

Confidential Health History

Patient Name: _____ DOB: _____

Who is your primary care physician? _____

Please check the symptoms you are currently experiencing. (Please Circle)

- | | | | |
|--------------------------|---|------|-------|
| <input type="checkbox"/> | Varicose Veins, Spider Veins, Purple (Reticular) Veins at the Ankles | Left | Right |
| <input type="checkbox"/> | Leg Pain: Aching, Tired, Heavy Legs, Tender Varicosities, Painful Calves | Left | Right |
| <input type="checkbox"/> | Leg Cramps: Night Cramps, "Charley Horses", Nocturnal Cramping | Left | Right |
| <input type="checkbox"/> | Swollen Ankles: Swelling at day's end or when traveling (w/o CHF, renal issues) | Left | Right |
| <input type="checkbox"/> | Skin Changes: Red/Brown Discoloration, Ulceration, Eczema, Itching & Burning | Left | Right |
| <input type="checkbox"/> | 'Secondary' Restless leg syndrome | Left | Right |

Please check any methods you have used to relieve your leg discomfort:

- Warm Soak
 Exercise
 Pain Meds
 Wrap
 Compression Stockings
 Leg Elevation
 Cold Packs
 Aspirin
 Walking
 Tylenol
 Ibuprofen
 Flexion/Extension of your feet

Other Method: _____

Have you previously worn Compression Stockings? If so, for how long? _____ Years _____ Months

Are you on you feet for long periods? Yes No How Long? _____

In what capacity? _____

Does walking/exercise relieve your discomfort? Yes No Which? Walking / Exercise

Have you ever been treated for your veins before? Yes No When? _____

What Method:

- Cosmetic Injection
 Ultrasound-Guided Injections
 Radiofrequency Closure
 Ambulatory Phlebectomy
 Ligation Stripping Laser for Spider Veins
 Laser Catheter Ablation
 Other _____ What were your results? _____

How do your vein symptoms effect your daily life? _____

ALLERGIES:

Do you have any allergies or sensitivities to medicines or tape? Yes No

Please list: _____

MEDICATION LIST: (Prescription, Non-Prescription, Vitamins and Herbal)

PAST MEDICAL HISTORY: (Please check all that apply to your PAST Medical History)

- | | |
|--|---|
| <input type="checkbox"/> Kidney/Bladder Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Diabetes: Insulin Dependent | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Stroke or TIA |
| <input type="checkbox"/> Atherosclerosis | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Coronary Heart Disease | <input type="checkbox"/> Deep Vein Thrombosis |
| <input type="checkbox"/> Heart Valve Problems | <input type="checkbox"/> Excessive Bleeding/Easy Bruising |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Carotid Disease |
| <input type="checkbox"/> Pulmonary Embolism | <input type="checkbox"/> Trauma to your Legs |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Intolerant of NSAIDS |

PAST SURGICAL HISTORY & HOSPITALIZATIONS: (Please include childbirths & pregnancies) **YEAR**

	YEAR

FAMILY HISTORY:

Family History of spider or varicose veins? **Yes No Mother/Father/Grandparent**

Please describe: _____

Family History of deep blood clot, stroke, or clotting disorder? **Yes No Mother/Father/Grandparent**

Please describe: _____

SOCIAL HISTORY:

Do you smoke? **Yes No How much? _____**

Do you consume alcohol? **Yes No How much? _____**

OCCUPATION: _____

Are you being treated for any current medical conditions? **Yes No**

Please list: _____

CURRENT MEDICAL - REVIEW OF SYSTEMS: (Please check all that apply to your CURRENT health)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Fever | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Vision Loss | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Cough of blood/sputum | <input type="checkbox"/> Headaches | <input type="checkbox"/> Painful Respiration |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Blood in Stool/Tarry Stool | | |

Patient Signature _____ **Date** _____



Veins matter.

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 takes effect on September 15, 2007 and remains in effect until we replace it.

I. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

II. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

III. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information.

We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you, to doctors, nurses, technicians, medical students, or other people who are assisting in your medical care. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on our accompanying the bill may include your medical information.

FOR HEALTH CARE OPERATIONS: *We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.*

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

- **Facility Directory:** Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name, your location in our facility; your condition described in general terms. We may disclose this information to members of the clergy, or to those who may call and ask for information about you by name.
- **Notification:** **We may use and disclose medical information to notify or help notify; a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share or give you the opportunity to refuse permission. In case of emergency, and if you, are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, xrays or medical information for you.**
- **Disaster Relief:** We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.
- **Research in Limited Circumstances:** We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.
- **Funeral Director, Coroner, Medical Examiner:** To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.
- **Specialized Government Functions:** Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.
- **Court Orders and Judicial and Administrative Proceedings:** We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

- **Public Health Activities:** As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to Jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities, required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.
- **Victims of Abuse, Neglect, or Domestic Violence:** We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.
- **Workers Compensation:** We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.
- **Health Oversight Activities:** We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.
- **Law Enforcement:** Under certain circumstances, we may disclose health information on to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.
- **Appointment Reminders:** We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.
- **Alternative and Additional Medical Services:** We may use and disclose medical information to furnish you with information about health related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

IV. YOUR INDIVIDUAL RIGHTS

You have a right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of the notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you \$15.00 for each request, \$0.50 per page over ten pages, and any cost incurred for postage.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.

3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement: (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or to different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. This request must be in writing. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added make reasonable efforts to tell others, including people you name, of the charge and to include the changes in any future sharing of that information.
6. If you have received this notice electronically; and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice, or if you, think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights in Section IV of this notice by writing to the following address:

Utah Vein Specialists, Inc.
ATTN: HIPAA/Suzanne
9690 South 1300 East, Suite 224
Sandy, Utah 84121
(801) 501-8346

Patient Service Agreement

Consent for Services

By signing this agreement I give consent to the physicians, medical staff and employees of Utah Vein Specialists to provide health care services _____, _____ (Date of Birth).
Patient Name

Financial Responsibility and Assignment of Benefits

I agree that all benefits from insurance companies or any other third party payer will be paid directly to Utah Vein Specialists for services rendered by the health care providers employed by Utah Vein Specialists. I authorize the use of my signature and any records pertaining to my services to all insurance companies, or third party payers to secure payment.

I understand that I am financially responsible for all charges whether or not paid by insurance or any other third party payer. I agree to pay all co-payments at the time of service, all deductibles, co-insurance, and all non-covered services regardless of the amount paid by my insurance or any other third party payer. I agree to pay all attorney fees, court costs, filing fees, including charges or commissions that may be assessed by any collection agency retained to pursue collection on outstanding balances, with or without suit. The cost of collection is 25% of the total balance owed. I further agree to pay interest fees at the rate of 1 ½% per month (18% annually) for any outstanding balance.

I agree to pay a return processing fee of \$20.00 for any check, or other payment method, that is returned unpaid to Intermountain Heart Center.

Release of Information and Privacy Notice

The law requires Utah Vein Specialists to make and keep records of the patient's medical treatment. Intermountain Heart Center safeguards those records and it uses and discloses such records and any information they contain only in accordance with Utah State and Federal privacy laws. Such uses and disclosures are described in detail in the Notice of Privacy Practices. The Notice of Privacy Practices is available for the patient to review at anytime.

Acknowledgement

I acknowledge I have received or been offered the Notice of Privacy Practices by Utah Vein Specialists. As the patient, or the representative of the patient, I have read the above information and give consent and agree to the terms. All of my questions regarding privacy and this agreement have been answered and a copy has been offered.

Date _____

Patient or Legal Representative Signature: _____

Legal Representative Name: _____

Witness Signature: _____

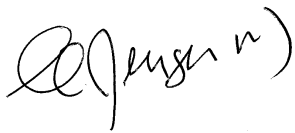

Photograph Consent

I agree to have Dr. Jensen or his assistants take photographs of my legs and my face for medical records purposes. These photographs will be held in confidentiality according to HIPPA regulations. Photographs of my name and face will not be used in the future for any publication. I do consent to the future use of my leg photographs, both before and after proposed procedures, at Dr. Jensen's discretion for the purpose of presentation, insurance authorization, and patient and physician education.

Date: _____

By: _____
Patient or Patient's Representative Signature

Utah Vein Specialists


By: _____
Signature of Physician Or Authorized Representative