RestoreMD
PHONE: (858) 800-2480 FAX: (858) 216 -1908

PATIENT MEDICAL INFORMATION

Date _____ Patient Name: _____

Birthdate: _____ Age: _____

Chief complaint/reason for visit: _____

Date of first symptoms (required by insurance):_____

Symptoms: Describe _____

Family History: Varicose Veins? No Yes (please circle one)

Other Cardiac Conditions? _____

Medications – include dosage Allergies – include reaction Latex allergy: No Yes

_____ _____

_____ _____

_____ _____

_____ _____

Over the counter medications/supplements:

_____

Aspirin daily: No Yes **Bleeding / Clotting History**

Plavix: No Yes DVT / Blood clot _____ when _____

Coumadin: No Yes Frequent miscarriages: _____

Do you smoke: No Yes # Packs per day _____ Years _____ Date Quit: _____
Alcohol use: No Yes Occasionally Daily (please circle one)

Employed: No Yes Retired Job _____ Years _____

Previous surgeries:

_____

Other hospitalizations: _____

_____

RestoreMD Staff ONLY – Reviewed By (initial): Physician: _____

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REGISTRATION FORM

Today's Date: [Date] | PCP: [PCP]

PATIENT INFORMATION

Patient's last name: [Last Name] First: [First Name]	Middle: [Initial] [Choose an item]	Marital status: [Choose an item]

Is this your legal name? ○ Yes ○ No	If not, what is your legal name? [Legal Name]	Former name: [Former Name]	Birth date: [Birthday]	Age: [Age]	Sex: ○ M ○ F

Address: [Address/ P.O Box, City, ST ZIP Code]

Social Security no.: [SS#]	Home phone no.: [Phone]	Cell phone no.: [Phone]
Occupation: [Occupation]	Employer: [Employer]	Employer phone no.: [Phone]

Chose clinic because/referred to clinic by (Please choose one option): ○ [Doctor's name]

○ [Choose an item]

Other family members seen here: [Other patients]

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: [Responsible party]	Birth date: [Birthday]	Address (if different): [Address]	Home phone no.: [Phone]
Is this person a patient here?	○ Yes ○ No	Is this patient covered by insurance?	○ Yes ○ No
Occupation: [Occupation]	Employer: [Employer]	Employer address: [Address]	Employer phone no.: [Phone]

Please indicate primary insurance: [Choose an item] | Other: [Other insurance]

Subscriber's name: [Name]	Subscriber's S.S. no.: [SS#]	Birth date: [Birthday]	Group no.: [Group #]	Policy no.: [Policy #]	Co-payment: $[Co-pay]

Patient's relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]

Name of secondary insurance (if applicable): [Secondary Insurance]	Subscriber's name: [Name]	Group no.: [Group #]	Policy no.: [Policy #]

Patient's relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): [Friend or relative name]	Relationship to patient: [Relationship]	Home phone no.: [Phone]	Work phone no.: [Phone]

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **[RestoreMD]** or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____

Heart Disease: Atrial fibrillation CAD Stents _____

History of MI / Heart Attack: When: _____

Other: _____ Pregnant? No Yes

Height: _____ Weight: _____

How did you learn about RestoreMD? (Please circle one)

Physician Ad Employee Self Family/Friend

Other: _____

You're Primary Physician:

_____ Address _____Phone_____

Others Physicians Involved In Your Care:
_____Address_____Phone_____

Phone Pharmacy Preference: _____

Pharmacy Name Address: _____Phone/Fax_____

Patient Signature: _____ Date: _____

Staff ONLY – Reviewed By (initial): Physician: _____

QUALITY OF LIFE WITH VENOUS INSUFFICIENCY

Patient Name:_____ Date:_____

Many people complain of leg pain. We would like to find out how often these leg problems occur and to what extent they affect the everyday life of those who have them.

Below is a list of symptoms, sensations and types of discomfort that you may or may not be experiencing and which might make everyday life hard to bear to a greater or lesser extent.

For each symptom, sensation or discomfort listed, please tell us if you have experienced what is described in each sentence, and if the answer is yes, please describe the intensity.

- Please circle the number that best describes your situation relative to the symptom, sensation of discomfort described.

During the past four ~~4~~ weeks….

1. Have you had any pain in your ankles or legs, and how severe has this pain been? Circle the number that applies to you.

No Pain Slight Pain Moderate Pain Considerable Pain Severe Pain

1 2 3 4 5

2. How much trouble have you had at work or with your usual daily activities because of your leg problems? Circle the number that applies to you.

No Pain Slight Pain Moderate Pain Considerable Pain Severe Pain

1 2 3 4 5

3. Have you slept poorly or your sleep interrupted because of your leg problems, and if yes how often? Circle the number that applies to you.

No Pain Slight Pain Moderate Pain Considerable Pain Severe Pain

1 2 3 4 5

Patient Signature:_____ Date_____

Patient Consent, Assignment of Benefits and Acknowledgement Form

Patient Name: _____DOB: _____

Please read and acknowledge the following consents, assignment and authorizations.

Consent for Diagnostic, Medical and/or Surgical Treatment: I wish to be evaluated and treated by the RestoreMD. I hereby agree and give my consent to the providers/staff of Restoremd to order, prescribe and provide diagnostic, medical and surgical treatment to me that they judge is appropriate in diagnosing and/or treating my medical condition(s).

Assignment of Insurance Benefits and Authorization to Pay Insurance Benefits: I authorize RestoreMD to apply for benefits for services rendered to me or the patient under my health insurance policies providing benefits. I assign and authorize payment of benefits from my insurance plan(s) to RestoreMD and grant permission to contact my employer or health plan(s) regarding insurance information and coverage of my health benefits.

No Show / Cancellation Policy: To accommodate scheduling of patient care and provide timely appointments, our practice has a No Show/Cancellation Policy. Any missed or no show appointments for diagnostic scans, visits or treatments that are not canceled 48 hours prior to the appointment time may be charged a $50.00 fee. Our office reserves time for your care in good faith; please extend the courtesy by contacting our office at least 48 hours prior to your appointment time to cancel or rescheduled an appointment – Thank You.

Patient Financial Agreement and Payment Policy: I understand that RestoreMD will bill my health insurance plan(s) for care I receive. I agree that payments from my health plan(s) will go directly to RestoreMD. I understand that RestoreMD can bill me directly when: (1) I choose to have care that my health plan covers but I do not secure needed referral or an approval for the care from my health plan; (2) I choose not to use my health coverage and agree to pay for the care myself; (3)RestoreMD does Not participate with my health plan I agree to pay out-of-network; or (4) Or Receive for services(s) or supplies that are non-covered by my health plan(s). I further agree to pay for any and all related collection costs related to my financial responsibility.

Authorization for Use of Copies: I permit a copy of these authorizations and assignments defined with my signature below to be used in place of the original on all insurance claim submissions and for the release of specific medical or other protected health information, whether manual, electronic or telephonic.

I understand and agree to the above consents, assignments and authorizations :(Please sign and date below.)

Patient / Responsible Party_____ Date_____

(Medicare Beneficiary Lifetime signature on File: (To be completed only if patient has Medicare coverage)

Request that payment of authorized Medicare benefits be made on my behalf to RestoreMD for services furnished me by RestoreMD providers. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) information needed to determine these benefits. I understand my signature below requests that payment be made and authorizes release of medical information necessary to pay the claim. My signature below authorizes releasing of the information to any other insurer. For assigned claims, RestoreMD agrees to accept the Medicare defined allowance as the basis for payment and I will be responsible for payment of the deductible, co-insurance, and non-covered services based on Medicare explanations of benefits.

Medicare Beneficiary / Authorized Representative_____Date_____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____