Midwest Vein Treatment Clinic, Inc

ROBERT TYRRELL M.D.
8101A MILLER FARM LANE CENTERVILLE, OH 45459
937-281-0200 • Fax 937-281-0203

You have been scheduled on _____ Please arrive at _____

PLEASE COMPLETE AND BRING THIS INFORMATION

NAME _____
Last First MI

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ _____Home ____ Cell ____

AGE _____ DATE OF BIRTH _____

SOC. SECURITY NO. _____

EMAIL: _____

OCCUPATION _____

WORK NUMBER _____

PREFERRED METHOD OF CONTACT:

___ PHONE ___EMAIL ___WRITTEN ___ SECURE MSG

MARITAL STATUS ___ S ___M ___D ___W

SPOUSES NAME _____

FAMILY DOCTOR _____

REFERRING DOCTOR _____

PHARMACY _____

PHARMACY NUMBER _____

HEALTH INSURANCE

Primary carrier _____

Insurance address _____

Insurance ID# _____

Group # _____

Policyholders name and date of birth and social security number (REQUIRED FOR INSURANCE)

_____

_____

Secondary carrier _____

Insurance address _____

Insurance ID# _____

Group # _____

Policyholders name and date of birth and social security number (REQUIRED FOR INSURACNE)

_____

Emergency Contact: _____

Relationship _____

Phone:_____

Your first visit is a consultation with the doctor. If you have any questions regarding the information enclosed, please call our office. Any applicable co-pays will be collected at time of each visit.

PLEASE BRING YOUR INSURANCE CARDS AND A PHOTO ID

Name: _____

MEDICAL HISTORY

THE FOLLOWING INFORMATION WILL HELP YOUR PHYSICIAN PLAN YOUR CARE. PLEASE PRINT AND COMPLETE THIS SECTION

Male _____ Female _____ Age _____ Height _____ Weight _____

What problem are you seeking care for?

_____

_____

Check and or list all illnesses/problems you have been treated for in the past and present:

____ none	____ heart attack	____angina	____ diverticulitis
____ heart murmur	____ mitral valve prolapse	____ high blood pressure	____ crohn's disease
____ stroke	____ asthma	____ low blood pressure	____ ulcerative colitis
____ blood clots	____ stomach trouble/ulcer	____ bleeding disorder	____ hepatitis
____ COPD	____ emphysema	____ kidney problems	____ seizures
____ bladder	____ arthritis	____ diabetes	____ tuberculosis
____ cancer	____ depression	____ cirrhosis	____ other

_____

_____

Please list any surgeries you have had:

_____

_____

_____

_____

LIST ALL MEDICATION YOU CURRENTLY TAKE, THE DOSE AND HOW OFTEN

_____ NONE **DRUG ALLERGIES** _____

Do you have a LATEX ALLERGY? _____Yes ____NO

MEDICATION, DOSE AND FREQUENCY

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Have you ever smoked tobacco? ___ No ___Yes If yes, are you currently smoking? ___No ___ Yes

How long have/did you smoke? _____ How many packs/day? _____ If you quit, when? _____

Name: _____

Venous History

Please answer the following questions.

Past Medical History – provide estimates for date of occurrence

1. Have you ever had vein stripping? ___ Yes ___ No When _____
2. Have you ever had vein injections? ___ Yes ___ No When _____
3. Have you ever had a blood clot? ___ Yes ___ No When _____
4. Have you ever had a pulmonary embolism? ___ Yes ___ No When _____
5. Have you ever had phlebitis? ___ Yes ___ No When _____
6. Bleeding varicose veins? ___ Yes ___ No When _____
7. Have you ever had migraines? ___ Yes ___ No When _____
8. Have you ever had an ulceration? ___ Yes ___ No When _____

Family History – (M) mother (F) father (S) sister (B) brother (CM) child male (CF) child female

Varicose Veins _____ Spider Veins _____ Deep vein clot _____ Stoke _____ Blood clotting disorder _____

Current Vein History – please answer the following questions completely as they will help us know if the recommended procedures are covered under your insurance.

Do you experience any of the following symptoms that interfere in activities of daily living?

Aching/pain	___ Right	___ Left
Heaviness	___ Right	___ Left
Tiredness/fatigue	___ Right	___ Left
Itching/burning	___ Right	___ Left
Swelling/edema	___ Right	___ Left
Restless legs	___ Right	___ Left
Bleeding	___ Right	___ Left
Sores/Ulcers	___ Right	___ Left

What pain medication have you taken for relief of symptoms?

___ Aspirin ___ Ibuprofen ___ Aleve ___ Tylenol ___ Other _____

Does elevation relieve your leg symptoms? ___ Yes ___ No

What else have you tried to improve your symptoms?

___ Exercise ___ Weight loss ___ Compression stockings How long _____

Midwest Vein Treatment Clinic, Inc.

8101A Miller Farm Lane
Centerville, OH 45459

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care. If you have medical insurance, we are qualified to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Vein Surgery Patients: As a courtesy, we will send your photos and medical information to your insurance company. The letter will request that your insurance company send you a letter stating whether these procedures/supplies are covered and how much they will pay. This letter is normally sent out within 1-2 weeks of your first visit to our office. If you do not hear from your insurance company within 6-8 weeks, we recommend that you contact them for their response. We have no control over whether they respond to this request. (This letter will not be sent to Medicare or secondary insurance since they do not require it). If an insurance plan requires a precertification for outpatient procedures, it is the patient's responsibility to alert their insurance plan themselves.

Payment for services not covered by insurance are due at the time the services are rendered unless payment arrangements have been approved in advance by our management. All other balances must be paid within 90 days of the date of service. Returned checks and balance older than 90 days will be subject to additional collection fees and interest charges of 1 ½% per month.

We require at least a two (2) week notice for all vein surgery cancellations. A $200.00 fee will be charged if a two (2) week notice is not given.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most insurance companies. This statement does not apply to insurance companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. Midwest Vein and Laser, Inc. and doctors participate ONLY with the insurance companies listed on our current information sheet.
5. For Medicare Risk Plan HMO patients, we do not participate with your HMO, therefore you will be responsible for all charges out of pocket.
6. For Medicare patients, we do accept assignment with Medicare. Therefore, we will file your vein surgery claims to Medicare and you will be responsible for the Medicare co-insurance amount and deductible. You will be responsible for payment of any non-covered, cosmetic services/supplies and no claim will be sent to Medicare.
7. **Any insurance payment paid to you by your insurance company must be paid to Midwest Vein and Laser, Inc. Within one (1) week of receipt.**

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment on your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

I request that payment of authorized Medicare/Insurance benefits are made to Midwest Vein and Laser, Inc. for any services furnished to me by that physician. I authorize release to the Health Care Financing Administration or said insurance company and its agents any medical information about me needed to determine these benefits or benefits payable for related services.

I have read and fully understand the above statements regarding payment policies and agree that I am responsible for any fees incurred on account of services provided to me.

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Patient/Guarantor's Signature Witness Date