Patient Name: ____

Date of Birth: ____________________________ Today's Date:__________________

1. Have you ever had vein stripping surgery? YES NO

   If yes, when and which leg.

____

2. Have you ever had vein injections? YES NO

   If yes, when and which leg.

____

3. Have you ever had a blood clot? YES NO

   If yes, when and which leg.

____

4. Have you ever had phlebitis? YES NO

   If yes, when and which leg.

____

Family History

Does anyone in your family have (or use to have) varicose veins, spider veins, leg ulcers, or swollen legs?

Father YES NO

Mother YES NO

Brother (s) YES NO

Sister (s) YES NO

Other YES NO

<u>Do you experience any of the following in your legs?</u>

<u>Aching/Pain</u> YES/NO Right Leg Left Leg

Both Legs

<u>Heaviness</u> YES/NO Right Leg Left Leg Both

Legs

<u>Tiredness/fatigue</u> YES/NO Right Leg Left Leg Both

Legs

<u>Itching/burning</u> YES/NO Right Leg Left Leg Both

Legs

<u>Swollen Ankles</u> YES/NO Right Leg Left Leg Both

Legs

<u>Leg Cramps</u> YES/NO Right Leg Left Leg Both

Legs

<u>Restless Legs</u> YES/NO Right Leg Left Leg

Both Legs

<u>Throbbing</u> YES/NO Right Leg Left Leg Both

Legs

<u>Other:</u> ____

2. Have your veins gotten worse in recent months? YES NO

3. Do you take any medications for pain (i.e., Advil, Motrin) YES

NO

If yes, what medication do you take and how many times/mgs per day. _______________________________________-

____

4. Do you elevate your legs to relieve discomfort? YES NO

If yes how long do you elevate and does it provide relief?

____

5. Do you exercise? YES NO

If yes, what kind of exercise do you do?

____

6. Do you wear RX Compression stockings? YES NO

If YES, what type and gradient? How long have you wore them?

____

If YES, what is the name of the MD who prescribed your compression stockings and when were they prescribed?

____

7. So you wear light support hose (i.e., Sheer Energy)

YES NO

If yes, do they provide relief? YES

NO

8. Do you have any problems walking? YES

NO

If yes, how does it affect you?

____

9. What type of work do you do?

____

10. How long do you stand (hours per day) at work ____________At home _____________

11. Have you ever had any test(s) done on your veins? YES

NO

If YES, when and what type of test and where on the legs.

____

11. Were you diagnosed with saphenous vein reflux? YES

NO

I, ____ have answered the above questions to the best of my knowledge and understand that by providing untrue answers, may lead to a denial of treatment.

Patient Signature: _____________________________________ Date: ____________

Witness Signature: _____________________________________ Date: _____________

NOTICE OF PRIVACY PRACTICES

This notice describes how Fox Valley Plastic Surgery may use and disclose your healthcare information and how you can obtain access to this information. Please review it carefully.

Fox Valley Plastic Surgery is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by Fox Valley Plastic Surgery or received by Fox Valley Plastic Surgery from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. Fox Valley Plastic Surgery will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.

Fox Valley Plastic Surgery reserves the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office at any time.

Uses and Disclosures of Your Protected Health Information not Requiring Your Consent

Fox Valley Plastic Surgery may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations.

Treatment may include:

- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
- Consultations between healthcare providers concerning a patient;
- Referrals to other providers for treatment;
- Referrals to nursing homes, foster care homes, or home health agencies.

For example, Fox Valley Plastic Surgery may determine that you require the services of a specialist. In referring you to another doctor, Fox Valley Plastic Surgery may share or transfer your healthcare information to that doctor.

Payment activities may include:

- Activities undertaken by Fox Valley Plastic Surgery to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits or health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collection activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
- Obtaining pre-certification and pre-authorization of services to be provided to you.

Fox example, Fox Valley Plastic Surgery will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

Healthcare operations may include

- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conducting outcomes evaluation and development of clinical guidelines;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review, legal services, and auditing functions.

For example, Fox Valley Plastic Surgery may use your diagnosis, treatment, and outcome information to measure the quality of the services that we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

Fox Valley Plastic Surgery may contact you, by telephone or mail, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a patient, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient.

There are additional situations when Fox Valley Plastic Surgery is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

- As permitted or required by law.
  In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime.

- For public health activities.
  We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency.
  We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child. We may release healthcare records, to the Food and Drug Administration when required by federal law. We may disclose healthcare records for the purpose of reporting elder abuse or neglect, provided the subject of the abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.

- For health oversight activities.
  We may disclose healthcare records in response to written request by any federal or state governmental agency to perform legally authorized functions, such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification.

- Judicial and Administrative Proceedings.
  Patient healthcare records may be disclosed pursuant to a lawsuit court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records.

- For activities related to death.
  We may disclose patient healthcare records to a coroner or medical examiner for purpose of completing a medical certificate or investigating a death.

- For research.
  Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.

- To avoid a serious threat to health or safety.
  We may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.

- For workers compensation.
  We may disclose your health information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

Fox Valley Plastic Surgery will not make any other use or disclosure of your protected health information without your written authorization. You may revoke such authorization at any time, except to the extent that Fox Valley Plastic Surgery has taken action in reliance thereon. Any revocation must be in writing.

Your Rights Regarding Your Protected Health Information

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by Fox Valley Plastic Surgery to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would no apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. Fox Valley Plastic Surgery may deny an access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that Fox Valley Plastic Surgery send protected health information, including billing information, to you by alternative means or to alternative locations. You also request that Fox Valley Plastic Surgery not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests by you.

You have the right to request that Fox Valley Plastic Surgery amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of the disclosures of your protected health information made by Fox Valley Plastic Surgery for the six years prior to the date of the request, beginning with disclosures made after April 14th, 2003. We are not required, however, to record disclosures we make pursuant to signed consent or authorization.

You may request and receive a paper copy of this Notice, if you had previously received or agreed to receive the Notice electronically.

Any person or patient may file a complaint with Fox Valley Plastic Surgery and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with Fox Valley Plastic Surgery, please contact the Privacy Officer at the following:

Privacy Officer
Fox Valley Plastic Surgery
2400 Witzel Ave Ste. A
Oshkosh, WI 54904
(920) 233-1540

It is the policy of Fox Valley Plastic Surgery that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

Fox Valley Plastic Surgery

Written Acknowledgement of Receipt

I, ______________________________________, acknowledge that I have received the written Notice of Privacy Practices from Fox Valley Plastic Surgery.

______________________________________ ________________________________

(Patient or Personal Representative Signature) (Date)

______________________________________ ________________________________

(Patient or Personal Representative Signature) (Date)

☐ The patient's condition prohibits the individual from signing an acknowledgement at the time. It will be obtained as reasonably practicable after the patient's condition improves.

☐ Acknowledgment was unable to be obtained.
Reason:____
____
____
____

______________________________________ ________________________________

(Employee Signature) (Date)

WISCONSIN MEDICAL SOCIETY CONSULTING, INC
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FOX VALLEY PLASTIC SURGERY, S.C.
2400 WITZEL AVENUE, SUITE A
OSHKOSH, WI 54904
(920) 233-1540

DAVID A. JANSSEN **WILLIAM G. DOUBEK**

WELCOME TO OUR OFFICE!

Today's Date: ________________

Mr/Mrs/Ms ____
First MI Last

Street Address ____

City ____________________________ State ________________ Zip ____________

Birthdate ______/______/______ Age _________ SS# ______-_____-______

Parent or Guardian if you are under 18 years of age ____________________________

Email Address ____________________ Current Employer ____________________
Work Phone # ______________________

Home Phone # ____________________ Cell Phone __________________________
May we contact you at Home ________ Cell __________ Work ____________

Marital Status: Single _________ Married _________ Other __________________

Spouse or Parents Name ____

Spouse or Parents Cell Phone Number ____________________________________

Spouse or Parents Employer __________________________ Work # _____________

Emergency Contact ____________________________ Relationship ______________

If different from spouse/parent , Home # ______________ Work # _______________

Personal Physician __________________________ Address ____________________
First Last

How did you learn about our practice? ____________________________________

Reason for today's office visit? ____

HISTORY INTAKE FORM

Patient Name: ________________________________ **Birth Date:** ___/___/___

Please answer all of the questions as accurately as possible. If you do not understand the question please ask for assistance.

CURRENT MEDICAL HISTORY:

Have you or any member of your family ever had a problem with anesthesia? YES NO

Are you allergic to any medication or substance (food, environment, or latex)? Please list them:

____

Please list any medications you are presently taking including over the counter, prescription, herbs or vitamins ____

____

____

List previous surgeries or major illnesses and dates: ________________________________

____

PERSONAL HISTORY:

Do you:

Smoke YES NO______________ Pkgs/Day

If former smoker, date quit: __________

Drink caffeine YES NO____________Amount/Day

Drink alcohol YES NO____________Day/Week

Current:

Height: ____________

Weight:____________

WOMEN ONLY:

Age period began ______________

Date of last mammogram ______________

Do you do regular breast self-exams? YES NO

Number of pregnancies _____

Did you breast feed? YES NO

Breast lump or discharge YES NO

FAMILY HISTORY:

Has any **blood relative** ever had the following?

Breast Cancer....YES NO	High blood pressure.... YES NO	Kidney Disease.. YES NO
Melanoma...... YES NO	Heart Disease........... YES NO	Depression....... YES NO
Stroke.......... YES NO	Diabetes................. YES NO	Blood Clots...... YES NO

PAST MEDICAL HISTORY:

Have **you** ever had the following?

Heart Disease.... YES NO	Cancer......... YES NO	Stomach Ulcer........YES NO
Arthritis.......... YES NO	Glaucoma..... YES NO	Kidney Disease.......YES NO
Rheumatic Fever..YES NO	Asthma........ YES NO	Thyroid Disease......YES NO
Anemia........... YES NO	AIDS or HIV..YES NO	Bleeding Tendency...YES NO
Tuberculosis...... YES NO	Stroke..........YES NO	High Blood Pressure..YES NO
Diabetes.......... YES NO	Hepatitis.......YES NO	Blood Clots.......... YES NO

REVIEW OF SYSTEMS:

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

Weight Change.....YES NO	Swollen feet/ankles.... YES NO	Seizures.................YES NO
Dry Eyes............YES NO	Skin rash.................YES NO	Joint or muscle pain...YES NO
Chronic Cough.....YES NO	Chronic Diarrhea.......YES NO	Swollen lymph nodes..YES NO
Chest Pain...........YES NO	Jaundice................. YES NO	Easy bleeding...........YES NO
Rapid Heart Beat...YES NO	Depression..............YES NO	Easy bruising...........YES NO

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X____ **DATE:** ___/___/___

Signature of patient or parent if minor

FOX VALLEY PLASTIC SURGERY, S.C.

FINANCIAL POLICY

Thank you for choosing us as your health provider. We are committed to your successful treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to treatment. If at any time you have questions regarding any treatment, fee, or service, please discuss them with us promptly and frankly. We will make every effort to avoid a misunderstanding.

ALLOWABLE FORMS OF PAYMENT

The patient or his/her legal representative is ultimately responsible for all charges incurred. Our office accepts payment by cash, check and for your convenience, Visa and MasterCard. We also offer patient financing through a couple different companies.

REDGARDING INSURANCE

As a courtesy to you, we will bill your insurance carrier for you. Please be aware some and perhaps all of the services provided may be "non-covered" services and are not considered reasonable and necessary under some medical insurance policies. If you are unable to pay in full, it is your responsibility to contact our billing department to set up an agreeable payment plan. Your insurance policy is a contract between you and your insurance company. Our office accepts assignment of benefits from many insurance companies, HMO & PPO programs. However we are not participating providers with all of them. Therefore please inquire as to whether we are with your plan.

INJURIES/ACCIDENTS

If your injury or accident involves litigation, a letter of protection needs to be obtained from the attorney involved.

MEDICARE

We do take Medicare assignment and we will bill Medicare and your secondary insurance for you.

CO-PAYS/DEDUCTIBLES

Payment is expected at time of office visit for co-payments and/or deductibles that is requested by your insurance policy.

BILLING

Statements are mailed monthly and expected to be paid in full within 60 days after your insurance has paid unless other arrangements have been made with the billing manager. If payment is not received in 90 days – it will be turned over to collection. Thank you for understanding our Financial Policy. If you should have questions or problems, please let us know and we will be happy to assist you in every way possible.
I have read the Financial Policy (above). I understand and agree to this.

____ ______________________________
Patients or Responsible Party Signature Date

I consent to having before and after photographs taken of me or parts of my body. These will be used for office and insurance prior authorizations purposes only.

____ ______________________________
Patients or Responsible Party Signature Date

I hereby authorize my insurance benefits to be paid directly to Fox Valley Plastic Surgery realizing I am responsible to pay any and all charges that exceed or that is not covered by insurance. I authorize the release of pertinent medical information to insurance and workers compensation carriers.

____ ______________________________
Patients or Responsible Party Signature Date