1700 W Dove Ave. Suite 20
McAllen, Texas 78504

Office: 956.803.0530
Fax: 956.803.0532

www.veinwellnessclinic.com

Patient Registration Form

Last Name: _____ First Name: _____ Middle Initial: _____

Male__ Female__ Date of Birth: _____

Marital Status (circle one): Single Married Divorced Widow

Address: _____ City: _____

State_____ Zip_____

Home Phone: _____ Cell: _____ Social Security #: _____

Pharmacy Name: _____ Phone: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Place of Employment: _____ Phone: _____

Insurance referral presented if necessary _____ Co-pay_____

E-mail address _____

Contact person in case of an Emergency:

Name: _____ Relationship_____

Address: _____ Telephone:_____

Assignment of Benefits Authorization for Treatment:
I hereby authorize treatment and authorize direct payment of surgical/medical benefits to Franz Velarde, M.D., PLLC, DBA Vein Wellness Clinic for services. I understand that I am financially responsible for any balance not covered by my insurance. I request that payment of authorized benefits be made on my behalf.

Print Patient Name: _____

Patient Signature: _____ Date: _____

HIPPA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPPA) provide safeguards to protect our privacy. Implementation of HIPPA requirements officially began on April 14, 2003.

What this is all about: Specifically, there are rules restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies as a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to person's records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPPA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within office concerning your PHI. However, we are not obligated to alter internal policies to confirm to your request.

I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

_____

Patients Name (Please Print)

_____

Patient Signature Date

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Authorization for Use or Disclosure of PHI Protected Health Information

Please select one of the following:

1. _____ I hereby authorize the use and disclosure of individually identifiable information related to me, which is called (PHI), protected health information, under a federal health privacy law, as described below.

2. _____ No one other than myself may have access to my medical records.

I, _____, authorize Franz Velarde, M.D., PLLC, DBA Vein Wellness Clinic to release and obtain my health information to/from:

Doctor/Office_____Relationship_____

Doctor/Office_____Relationship_____

With my consent, Franz Velarde, M.D., PLLC, DBA Vein Wellness Clinic may release my information to third party providers including but not limited to plans, clinical care, and diagnostic results. Yes_____ No _____

May our office leave a message on your machine: Yes_____ No_____

The PHI will be disclosed to confirm appointments, to render caregivers counseling on my treatment, for prescription pick-ups, and any other reason to ensure I obtain optimum treatment and care while I am patient of Franz Velarde, M.D., PLLC, DBA Vein Wellness Clinic. I understand that I have the right to revoke this authorization in writing, at any time, by sending such written notification to the attention of Tracy Velarde, Manager, Vein Wellness Clinic, 1700 W Dove Ave., Suite 20, McAllen, TX 78504. I understand that my revocation will not affect any actions taken by Franz Velarde, M.D., PLLC, DBA Vein Wellness Clinic prior to receiving my revocation. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may refuse to sign this authorization and that my refusal in no way affects my treatment. My physician will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. This authorization shall be effective one year from the date signed, or until revoked in writing, at which time this authorization to obtain and release this protected health information expires.

_____ _____

Patient Signature or Authorized Representative / Relationship Date

Patient History

Patient Name: _____

DOB: _____

Have you ever had? (check all that apply)				**Are you experiencing?**	
Hypertension		Hepatitis		Chills	
Chest pain		Diabetes		Fever	
Heart Attack		Anemia		Shortness of breath	
Irregular Heartbeat		Gout		Numbness	
Pacemaker / Defibrillator		Thyroid Disease		Extremity weakness	
Asthma		Phlebitis		Resting pain	
COPD / Emphysema		Stroke		Pain when walking	
Sleep Apnea		Cancer		Temporary blindness	
Kidney Disease		High Cholesterol		Slurred speech	

Do you have an **Advance Care Plan**? (Have you assigned a surrogate to make medical decisions for you in case of an emergency?) If yes, please provide:

Surrogate's Name: _____

Telephone: _____

Ethnicity (circle one):

White Hispanic

African American Other

Nationality: _____

Primary Language: _____

Patient History

Patient Name: _____ Date: _____

Social History		Quantity or Frequency
Alcohol		
Tobacco		
Illicit Drugs		

If attending Adult Day Care please provide information below:

Adult Day Care Name: _____

Address: _____

Office Number: (___) _____ Alt #: (___) _____

Driver's #: (___) _____ Alt #: (___) _____

Patient Signature: _____

Date: _____

Medications and Surgeries

Patient Name:_____ **DOB**_____

Medication Name and Strength	How often do you take the medication

Blood Thinners: Yes No
Plavix: Yes No

Allergies	

Flu Vaccine: Yes No Date:
Pneumococcal Vaccine: Yes No Date:

Surgeries	Date		Dates

Have you had any Leg surgery: Yes No Date:
(varicose veins, arteries):

Heart Surgery (CABG): Yes No Date:

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APPOINTMENT CANCELATION AND/OR NO SHOW POLICY
PATIENTS RUNNING LATE FOR APPOINTMENTS

In consideration of others we do request **at least 24-hour notice prior to cancellation of ANY appointment**. We do understand there are circumstances that may prevent you from keeping your appointment; however, in providing us with as much notice as possible, we may be able to contact another patient needing an appointment on the day yours was scheduled.

Patients who are running late are asked to call the office as soon as possible to check with the staff if they will still be able to keep their appointment. If you need to make any changes to your appointment, please contact us via:

- **Phone: 956-803-0530** (time and date changes)
- email: grisel@veinwellnessclinic.com (date changes only)

Ultrasound patients who are more than 15 minutes late for their appointment may need to be re-scheduled to another day and time.

Morning and afternoon appointments fill quickly and cancelling with less than 24-hour notice does not allow us enough time to schedule another patient in need of treatment. Therefore, a cancellation or no-show fee may apply if our office is not notified within 24 hours. Fees are as follows:

- Office visits / Ultrasounds: $25
- Procedures / Surgeries: $100

We greatly appreciate your understanding of and cooperation with our office.

Please sign below that you have read, and acknowledge the above information provided to you. If you would like a copy of any of your paperwork, please ask one of our team members to make copies for you.

Patient Printed Name: _____

Signature: _____

Date: _____

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Financial Policy

Thank you for choosing Vein Wellness Clinic. Our primary mission is to deliver the best and most comprehensive care available. An important part of the mission is making the cost of optimal care as easy and manageable as possible for our patients by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa®, MasterCard®, American Express® or Discover Card®
- Convenient Monthly Payment Plans from **CareCredit** [1]
    - Allows you to pay over time
    - No annual fees or pre-payment penalties

Please note:

Vein Wellness Clinic requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For patients with insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

Vein Wellness Clinic charges $35 for returned checks.

Per Vein Wellness Clinic's management, the Doctor's staff will not complete or submit FMLA, Social Security, or disability documents.

If you have any questions, please do not hesitate to ask. We are here to help you get the treatment and care you want and need.

_____ _____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 120 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

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Notice of Patient Rights and Responsibilities

This document is meant to inform our patients of their rights and responsibilities while undergoing medical care. To the extent permitted by law, patient rights may be delineated on behalf of the patient to his or her guardian, next of kin, or legally authorized responsible person if the patient: a) has been adjudicated incompetent in accordance with the law, b) is found to be medically incapable of understanding the proposed treatment or procedure, c) is unable to communicate his or her wishes regarding treatment, or d) is a minor. If there are any questions regarding the contents of this notice, please notify any staff member.

Patient Rights

1. **Access to Care.** You will be provided with impartial access to treatment and services within this practice's capacity, availability, and applicable law and regulation. This is regardless of race, creed, sex, national origin, religion, disability/handicap, or source of payment for care/service.
2. **Respect and Dignity**. You have the right to considerate, respectful care/service at all times and under all circumstances. This includes recognition of psychosocial, spiritual, and cultural variables that may influence the perception of your illness.
3. **Privacy and Confidentiality**. You have the right, within the law, to personal and informational privacy. This includes the right to:
    - Be Interviewed and examined in surroundings that assure reasonable privacy.
    - Have a person of your own sex present during physical examination or treatment.
    - Not remain disrobed any longer than is required for accomplishing treatment/services.
    - Expect that any discussion or consultation regarding care will be conducted discreetly.
    - Expect all written communications pertaining to care will be treated as confidential.
    - Expect medical records to be read only by individuals directly involved in care, quality assurance activities, or processing of insurance claims. No other persons will have access without your written authorization.
4. **Personal Safety**. You have the right to expect reasonable safety insofar as the office practices and environment are concerned.
5. **Identity.** You have the right to know the identity and professional status of any person providing services and which physician or other practitioner is primarily responsible for care.
6. **Information.** You have the right to obtain complete and current information concerning diagnosis (to the degree known), treatment, and any known prognosis. This information should be communicated in terms that you understand.
7. **Communication**. If you do not speak or understand the predominant language of the community, you should have access to an interpreter. This is particularly true when language barriers are a continuing problem.
8. **Consent**. You have the right to information that enables you, in collaboration with the physician, to make treatment decisions.
    - Consent discussions will include explanation of the condition, risks and benefits of treatment, as well as consequences of no treatment.
    - You will not be subjected to any procedure without providing voluntary, written consent.

- You will be informed if the practice purposes to engage in research or experimental projects affecting its care or services. If it is your decision not to take part, you will continue to receive the most effective care the practice otherwise provides.

9. **Consultation.** You have the right to accept or refuse medical care to the extent permitted by law. However, if refusing treatment prevents the practice from providing appropriate care in accordance with ethical and professional standards, your relationship with this practice may be terminated upon reasonable notice.
10. **Charges**. Regardless of the source payment for care provided, you have the right to request and receive itemized and detailed explanations of any billed services.
11. **Rules and Regulations**. You will be informed of practice rules and regulations concerning your conduct as a patient at this facility. You are further entitled to information about the initiation, review, and resolution of patient complaints.

Patient Responsibilities

1. **Keep Us Accurately Informed**. You have the responsibility to provide, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health, including unexpected changes in your condition.
2. **Follow Your Treatment Plan.** You are responsible for following the treatment plan recommended by the physician. This may include following the instructions of health care personnel as they carry out the coordinated plan of care and implement the physician's orders and as they enforce the applicable practice rules and regulations.
3. **Keep Your Appointments**. You are responsible for keeping appointments and, when unable to do so for any reason, for notifying this practice.
4. **Take Responsibility for Noncompliance**. You are responsible for your actions if you do not follow the physician's instructions. If you cannot follow through with the prescribed treatment plan, you are responsible for informing the physician.
5. **Be responsible for Your Financial Obligations**. You are responsible for assuming that the financial obligations of health care services are fulfilled as promptly as possible, and for providing up-to-date insurance information.
6. **Be considerate of others.** You are responsible for being considerate of the rights of other patients and personnel, and for assisting in the control of noise, smoking, and the number of visitors. You also are responsible for being respectful of practice property and property of other persons visiting the practice.
7. **Be responsible for Lifestyle Choices**. Your health depends not just on the care provided at this facility but on the long-term decisions you make in daily life. You are responsible for recognizing the effects of these decisions on your health.