New Patient Intake Form

Vein and Laser Center, Surgical LTD.

Saeed Darbandi, MD

Patient Full Name:_____ MI:_____

Date of Birth: _____ Social Security Number:_____ Sex: M☐ or F☐

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone Number:_____ Cell Phone Number:_____

May we leave a message of the answering machine/voicemail? ☐ Yes or ☐ No

Do you wish to receive text message or email communication regarding your appointments? Yes☐ or No☐

Please specify which: _____

E-mail Address: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employer: _____Occupation: _____

Is this a work related injury? ___No ___Yes Result of an auto accident? ___No ___Yes

In Case Of an Emergency Notify: _____

Relationship: _____ Phone Number: _____

Insurance Policy Holder:_____ Date of Birth:_____

Social Security Number: _____ Phone Number: _____

How did you hear about us/referred by: _____

Saeed Darbandi, MD

Vein and Laser Center, Surgical LTD.

Patient Medical History

Family Physician: _____ Allergies:_____

Medical History: (Diagnosed Illness, years and dates)	Surgeries and Dates: (major surgeries and dates)	Family History: (Please circle if anyone in YOUR FAMILY has the following)
_____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____	**HIGH BLOOD PRESSURE☐ STROKE☐** **DIABETES☐ HEART ATTACK ☐** **CANCER☐** **BLOOD CLOT☐ KIDNEY ILLNESS☐** **THYROID DISFUNCTION☐** **HIGH CHOLESTEROL☐**
Medications: (All medications including supplements and OTC. If you have a list, please write "see list")	Pharmacy:	Please Circle Your Answer:
_____ _____ _____ _____ _____ _____ _____ _____	Name:_____ Address:_____ _____ Phone:_____ Fax:_____	☐ ☐ Do you drink Alcohol? YES or NO If yes, how many per day? _____ ☐ ☐ Do you smoke tobacco? YES or NO If yes, how much per day? _____ How long? _____ Do you have Hepatitis A,B,C, or HIV/AIDS? YES☐ NO☐

Saeed Darbandi, MD

Vein and Laser Center, Surgical LTD.

Vein Questionnaire

1. Have you had any prior treatment for varicose/spider Veins? YES☐ NO☐
   If yes, date of last treatment: _____
   Type of treatments if known: _____

2. Do you have a history of ulcerations, clots in the veins, or deep vein thrombosis? YES☐ NO☐

3. Do you have a positive family history of varicose/spider veins? YES☐ NO☐
   If yes, relationship to you:_____

4. Are you currently or have been on any hormone therapy of birth control? YES☐ NO☐

5. Have you had any pregnancies? YES☐ NO☐
   If yes, how many? _____
   Did your varicose/spider veins increase or begin during or after pregnancy? YES☐ NO☐

6. Do you or have you worn compression stockings? YES☐ NO☐
   If yes, are they prescription or over the counter? _____
   If yes, how long have you worn them? _____

7. Do you sit or stand for long periods of time? YES☐ NO☐
   If yes, how many hours per day? _____

8. Are your symptoms worse at the end of the day? YES☐ NO☐

9. Are the problems you're having interfering with your lifestyle? YES☐ NO☐
   If yes, how so? _____

Please check any of the following symptoms you may have in your legs:

Pain/aching ☐	Tiredness/ Fatigue ☐	Leg Cramps ☐
Heaviness ☐	Itching ☐	Ulceration(s) ☐
Throbbing ☐	Burning ☐	Fatigue ☐
Swollen ankles ☐	Restless legs ☐	Bulging ☐

Saeed Darbandi, MD

Vein and Laser Center, Surgical LTD.

You may discuss my medical treatment with:

Name: _____ Relationship: _____

Phone number: _____

Name: _____ Relationship: _____

Phone number: _____

Information that may be discussed with above:

- ☐ Appointment confirmation/making of appointment
- ☐ Procedure information
- ☐ Billing/Insurance information
- ☐ Entire record
- ☐ Care of patient without limitations

Please initial next to all after reading

_____My signature acknowledges that I have provided complete and accurate information to the best of my ability and authorize Dr. Saeed Darbandi and staff to evaluate and treat.

_____Federal Privacy rules permits my personal and medical information to be used and disclosed without my permission for billing, medical treatments, process insurance claims, and healthcare operations. For other purposes, my information will only be released with my written permission using a HIPAA form.

_____I hereby authorize the release of any medical information necessary to process my insurance claims and that any benefits to be paid directly to Dr. Saeed Darbandi.

_____I have received this Physician's Notice of Privacy Policy sheet (attached on the back)

Patient Signature: _____ Date: _____

****Please initial next to your selection**

_____ I do not wish to receive a copy of the form I am signing

_____ I would like to receive a copy of the form I am signing.

Saeed Darbandi, M.D.

Vein and Laser Center, Surgical LTD.

Financial Responsibility:

I understand that I am responsible for the total charges for the services rendered and for knowing my insurance coverage. I understand that I may ask at any time for the procedural CPT codes to verify insurance coverage on my behalf but acknowledge that the Vein and Laser Center only processes authorizations. I understand that insurance authorization means the insurance covers their portion and I may have an out of pocket balance depending on the percentage of coverage and any deductible. I further agree that all amounts are due upon request and are made payable to Saeed Darbandi, M.D. in the event of collection. I understand that all co-payments are due at time of service. I will be responsible for any of the charges for the collection of overdue payment.

Patient Signature:_____ **Date:** _____

Cancellation Policy

Our Cancellation fee is applicable to all patients with no pardons. There will be a $50.00 charge for any cancellation with the exclusion of a procedure and a $100 charge for a procedure cancellation with less than 24 hours' notice and no show appointments. Patients who have cancelled/rescheduled appointments more than 3 times consecutively may not be able to be scheduled for future appointments or may be subject to a $50.00 fee after the 3rd visit cancellation.

By signing below, you agree and understand these policies listed above.

Patient Signature: _____ **Date:** _____

Staff Witness: _____**Date:** _____

HASTI™ VARICOSE VEIN SYMPTOMS OF THE LEGS

On a scale from 0 to 5, 0 meaning no experience of symptoms and 5 meaning you experience these symptoms frequently please enter the number for each symptom listed below.

HEAVINESS	0	1	2	3	4	5
ACHING	0	1	2	3	4	5
SWELLING	0	1	2	3	4	5
TIREDNESS	0	1	2	3	4	5
ITCHING	0	1	2	3	4	5

TOTAL SCORE: _____

Patient name: _____

Patient Signature: _____

Notice of Privacy Practices

Surgical LTD - Dr. Saeed Darbandi - Vein and Laser Center

This notice describes how health information about you may be used or disclosed and how you can get access to this information. Please review it carefully.

The privacy of your health information is important to us.

OUR LEGAL DUTY:

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, legal duties, and you rights concerning your health information. We must follow the privacy practices and the terms of this notice while it is in effect. This notice takes effect the day you sign for receipt of this form, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available by request. You may request a copy of our notice at any time, For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION:

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use and disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services provided to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include: quality assessment and improvement activities, reviewing the competence or qualifications of healthcare providers, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing criteria.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare, We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health 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 disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may also disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail, e-mails, or text messages).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain copies of your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $0.75 for each page and $20 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request and alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure).

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than the treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we will charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on or use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do so, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternate means or to alternate locations (You must make your request in writing). Your request must specify alternate means or location, and provide satisfactory explanation how payments will be handled under the alternate means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended), we may deny your request under certain circumstances.

Electronic Notices: If you receive this notice on our website or by electronic mail (E-Mail), you are entitled to receive this notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternate locations, you may complain to us using the contact information listed at the end of this notice. You may also submit a written complaint to U.S. Department of Health and Human Services.

Surgical LTD - Dr. Saeed Darbandi - Vein and Laser Center

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