GVS
GLOBAL VEIN
SPECIALISTS
EMPOWERING CIRCULATION FROM WITHIN

Primary Physician (PCP): _____ Telephone: _____

Last name: _____ First name: _____

Date of birth: _____ SS#:_____ Sex: O male O female
Address: _____ City: _____ Zip: _____
Home phone: _____ Cell phone: _____
Email address: _____
Marital status: O married O single O divorced O widowed O other
Primary language: O English O Spanish O Creole O French O other
Ethnicity: O White/Caucasian O Black/Afro-American
O Hispanic/Latino O Asian/Pacific Islander O other

Emergency contact: _____
Relationship to patient: _____ Telephone: _____

Person authorized to release medical information: _____

Insurance information:

Policyholder: _____
Primary insurance: _____ ID# _____
Secondary insurance: _____ ID# _____

Pharmacy:

Pharmacy: _____ Phone number: _____

I hear by acknowledge that all information indicated above is correct. If anything is incorrect, I have indicated what has changed or advise the office. I understand that it is my responsibility to update my information, and failing to do so will result in delay of claims.

_____ _____ _____
Print Name/Legal name Signature: Date:

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No-Show Policy

I understand that a 24-hour notice is required for cancellation of appointments. Different cancellation policies are effective for diagnostic testing. This will be given to the patient at check out.

Physician Assistants

Our office utilizes physician assistants. The majority of your care will be physician based and always physician supervised. A physician assistant is a healthcare provider educated under the medical school model, however, they are not independent providers and all medical decisions are reviewed by the supervising physician. Physician assistants have specific experience and training provided by a doctors in cardiology.

Financial Policy, Release of Information and Assignment of Benefits

Payment is due at time services are rendered and insurance payment benefits has been approved. Credit cards, cash and checks are excepted forms of payment. Insurance coverage is a contract between you and your insurance company. *You are ultimately responsible for payment of services.*
I understand that I am financially responsible for services provided by Cardiovascular Specialist of South Florida, PA, DBA, Global Vein Specialists, LLC, whether or not paid by insurance company. I understand any out-of-pocket expenses and reasonable collection fees will be charged, if my account is not paid in full within 90 days.

I hereby authorize and direct my insurance company to make payment to my physician, provider and/or associates for services rendered. I understand I am responsible for all non-coverage services. I hereby authorize the release of relevant medical information to my insurance company.

Acknowledgment of Receipt of Notice of Privacy Practices

The undersigned patient or legally authorized representative of the patient acknowledges that he or she personally was offered and/or received a copy of Cardiovascular Specialists of South Florida, PA, DBA Global Vein Specialists, LLC, Notice of Privacy Practices on the date indicated below.

I hereby acknowledge that I have read and authorized Cardiovascular Specialists of South Florida, PA, DBA Global Vein Specialists, LLC, following policies: No-Show Policy, Physician Assistant, Financial Policy, Release of Information, Assignment of Benefits, and Notice of Privacy Practices.

Patient name (print):_____

Patient signature: _____ Date: _____

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Declaration,

I consent to the practice contacting me by text message or email for the purpose of health promotions, appointment reminders and general questions.

I acknowledge that the appointment reminders by text or email an additional service, and that the responsibility of attending or canceling appointments still rets with me. I can cancel the appointment at any time.

Texts or emails are generated using a secure facility. I understand that they are transmitting over public network onto a personal device that may not be secure. However, the practice will not transmit any information which would enable an individual patient to be identified.

I agree to advice the practice if my mobile number or email changes or if it is no longer in my possession.

Patient Name (please print): _____

Signature: _____

Home phone number: _____

Mobile phone number: _____

Email Address: _____

This practice does not share mobile phone contact details or email addresses with any external organizations.

☐ **I do not consent to the practice contacting me by text or email**

☐ **I do consent to the practice contacting me by text or email**

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

DOCTOR/HOSPITAL: _____

ADDRESS: _____

PHONE: _____ FAX: _____

Please be advised that we may send your medical records via Email, fax, carrier, and UPS. By signing this release, you authorize us to send your medical records.

I hereby authorize and request the release of my medical records pertaining to the dates of service from: _____ to _____. Please release all records to:

Business Name: Interventional Global Vein Specialists, LLC.
Tax I.D: 20-0337721
P: 844-GVS-VEIN
P: 844-487-8346
F: 561-510-8744

THANK YOU IN ADVANCE FOR YOUR COOPERATION

_____ _____
Patient's Signature Date

_____
Patient Name- Printed DOB: SS#

_____
If patient is a minor, signature of parent or legal guardian

_____
Witness to the above signature please print name

VEIN SCREENING FORM

Date: _____

Name: _____

DOB: _____ Sex: ☐M ☐F

I. Vascular History

Do you have or have you ever been diagnosed with:

Varicose vein problems	☐Y ☐N	Leg: ☐R ☐L
Phlebitis (vein redness/tenderness)	☐Y ☐N	Leg: ☐R ☐L
Blood clots	☐Y ☐N	Leg: ☐R ☐L
Deep vein thrombosis (DVT)	☐Y ☐N	Leg: ☐R ☐L
Saphenous vein reflux	☐Y ☐N	Leg: ☐R ☐L

Do you experience any of the following in your leg(s):

Aching/pain	☐Y ☐N	Leg: ☐R ☐L
Heaviness	☐Y ☐N	Leg: ☐R ☐L
Tiredness/fatigue	☐Y ☐N	Leg: ☐R ☐L
Itching/burning	☐Y ☐N	Leg: ☐R ☐L
Swelling	☐Y ☐N	Leg: ☐R ☐L
Cramps	☐Y ☐N	Leg: ☐R ☐L
Restless legs	☐Y ☐N	Leg: ☐R ☐L
Throbbing	☐Y ☐N	Leg: ☐R ☐L
Skin or ulcer problems	☐Y ☐N	Leg: ☐R ☐L
Other:	☐Y ☐N	Leg: ☐R ☐L

Which of the following do you currently do to improve your leg vein symptoms:

Medication for pain	☐Y ☐N	What? _____
Elevation of legs	☐Y ☐N	What? _____
Wear support hose	☐Y ☐N	What? _____

II. Family History

Have any of your family members had:

Varicose veins	☐Y ☐N	Who? _____
Vein stripping	☐Y ☐N	Who? _____
Blood coagulation disorder	☐Y ☐N	Who? _____
Blood clots	☐Y ☐N	Who? _____
Stroke, heart attacks or pulmonary emboli	☐Y ☐N	Who? _____

III. Vein Treatment History

Have you ever been treated for varicose veins with:

Sclerotherapy	☐Y ☐N	Leg: ☐R ☐L
Laser therapy (spider veins)	☐Y ☐N	Leg: ☐R ☐L
Phlebectomy	☐Y ☐N	Leg: ☐R ☐L
Vein stripping surgery	☐Y ☐N	Leg: ☐R ☐L
RF ablation (VNUS Closure®)	☐Y ☐N	Leg: ☐R ☐L

IV. Personal Activities List

Does your work require:

Prolonged standing periods	☐	☐
Prolonged sitting periods	☐	☐

NOTES:

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PATIENT INSTRUCTIONS PRIOR TO ULTRASOUND POROCEDURE

Patient Name: _____

NO CAFFEINE

DRINK 32 OZ OF WATER PRIOR TO PROCEDURE

NORMAL EATING HABITS

REMOVE COMPRESSION SOCKS 24HRS BEFORE PROCEDURE

Patient Signature: _____ Date: _____

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PATIENT MEDICAL HISTORY FORM

PATIENT NAME: _____ DATE: _____

Height: _____ Weight: _____ BP: _____/_____ Pulse: _____

1. Please list any and all known allergies (include both food and medical):

_____

_____

2. Please provide a brief description of your past medical history. Include any and all previous injurie, hospitalizations, etc.:

_____

_____

_____

3. Please provide a brief description of your CURRENT medical condition and problems (BE SPECIFIC):

_____

_____

_____

4. Please list any and all previous surgeries/operations you have had:

_____

_____

_____

5. Please list any and all medications you are CURRENTLY taking and the reason you are taking the medication:

_____

_____

_____

6. Please list any family medical history of venous insufficiency, spider or various veins:

_____

_____

7. Are you a smoker? Yes / No If yes, how often and how long have you been smoking?

_____

8. Do you drink? Yes / No If yes, how many per day or how often?

_____

9. Do you use any recreational drugs? Yes / No If yes, what are you using?

_____

10. Number of pregnancies if applicable: _____

11. Parents: Mom _____ living _____ Deceased Dad _____ living _____ Deceased