Midwest Vein Treatment Clinic, Inc

ROBERT TYRRELL M.D.
8101 MILLER FARM LANE CENTERVILLE, OH 45458
937-281-0200 • Fax 937-281-0203

You have been scheduled on _____ Please arrive at _____

PLEASE COMPLETE AND BRING THIS INFORMATION

NAME_____
LAST FIRST M

Address _____

City _____State_____ ZIP_____

Phone _____Home ☐ Cell ☐

Age _____ Date of Birth _____

Social Security #_____

Occupation _____

Work Phone _____

Marital Status ☐ M ☐ D ☐ S ☐ W

Spouses Name _____

Family Doctor _____

Address: _____

Phone_____

Referring Doctor _____

Address: _____

Phone:_____

Preferred Pharmacy_____

Pharmacy Phone _____

Email Address: _____

HEALTH INSURANCE

Primary Carrier _____

Insurance Address _____

Insurance ID#_____

Group #_____

Policy holder's name, date of birth and social security number **(required for insurance)**

_____

_____

_____

Secondary Carrier _____

Insurance Address _____

Insurance ID# _____

Group # _____

Policy holder's name, date of birth, and social security Number (required for insurance)

_____

_____

_____

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 the time of each visit.

PLEASE BRING OUR INSURANCE CARD WITH YOU

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
☐ OPD	☐ emphysema	☐ kidney problems	☐ seizures
☐ ladder	☐ arthritis	☐ diabetes	☐ tuberculosis
☐ cancer	☐ depression	☐ cirrhosis	☐ other

_____

_____

Are you having any pain? ☐ **back** ☐ **neck** ☐ **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 to help us evaluate insurance coverage.

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 _____

Family History

Anyone in your **family** with a history of blood clots, pulmonary embolism or ulcers? ☐ Yes ☐ No
Are you currently pregnant or breast feeding? ☐ Yes ☐ No

Current Vein History

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? This is required for any potential insurance coverage.

☐ Exercise ☐ Weight loss ☐ Compression stockings How long _____

Midwest Vein Treatment Clinic, Inc.

8101A Miller Farm Lane
Centerville, OH 45458

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 week of your first visit to our office. If you do not hear from your insurance company within 4-6 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 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 fee of $25 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 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 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**. **If payment is not received in full, this money will incur a monthly 1.5% interest charge.**

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 Treatment Clinic, 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.

| --- | --- | --- |
| Patient/Guarantor's Signature | Witness | Date |