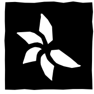


Florida Vein Care
and cosmetic center

Thank you for your confidence in our practice.
To better serve you, please take note of the following:

- For your convenience, our practice may be accessed online at www.floridaveincare.com. Please check back often to learn more about our centers, services, and special events.
- Major credit cards, debit cards, checks, and cash are happily accepted.
- Florida Vein Care and Cosmetic Center takes great effort to protect your personal and medical information. We comply with all HIPPA laws, and welcome any input you may have about how we can better serve you.
- Thank you in advance for respecting our busy schedule. Missed appointments are subject to a $50 lost appointment fee; and rescheduled appointments require at least twenty-four hours notice.
- To better serve all of our clients, individuals arriving more than fifteen minutes after their scheduled appointment time will need to re-schedule.
- Regular business hours are Monday through Thursday 8 a.m. to 5p.m., and Fridays from 8 a.m. to 12:00 p.m. Estheticians are available after hours and Saturdays.
- On selected occasions, we stay open late and offer specials on treatments and products for our valued clients. Ask about our *Day of Beauty*, or other fabulous skin care events.
- Because sold skin care products are customized for your unique skin type and prescribed regimen, we are unable to refund or exchange skin care products.
- Tell your friends about Florida Vein Care to receive special rewards towards products and services. To find out how, ask us about our *Referral Rewards Program*.

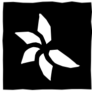
Print Name: ____

Signature: ____ Date______________

Dr. Phillips Location
7009 Dr. Phillips Blvd. Suite 240
Orlando, FL 32819
(407) 352-9877

Lake Mary Location
580 Rinehart Road Suite 110
Lake Mary, FL 32746
(407) 841-8800

FORM FVC070909



Florida Vein Care
and cosmetic center

Insurance Information Form

Your Name: | **Date:**

Name of person insured: | **Insured person's birth date:**

Insured person's social security number: | **Insured person's employer:**

Insurance Information

Insurance name:

Insurance address: | **Insurance City:**

Insurance State: | **Insurance Zip Code:**

Insurance ID#: | **Insurance Group#:**

Our office is happy to submit your medical claim to your insurance company. There are occasions when your insurance company may deny payment of certain procedures, visits, or treatments. Should your insurance company deny payment for any reason, you are responsible for the services provided. If you agree with these terms, please sign and date below.

If my insurance company denies payment, I agree to be personally and fully responsible for any cost incurred.

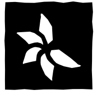
X ____ Date: ______________________________

PLEASE BRING THIS FORM TO THE RECEPTIONIST ALONG WITH
YOUR DRIVERS LICENSE AND INSURANCE CARD.

Dr. Phillips Location
7009 Dr. Phillips Blvd. Suite 240
Orlando, FL 32819
(407) 352-9877

Lake Mary Location
580 Rinehart Road Suite 110
Lake Mary, FL 32746
(407) 841-8800

FORM FVC070909


Florida Vein Care
and cosmetic center

Welcome

Please help us get to know you better by completing the following:

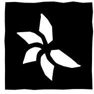
Your Name:	**Date:**
Address:	**Birth Date:** (month/day/year)
	Sex: M F
Social Security #:	**Height:**
Home Phone:	
Insured person's social security number:	**Insured person's employer:**

Please circle any of the following that you are interested in learning more about.

- ☐ Varicose/Spider Veins
- ☐ Botox
- ☐ Juvederm
- ☐ Restylane
- ☐ Glycolic Facials
- ☐ Laser Hair Removal
- ☐ Micordermabrasion
- ☐ Wrinkle Reduction
- ☐ Light Treatment
- ☐ Anti-Aging Products
- ☐ Acne Treatment
- ☐ DNA Stem Cell Skin Care
- ☐ Weight Loss

Dr. Phillips Location
7009 Dr. Phillips Blvd. Suite 240
Orlando, FL 32819
(407) 352-9877

Lake Mary Location
580 Rinehart Road Suite 110
Lake Mary, FL 32746
(407) 841-8800



How did you learn about our practice?

My Doctor: (name)

Current Client: (name)

Other: (where)

Significant other or closest family member's information:

Name:

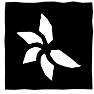
Relationship:

Phone #:

Do you have any allergies? (Please list)

Dr. Phillips Location
7009 Dr. Phillips Blvd. Suite 240
Orlando, FL 32819
(407) 352-9877

Lake Mary Location
580 Rinehart Road Suite 110
Lake Mary, FL 32746
(407) 841-8800



Florida Vein Care
and cosmetic center

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

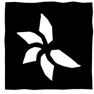
Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however,


Florida Vein Care
and cosmetic center

you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

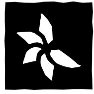
Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: ____

Signature: ____ Date______________

Dr. Phillips Location
7009 Dr. Phillips Blvd. Suite 240
Orlando, FL 32819
(407) 352-9877

Lake Mary Location
580 Rinehart Road Suite 110
Lake Mary, FL 32746
(407) 841-8800



Florida Vein Care
and cosmetic center

Medical Questionnaire for Clients with Varicose and Spider Veins

Patient's Name: ______________________________ Occupation: ______________________________

Date of Birth: ______________________________ Height: ____________ Weight: ____________

Please check any of the following symptoms you have experienced in the last year.

- ☐ Aching
- ☐ Swelling
- ☐ Heaviness
- ☐ Cramps
- ☐ Itching
- ☐ Dermatitis
- ☐ Pigmentation
- ☐ Burning
- ☐ Ulcers
- ☐ Cellulitis
- ☐ Fatigue
- ☐ Restlessness
- ☐ Erosion of the Skin

Other:

Please indicate which areas of your body are involved (check all that apply)

- ☐ Both Legs
- ☐ Left Leg
- ☐ Right Leg
- ☐ Face

At what age did the problem with your veins first occur? __________ **Years of Age**

If you've ever been treated for this problem, check the method you've had performed.

- ☐ Injection
- ☐ Electrocautery
- ☐ Laser
- ☐ Surgery
- ☐ Endovenous Laser Ablation
- ☐ Phlebitis
- ☐ Protein C or S Deficiency

Do you have a history of, or ever been treated for: *(check all that apply)*

- ☐ Blood Clots
- ☐ Lupus
- ☐ Scleroderma
- ☐ Dermatomyositis
- ☐ Cancer
- ☐ Bleeding Disorders
- ☐ Easy Bruising
- ☐ Leg Ulcers
- ☐ CREST Syndrome
- ☐ Pulmonary Embolism

If yes, when were you treated? ______________

Have your veins ever become red, swollen or painful to touch? Yes No

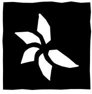
Have you tried wearing prescription compression stockings? Yes No

If yes, how long? __________

Have you ever had bleeding from your veins? Yes No

Dr. Phillips Location
7009 Dr. Phillips Blvd. Suite 240
Orlando, FL 32819
(407) 352-9877

Lake Mary Location
580 Rinehart Road Suite 110
Lake Mary, FL 32746
(407) 841-8800


Florida Vein Care
and cosmetic center

How does the pain affect your daily life?

____
____

Do you use any pain relief? Yes No
Is your sleep disturbed? Yes No

Are you currently taking cortisone, tetracycline, aspirin or Coumadin (blood thinners)? Yes No

Please list all medications you are currently taking.

____
____
____
____
____

Do you have any drug allergies? Yes No

If yes, please list: ____
____
____

Females Only:

Are you pregnant or nursing? Yes No

How many times have you been pregnant? ___________

Are you currently taking a birth control pill? Yes No