Kentucky vein care

Glen W. Simons, MD
3080 Harrodsburg Rd., Suite 200
Lexington, Kentucky 40503

Phone: (859) 455-8346
Fax: (859) 455-8866
KVC@KYVeinCare.com

Dear Patient,

Dr. Glen Simons and staff would like to welcome you to our practice.

Please have your forms completed prior to your appointment.

Try to DRINK some fluids prior to your appointment! This helps with the ultrasound process.

Please bring your shortest pair of loose-fitting, non-denim shorts to all your appointments. (Examples: boxer shorts, running shorts, cut off sweats, etc.) **This is so that we can ultrasound your legs from the groin to the ankle.**

We provide timely, personal services to our patients, so we do not overbook. Your time is your time. Please extend the same courtesy to our office staff and patients.

You will receive a text message and a phone call to confirm your appointment. If you need to reschedule your appointment, please let us know ***24 hours prior to your appointment***. This allows us to bring in patients who are waiting for an earlier appointment. Patients who fail to provide advanced notice twice, will not be rescheduled.

Please bring a photo ID and your insurance card(s) to your appointment.

All co-pays, deductibles, and/or other fees *must* be paid at the time of service.

Feel free to call us with any questions or concerns that you may have at (859) 455-8346. We look forward to your visit.

Sincerely,

Dr. Glen Simons and Staff

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Patient Information:

First Name: _____ Last Name: _____ Date of Birth: ____/____/_____

Street: _____ Zip Code: _____

City: _____ State: _____ Gender: □ Male □ Female

Social Security #: _____-____-_____ Driver's License #: _____ Email: _____

Cellular Telephone: (____) _____-_____ Home Telephone: (____)_____

Marital Status: □ Single □ Married □ Widowed □ Divorced

Race / Ethnicity: _____

Employment Status: □ Employed □ Retired □ Disabled Occupation: _____

Employer: _____

City: _____

Referred By: _____

Family Physician: _____ Physician Telephone #: (____) _____-_____

Pharmacy: _____ Telephone #: (____) _____-_____

Emergency Contact: _____ Relationship: _____ Telephone #: (____) _____-_____

Insurance Information:

Primary Insurance: _____ Policy #: _____

Group #: _____ Insured Name: _____

SSN of Responsible Party: _____-____- _____ Date of Birth of Responsible Party: ____/____/_____

Responsible Party Name (other than patient): _____

Relationship to Patient: _____

Assignment of Benefits:

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Dr. Glen W. Simons, MD, PSC for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by my insurance.

Authorization to Release Information:

I hereby authorize Dr. Glen W. Simons, MD, PSC to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Dr. Glen W. Simons, MD, PSC on behalf of myself and/or my dependents, and understand that by making this request I become fully financially responsible for any and all charges incurred in the course of treatment.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this agreement is to be considered as valid at the original.

Signature: _____ **Date:** _____/_____/_____

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Medical History:

First Name: _____ Last Name: _____ Gender: □ Male □ Female

Date of Birth: ____/____/_____ Height: ____'____" Weight: _____lbs

Briefly describe current symptoms: _____

How long have you had this problem? _____ □ Pain □ No Pain Severity (0=none to 10=severe) _____

Side: □ Left □ Right □ Both Location: □ Groin □ Thigh □ Knee □ Calf □ Ankle □ Foot □ Other: _____

Onset: □ Predictable □ Unpredictable Triggered By: □ Exercise □ Elevation □ Sleep □ Cold □ Heat □ Position □ Activity

Made Worse By: □ Standing □ Standing for long periods of time □ Wearing compression hose □ Not wearing compression hose

Made Better By: □ Resting □ Walking □ Elevation □ Using Heat □ Using Cold □ Wearing compression hose

Have you worn compression hose? □ Yes □ No If yes, How long did you wear them? _____

Do you take analgesics (Motrin, Advil, Tylenol, Aleve, etc.) □ Yes □ No How often: _____ For how long: _____

Discoloration: □ Bruised □ Red □ Purple □ Rash □ Brown □ Ulcerated □ Other: _____

History: □ Deep Venous Thrombosis □ Pulmonary Embolus □ Superficial Phlebitis □ Previous Venous or Arterial Surgery
□ Varicose or Spider Vein Treatments □ Laser □ Sclerotherapy □ Surgery When: _____

Please check and/or list ALL illnesses for which you have received medical attention:

□ None	□ Bleeding Disorders	□ Depression	□ Hepatitis	□ Seizures
□ Anemia	□ Blood Clots	□ Diabetes	□ High Blood Pressure	□ Stroke
□ Angina	□ Cancer	□ Diverticulitis	□ Kidney Disease	□ Thyroid Disease
□ Arthritis	□ Cirrhosis	□ Emphysema	□ Low Blood Pressure	□ Ulcer Disease
□ Asthma	□ Chronic Bronchitis	□ Heart Attack	□ Migraine Headaches	□ Tuberculosis
□ Bladder Infections	□ Crohn's Disease	□ Heart Murmur	□ Mitral Valve Prolapse	□ Ulcerative Colitis

□ Other: _____

Please check and/or list ALL surgeries:

□ None	□ Cataracts	□ Hernia	□ Orthopedic Surgery	□ Tonsillectomy
□ Appendix	□ Colon Surgery	□ Hysterectomy	□ Pacemaker	□ Tubal Ligation
□ Breast Surgery	□ D & C	□ Lung Surgery	□ Prosthesis	□ Ulcer Surgery
□ Cardiac Cath	□ Gallbladder	□ Open Heart Surgery	□ Thyroid Surgery	□ Vascular Surgery

□ Other: _____

Do you have an artificial joint or hardware? □ Yes □ No Location: _____

Have you ever been treated for MRSA? When? _____

Please list ALL medications (including herbal and over the counter) you currently take: □ None

_____

_____

Drug Allergies: _____ □ None

History of reaction to iodine, shellfish, or X-ray contrast: □ Yes □ No If yes, type of reaction: _____

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Social History

Name: _____ Birthplace: _____

Tobacco: □ None □ Pipe □ Snuff □ Cigars □ Cigarettes # of packs per day: _____ # of years: _____

Coffee: □ None □ Yes # of cups per day: _____ Tea: □ None □ Yes # of cups per day: _____

Alcohol: □ None □ Beer □ Wine □ Hard Liquor Weekly amount : _____

Family History: Please write down **ALL** health information for each of the following pertaining to your family

Father: □ Alive; List current health problems : _____

□ Deceased; List cause of death: _____

Mother: □ Alive; List current health problems : _____

□ Deceased; List cause of death: _____

Brothers: _____

Sisters: _____

Father's Family: _____

Mother's Family: _____

Review of systems:

Do you now have or have you had within the past year:

Weakness or paralysis	□ Yes □ No	Palpations or fluttering of the heart	□ Yes □ No
Tire easily or weakness	□ Yes □ No	Leg cramps on walking or at night	□ Yes □ No
Recent weight changes	□ Yes □ No	Enlarged veins	□ Yes □ No
Change in appetite	□ Yes □ No	Difficulty swallowing	□ Yes □ No
Sensitivity to cold or heat	□ Yes □ No	Heartburn	□ Yes □ No
Headaches	□ Yes □ No	Frequent belching	□ Yes □ No
Easy bleeding or bruising	□ Yes □ No	Abdominal cramping	□ Yes □ No
Double Vision	□ Yes □ No	Nausea	□ Yes □ No
Blurred Vision	□ Yes □ No	Vomiting	□ Yes □ No
Do you wear glasses or contacts?	□ Yes □ No	Rectal bleeding	□ Yes □ No
Date of last eye examination: ____/____/____		Black tarry stools	□ Yes □ No
Ringing in the ears	□ Yes □ No	Dark urine	□ Yes □ No
Ear pain	□ Yes □ No	Frequent urination	□ Yes □ No
Decrease in hearing	□ Yes □ No	Increase in thirst	□ Yes □ No
Frequent nosebleeds	□ Yes □ No	Painful urination	□ Yes □ No
Persistent hoarseness	□ Yes □ No	Blood in urine	□ Yes □ No
Sore throat	□ Yes □ No	Lack of sex drive	□ Yes □ No
Lump in breast	□ Yes □ No	Hemorrhoids	□ Yes □ No
Discharge from nipple	□ Yes □ No	Joint pain or stiffness	□ Yes □ No
Chronic or frequent cough	□ Yes □ No	Swollen joints	□ Yes □ No
Shortness of breath	□ Yes □ No	Muscle cramps or spasms	□ Yes □ No
Bloody sputum	□ Yes □ No	Sleeplessness	□ Yes □ No
Wheezing	□ Yes □ No	Seizures	□ Yes □ No
Chest pain or discomfort	□ Yes □ No	Depression	□ Yes □ No
Purple fingers or lips	□ Yes □ No	Memory loss	□ Yes □ No
Swelling of hands, feet, or ankles	□ Yes □ No	Poor coordination	□ Yes □ No
Difficulty in breathing	□ Yes □ No	Dizziness or fainting spells	□ Yes □ No

Men

Discharge from penis	□ Yes □ No
Pain or lump in testicles	□ Yes □ No
Impotence	□ Yes □ No

Women

Age period began: _____ years old

Date of last menstrual cycle: ____/____/____

Date of last pelvic examination: ____/____/____

Date of last mammogram: ____/____/____

Number of pregnancies: _____

Birth control pills	□ Yes □ No
Hormone replacement therapy	□ Yes □ No

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Office Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policies allows for a good flow of communication and enables us to achieve our goal. **Please read each section carefully and sign at the bottom of the page to indicate that you fully understand each section**.

If you have any questions, do not hesitate to ask a member of our staff.

Appointments

- We value the time we have set aside to treat you. We do not double book appointments. If you are not able to make an appointment, we require 24-hour notice. ***There is a $50.00 charge for a missed appointment and will be charged to your credit card on file.***
- If you are more than 15 minutes late for your appointment, we will do our best to accommodate you; however, if the schedule does not permit then you must reschedule your appointment.
- We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.

Insurance Plans

- It is your responsibility to keep us updated with your current insurance information.
- It is your responsibility to understand your benefit plan with regard to covered services.

Financial Responsibility

- According to your insurance plan, you are responsible for any and ***ALL*** *co-payments, deductibles, and coinsurances.*
- ***Co-payments*** are due at the time of service. A ***12.9% interest fee*** will be charged in addition to your co-payment if the co-payment is not paid by the end of that business day.
- Self-pay patients are expected to pay for services in ***FULL*** at the time of the visit
- If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.
- Patient balances are billed on receipt of your insurance plan's explanation of benefits. Your remittance is due within ***20 days*** of your receipt of your bill.
- If previous arrangements have ***not*** been made with the Office Manager, any account balance outstanding longer than ***28 days*** will be charged a ***1.1% interest fee*** for each 28-day cycle. Any balance outstanding longer than 90 days will be forwarded to a collection agency and a $50 turnover fee will be added.
- For scheduled appointments, prior balances must be paid prior to the visit.
- We accept cash, checks, Visa, and MasterCard credit and debit, and Care Credit.
- A $30.00 fee will be charged for any checks returned for insufficient funds.

Forms

Family and Medical Leave Act forms are $25.00. Payment is due when forms are dropped off. We require a minimum of 3 business days turnaround time.

Transfer of Records

One (1) free copy of medical records can be obtained for each patient, non-inclusive of postage. Additional copies are provided for a $0.25/page fee (minimum of $10.00 including postage) or $25.00 maximum fee for large charts not including postage.

Consent

If at any time I provided a wireless telephone number or email address at which I may be contacted, unless I notify the office in writing, I consent to receive calls, text messages, and/or email communications regarding billing and payment for services. calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text message or any other form of electronic communication from the doctor, affiliates, contractors, services, clinical providers, attorneys or agents including collection agencies.

Signature: _____ **Date:** _____/_____/_____