____(Home/Cell)

Address: _____ City/State/ZIP: _____

I authorize North Georgia Vein and Aesthetics to release or obtain my medical information. I also give North Georgia Vein and Aesthetics permission to speak with any physician at any time in reference to me or my medical condition.

THIS INFORMATION MAY BE DISCLOSED AND USED BY THE

FOLLOWING INDIVIDUAL OR ORGANIZATION:

Release records TO and/or FROM:

Name: _____

Address: _____

City/State/ZIP: _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to North Georgia Vein and Aesthetics. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____
Signature of Patient / Authorized Representative

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, North Georgia Vein & Aesthetics may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to North Georgia Vein and Aesthetics Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

North Georgia Vein and Aesthetics reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer, North Georgia Vein and Aesthetics, at any of our locations.

With my consent, North Georgia Vein and Aesthetics may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice is carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, North Georgia Vein and Aesthetics may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, North Georgia Vein and Aesthetics may email to my home or other designated location any items that assist the practice is carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that North Georgia Vein and Aesthetics restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to North Georgia Vein and Aesthetics use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign consent, North Georgia Vein and Aesthetics may decline to provide treatment to me.

_____ _____
Patient Name (Please Print) Date of Birth

_____ _____
Patient / Legal Guardian Signature Today's Date

_____
Print Name of Legal Guardian

North Georgia Vein & Aesthetics may discuss my medical condition / information with the following:

_____ _____
Name of Contact Relationship Emergency Contact

_____ _____
Name Phone

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MEDICAL HISTORY

Patient Name: _____ Date: _____

Date of Birth: _____ Phone: _____

Current Medications and Dosage:

Medical Conditions:

Allergies:

Patient Signature: _____ Date: _____

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VEIN HISTORY

Patient Name: _____ Date: _____

Date of Birth: _____

Which of the following symptoms are you experiencing?

❑ Aching ❑ Pain ❑ Heaviness ❑ Fatigue
❑ Itching ❑ Burning ❑ Restless Legs ❑ Cramps
❑ Swelling ❑ Exercise Intolerance ❑ Spider/Varicose Veins
❑ Other: _____

How long have you been experiencing these symptoms?
❑ 0-6 months ❑ 6-12 months ❑ 12-24 months ❑ 24+ months ❑ Other: _____

Do your symptoms interfere with your activities of daily living? ❑ Yes ❑ No
Please explain: _____

Does your job require prolonged standing or sitting? ❑ Yes ❑ No
If so, what do you do for a living? _____

Have you ever been pregnant? ❑ Yes ❑ No If so, how many children? _____

Is one leg more symptomatic? ❑ Yes ❑ No Which Leg: ❑ Right ❑ Left

Given the opportunity, would you rest your legs throughout your day? ❑ Yes ❑ No

Does prolonged sitting or standing aggravate your legs? ❑ Yes ❑ No
Please explain: _____

Have you ever had any of the following?
❑ Bleeding from a varicose vein or spider vein ❑ Slow or non-healing skin
❑ Significant, recurrent superficial phlebitis ❑ Discoloration of the skin ❑ None

Family history of vein disease? ❑ Yes ❑ No Who: _____

Family history of clotting disorder? ❑ Yes ❑ No Who: _____

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VEIN HISTORY (CONTINUED)

Have you ever been treated for a blood clot in your leg? ❑ Yes ❑ No

If so, when, and how was it treated? _____

Which leg? ❑ Right ❑ Left

Are you on a blood thinner? ❑ Yes ❑ No

In past months or years, how have you attempted to manage your symptoms?

❑ Attempted Weight Loss/ Maintained weight ❑ Leg Elevation ❑ Pain Medications

Have you ever had any vein procedures? ❑ Yes ❑ No

If so, which procedures? ❑ Stripping ❑ Ablation ❑ Sclerotherapy ❑ Other ❑ Unknown

Which leg? ❑ Bilateral ❑ Right ❑ Left

Have you tried compression or support stockings? ❑ Yes ❑ No

If so, how long have you tried them?

❑ 0-3 months ❑ 3-6 months ❑ 6-12 months ❑ 12-24 months ❑ 24+ months ❑ Other: _____

Patient Signature: _____ Date: _____

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COMPRESSION STOCKINGS

Patient Name: _____ Date: _____

Date of Birth: _____

Leg Measurements:	**Type of Stocking:**
Ankle:	Open toe
Calf:	Closed toe
Thigh:	Black / Tan
Leg Length:	
Knee Length:	
SIZE: SS SL MS ML LS LL	

Measured By: _____