Midwest Vein Treatment Clinic, Inc

Robert Tyrrell M.D.
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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 _____

Email Address: _____

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 _____

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 AND PHOTO ID 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
____ COPD	____ emphysema	____ kidney problems	____ seizures
____ bladder	____ arthritis	____ diabetes	____ tuberculosis
____ cancer	____ depression	____ cirrhosis	____ other

_____

_____

Are you having any pain? ____ back ___ neck ____ Other _____

Please list any surgeries you have had:

_____

_____

_____

_____

_____ 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 Are you currently smoking? ___No ___Yes

The age you started smoking: _____ 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 – (M) mother (F) father (S) sister (B) brother (CM) child male (CF) child female

Varicose veins ____ Spider veins ____ Deep vein clot ____ Stroke ____ Blood clotting disorder ____

Pulmonary Embolism ____

Current Vein History

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

Pain/aching	___ 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

**The following questions are asked in order to obtain potential insurance coverage: **

Have you taken any pain medication for relief of symptoms?

___ Aspirin ___ Ibuprofen ___ Aleve ___ Tylenol ___ Other _____

Do you elevate your legs to relieve your leg symptoms? ___ Yes ___ No

Do your vein symptoms interfere in your activities of daily living? ___ Yes ____No

Have you ever worn compression stockings? ____ Yes ____No If yes, how long? _____

Have you done any of the following measures?

___ Exercise ___ Weight loss

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8101A Miller Farm Lane Centerville, OH 45458
900 S. Dixie Dr. Suite A Vandalia, OH 45377

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).

Payment for services not covered by insurance is 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 balances 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/Guarantors Signature Date

_____ _____

Witness Date