THANK YOU FOR PRINTING CLEARLY WITH BLACK OR BLUE INK

McQUAID
Vein Care

Patient Registration Form

Last Name: ____________________First Name: _______________ Middle Initial: ____ Date of Birth: ____/____/____

Age: ____ Sex: ☐ Male ☐ Female Marital Status: __________________

Address: ____ City, State, and Zip: ________________________________

Home Phone: _______________ Cell Phone: _______________ Primary phone: Home / Cell

Soc. Sec. #: ______-____-_______ Email: _____________________

Referred by: ____ Primary Care Dr.: ______________________________

Dr. Phone #: ____ Dr. Phone #: __________________________________

EMERGENCY CONTACT INFORMATION

Name: _____________________________ Relationship: __________________________ Phone: ______________________

Primary Insurance: ____ Phone: ______________________

Insured's name: __________________________________Date of Birth: ____/____/____ Soc. Sec. #: ______-____-_______

Relationship to patient: Self / Spouse / Parent

Member ID#: _____________________________________Group #: ____

Secondary Insurance: ____ Phone: _______________________

Insured's name: __________________________________Date of Birth: ____/____/____ Soc. Sec. #: ______-____-______

Relationship to patient: Self / Spouse / Parent

Member ID#: ____________________________________Group #: ____

FINANCIAL POLICY

Charges for medical services are due and payable at the time the services are rendered. As a courtesy to you, we will file your insurance claims. You are responsible for the payment of your bill regardless of the status of your insurance claim. If unusual circumstances should make it impossible for you to meet our credit terms we invite you to call or personally discuss the matter with the Office Manager. Charges for medical care rendered by this office will be through this office and should not be confused with charges of care received in the hospital.

RELEASE

I authorize assignment of benefits to McQuaid Vein Specialists/North Texas Vascular & Varicose Veins, PA. I also permit the release of any information from my medical record to my insurance company as may be required to facilitate payment of services rendered. I understand I am responsible for all charges.

Signature: ____ **Date:** _______________

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NEW PATIENT MEDICAL HISTORY

Name: ______________________________________ **Date of Birth:** _______________ **Sex: M / F**

Are you pregnant or nursing? ☐ Yes ☐ No ☐ N/A

When was your last menstrual period: _____________ ☐ N/A

Do you have a personal or family history of: (Check all that apply)

Personal	Family		Personal	Family	
☐	☐	Varicose Veins/ Chronic Venous Disease (CVD)	☐	☐	Diabetes
			☐	☐	Heart Disease / Heart Attack
☐	☐	Bleeding Disorder	☐	☐	High Blood Pressure
☐	☐	Blood Clotting Disorder	☐	☐	Migraine Headaches
☐	☐	Small vein blood clots (Phlebitis)	☐	☐	Thyroid Disease
☐	☐	Deep vein blood clots (DVT)	☐	☐	Lupus/ Auto-Immune Issues
☐	☐	Blood clots in the lungs (PE)	☐	☐	HIV
☐	☐	Multiple miscarriages			

Review of systems (Check all that apply)

GENERAL
- ☐ Fever
- ☐ Fatigue
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Other__________________

HEAD / EYES / EARS
- ☐ Frequent Headaches
- ☐ Migraines
- ☐ Dizziness
- ☐ Ringing in Ears
- ☐ Change in Hearing
- ☐ Sinus Issues
- ☐ Sore Throat
- ☐ Nosebleeds
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Other__________________

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Palpitations
- ☐ Use Oxygen at home
- ☐ Pacemaker/Defibrillator
- ☐ Swelling in Ankles/Legs
- ☐ Other__________________

RESPIRATORY
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Asthma/Hay Fever
- ☐ Frequent Colds
- ☐ Other ________________

BLADDER/ KIDNEY / LIVER
- ☐ Burning with Urination
- ☐ Blood in Urine
- ☐ Difficulty Urinating
- ☐ Prostate/Testicular Problems
- ☐ Cirrhosis of the Liver
- ☐ Hepatitis
- ☐ Hemophilia
- ☐ Other__________________

MUSCULOSKELETAL
- ☐ Leg pain at rest
- ☐ Leg pain with exertion
- ☐ Back pain
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Joint Swelling
- ☐ Decreased range of motion
- ☐ Trouble with Balance
- ☐ Other__________________

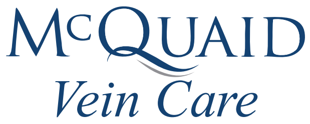
HEMATOLOGIC
- ☐ Clotting issues (õThick Bloodö)
- ☐ Bleeding issues (õThin Bloodö)
- ☐ Unusual bruising
- ☐ Anemia
- ☐ Other__________________

DIGESTIVE
- ☐ Heartburn
- ☐ Vomiting
- ☐ Vomiting Blood
- ☐ Constipation
- ☐ Diarrhea
- ☐ Black Stools
- ☐ Other__________________

NEUROLOGICAL
- ☐ Memory Problems
- ☐ Speech Problems
- ☐ Weakness
- ☐ Numbness
- ☐ Seizures
- ☐ Other__________________

PSYCHIATRIC
- ☐ Depression
- ☐ Anxiety
- ☐ Other__________________

SKIN
- ☐ Skin Cancer
- ☐ New Growths/Lumps
- ☐ Color change in mole(s)
- ☐ Rash
- ☐ Itching
- ☐ Other______________



NEW PATIENT MEDICAL HISTORY

Do you use: (check all that apply) ☐ Alcohol (# of drinks per week ____)

☐ Recreational Drugs

☐ Tobacco (current smoker / quit ____ years ago)

Are you allergic to: (check all that apply)

☐ Latex
☐ Iodine
☐ Medication: ____________________________
☐ Food: _________________________________
☐ Other: _________________________________

Do you need to take antibiotics before all surgical or dental procedures? ☐ Yes ☐ No

Name: ____________________________________ **Date of Birth: _______________________**

Please list your current medications (including prescription, non-prescription, herbal, vitamins and home remedies)

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Please list any previous surgeries:

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STANDARD AUTHORIZATION OF USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION AND PATIENT CONSENT

Information to be used or disclosed
*****The information covered by this authorization includes:**

All medical Information   Confirm Appointments   Pick up medications   Prescriptions

Persons to Whom Information May be disclosed to:
(Please Initial)

___________ ***My primary care provider:*** ____
___________ ***My referring provider:*** ____
___________ ***Name of other person or persons:*** __________________________________
___________ ***No one at this time***

Right to Terminate or Revoke Authorization:
You may revoke or terminate this authorization by submitting a written request to McQuaid Vein Care / North Texas Vascular & Varicose Veins, PA.

Potential for Re-Disclosure:
The person or organization to which information is sent may disclose information that is disclosed under this authorization again. The privacy of this information may not be protected under the federal privacy regulations.

I understand that as part of the provision of healthcare services, McQuaid Vein Care / North Texas Vascular & Varicose Veins, PA creates and maintains health records and other information describing, among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that a copy of the Notice of Privacy practices that provides a more complete description of the uses and disclosures of certain health information is posted on the website at McQuaidvein.com. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notices and practices and prior to implementation will mail a copy of any revised notice to the address that I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment, and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy, fax or scan of the consent is as valid as the original.
3. I may revoke this consent at any time, except where information has already been released. This consent is valid until revoked by me in writing.
4. I have the right to request that my Protected Health Information which is used or disclosed for the purposes of treatment, payment, or healthcare operations be restricted. McQuaid Vein Care / North Texas Vascular & Varicose Veins, PA is not bound by the restriction unless it is in agreement with the restriction.

Patient's Name (printed): ____

Signature:____ **Date:**___________________________________

Expiration Date of Authorization: This authorization is effective for 1 year unless revoked or terminated by the patient or the patients personal representative.

McQuaid Vein Care

PATIENT PHOTOGRAPHIC AND TESTIMONIAL AUTHORIZATION AND RELEASE

I, ______________________________, authorize McQuaid Vein Care/ North Texas Vascular & Varicose Veins, PA and/or Mark A. McQuaid, MD, J. Andrew Skiendzielewski, DO, and/or representative(s), to collect and use testimonials, photographs, slides, videotapes of me or parts of my body for the following procedure(s), program(s) and for medical purposes to be used for my care, medical presentations and/or articles.

In addition, I authorize the use of these words or images, without compensation to me, for the following specific purposes: (Please initial and circle Yes or No for each item)

____ Yes No In the office photo album for prospective or current patients.
____ Yes No In office seminars for prospective or current patients.
____ Yes No On our website for prospective or current patients.
____ Yes No On social media accounts, including Facebook, Instagram and Twitter.
____ Yes No In printed material or advertisements.
____ Yes No On television.

Additional Comments:

I understand that:

1. Such testimonials, photographs, slides or videotapes may be published by McQuaid Vein Care / North Texas Vascular & Varicose Veins, PA and/or Mark A. McQuaid, MD, and/or J. Andrew Skiendzielewski, DO, in any print, visual, or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, for the purpose of informing the medical profession or the general public about general and vascular surgery methods or weight loss or wellness programs. I understand that such uses may also include marketing on behalf of McQuaid Vein Care / North Texas Vascular & Varicose Veins, PA and/or Mark A. McQuaid, MD, for which Dr. McQuaid may or may not receive direct or indirect remuneration.

2. I will not be identified by name in any of the imagery media described above; however, I also understand that testimonials may identify me by first name and last initial.

3. I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to McQuaid Vein Care at 1518 Legacy Drive, Ste 120, Frisco, TX 75034 or by email at info@McQuaidVein.com. A revocation shall not affect any release of information made prior to revocation in reliance upon this Authorization. Any revocation may take up to 60 days to become effective. If I do not revoke this authorization, it shall not expire, except to the extent action has been taken thereon.

Patient Signature: ____________________________________ **Date:** ____________________

Printed Name: ____________________________________

McQUAID
Vein Care

OFFICE FINANCIAL POLICY

We strive to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve that goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

INSURANCE

1. **Upon arrival, please check in at the front desk and present your current insurance card and official identification**. If you do not notify us at that time of a change in insurance, we will assume all the information on file is current and accurate. You will be required to sign and date the file copy of the chart cover sheet. This is your verification of the correct insurance and consent to bill them on your behalf. IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU MAY BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND YOU ALSO MAY NEED TO SUBMIT THE CHARGES TO THE CORRECT PLAN.
2. Although we try to get current and accurate benefits from your insurance company, it is ultimately your responsibility to understand your benefit plan. It is your responsibility to know if a written authorization or preauthorization is required prior to a procedure, and what services are covered. We try to keep you informed on the status of any authorizations/denials but you should also take an active role in understanding your insurance status, as you are responsible for any balances as a result of not meeting their criteria.

MANAGED CARE

3. If your insurance company requires you to obtain a referral from your primary care physician to see a specialist, you are responsible for providing our office with this information. Any claims denied as a result of not getting a referral may be billed to you directly.

REFUNDS

4. Overpayments will be refunded to the appropriate party, normally the insurance company or guarantor. Patientsø refunds will not be processed until all active or past due accounts are paid in full. Refunds of less than $20 will be retained for future services unless requested in writing from the patient or guarantor.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

5. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances for all services determined to be medically necessary. Failure to fulfill your obligations will require our office to report this to your insurance company (may result in termination of your policy) and the IRS (you would be required to report any fees as income on your taxes).
6. Co-payments are due at time of service. If you owe toward your deductible/co-insurance for your visit, you will be asked to pay these fees based on an estimated charge by your insurance companyøs contracted rate.
7. If our physician does not participate in your insurance plan or you do not have insurance, payment in full is expected from you at the time of your office visit unless other agreements are in place. For scheduled appointments, all existing balances must either be paid prior to the visit.
8. We are not a Medicaid provider. Therefore, we do not bill Medicaid as primary or secondary and you will be responsible for all charges.
9. Not all services provided by our office are covered by every plan. **Any service determined to be non-covered or not medically necessary by your plan will be your responsibility.**

PROCEDURES

PLEASE UNDERSTAND THAT GETTING AUTHORIZATION, AND THE PROCESS FOR SCHEDULING ANY PROCEDURES, TAKES CONSIDERABLE TIME AND EFFORT FROM OUR STAFF. WE UNDERSTAND THAT THERE MAY BE CIRCUMSTANCES THAT REQUIRE YOU TO RESCHEDULE OR POSTPONE YOUR TREATMENTS WITH US. HOWEVER, **IF WE HAVE TO CANCEL, RESCHEDULE, OR POSTPONE YOUR TREATMENTS MORE THAN ONCE FOR NON-MEDICAL/INSURANCE ISSUES YOU MAY BE ASKED TO PAY A $75 FEE.**

10. For all procedures requiring sedation, you need to arrive 45 minutes before your scheduled appointment time.

11. Failure to do so may result in your procedure (and subsequently scheduled appointments) being rescheduled and will be considered a õlate cancellationö subject to applicable fees.

12. We provide treatment plan estimates upon request with the understanding that they are subject to change as your policy, benefits, and information provided by your insurance company changes.

APPOINTMENT FEES

WE REALIZE THERE ARE UNEXPECTED CIRCUMSTANCES THAT ARISE WHICH MAY CAUSE YOU TO BE LATE OR NOT CANCEL YOUR APPOINTMENT WITHIN THE REQUESTED TIME FRAME. HOWEVER, WE HAVE TO MAINTAIN A STANDARD POLICY FOR ALL PATIENTS AND BE CONSISTENT IN ITS ENFORCEMENT.

If you are more than 15 minutes late checking in for an appointment you may be charged a $25 late fee and may be asked to reschedule your appointment.

13. We require 24-hour notice for canceling any non-procedure appointments. There is **a $25 charge for appointments if they are not canceled OR if 24-hour notice is not given**.

14. We require 48- hour notice for cancelling any procedures (ablations, phlebectomy, ultrasound guided sclerotherapy, mass removal, general surgeries/procedures, etc.). **Failure to notify our office within 48- hours of a cancellation may result in a non-negotiable $75 fee.**

OTHER FEES

15. A **$25 fee will be charged for any checks returned for insufficient funds**, plus any bank fees incurred.

16. **We charge $25 to copy or transfer medical records (each time)**. You must provide written consent to send this information and our turnaround time is 48-72 hours for completion.

17. **If you have any disability, FMLA, or any other paperwork/forms that need to be filled out by our clinical staff for work or insurance, there is a $25 charge.** Payment is due when the forms are dropped off. We have a 48-72 hour turnaround time for forms.

I, ____, have been given the Office Financial Policy of McQuaid Vein Care / North Texas Vascular & Varicose Veins, PA.

I have read and understand this Office Financial Policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

______________________________	______________________________	____________
Signature of Patient/Responsible Party	**Printed Name (First Last)**	**Date**
______________________________	______________________________	____________
Witness	**Patient Name (If Different Than Above)**	**Date**

*Should you decline this portion of the agreement, there is an alternative form that may be signed. **Initial**__________

ACKNOWLEDGMENT OF PRIVACY PRACTICES RECEIPT
AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have been offered and/or received this practice's *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below. *If you have not reviewed the Notice of Privacy Practices, but would like to, please ask the front desk staff for a copy or visit our website at www.McQuaidVein.com*

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

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Patient Name: ______________________________________
(Please Print Name)

Patient Date of Birth: _______________________________

SIGNATURES:

Patient/Legal Representative: _________________________________ Date: _________________

If Legal Representative, relationship to Patient:____

Witness (optional):____Date:_________________