THE NEW JERSEY
VEIN AND VASCULAR CENTER

390 Route 10 West, North Building, Suite 102
Randolph, NJ 07869
Stuart H. Miller, M.D.

VENOUS EVALUATION

Patient Last Name: **First Name:** **Date:**

Date of Birth: **Age:** **Height:** **Weight:** **Sex:** ☐ Female ☐ Male

Primary Care Physician:

Allergies or Reactions:

Past Medical History:

- ☐ Cancer (if yes, which type? Are you currently undergoing any treatments?)
- ☐ Lung Disease (asthma, emphysema, chronic bronchitis, other)
- ☐ Heart Disease (heart attack, coronary heart disease, arrhythmia, murmur, enlarged heart, heart failure, other)
- ☐ Diabetes (Insulin or Non-Insulin dependent)
- ☐ Hypertension (high blood pressure)
- ☐ Hypercholesterolemia (high cholesterol/triglycerides)
- ☐ Stroke
- ☐ Blood clots (phlebitis, DVT)
- ☐ Thrombophilia (HIT, Factor V Leiden, protein C/S deficiency, homocysteinemia, other)
- ☐ Infectious diseases (HIV, hepatitis, tuberculosis, other)
- ☐ Arthritis (osteo/rheumatoid)
- ☐ Neurological disorder (migraines, multiple sclerosis, myasthenia gravis, Parkinson's disease, Alzheimer's disease, other)
- ☐ Peripheral arterial disease
- ☐ Thyroid dysfunction (if yes, please specify)
- ☐ Gastrointestinal condition (GERD, PUD, colitis, liver disease, hemorrhoids, other)
- ☐ Skin disorders (psoriasis, eczema, idiopathic thrombocytopenic purpura, other)

Medications:

- ☐ Blood thinners (Aspirin, Plavix, Coumadin, other)
- ☐ Hormone replacement therapy (HRT) or Contraception (oral, injection, other)
- ☐ Other prescriptions
  Please specify.
- ☐ Other over the counter
  Please specify.
- ☐ Vitamins/Supplements
  Please specify.

Past Surgical History:

☐ Vein surgery (stripping & ligation, phlebectomy, sclerotherapy, laser)
Which leg? When? Please specify.

☐ Stents (hearts, carotid, peripheral/legs or arms)
Please specify.

☐ Other

Social History:

☐ Smoking (Yes/No) Please specify.
☐ Alcohol (Yes/No) Please specify.
☐ Illegal drugs (Yes/No) Please specify.
☐ Work history (standing occupation, i.e. teacher, hairdresser, retail, other)
☐ Athletic history (if yes, please specify, i.e. sports. Injuries?)
☐ Exercise history (if yes, please specify, i.e. weight lifting, running, kick boxing, other)
☐ Ambulatory status (bedridden, wheelchair, walker, cane, limp, none)

Family History:

☐ Varicose veins (who?)
☐ Blood clots (who?)
☐ Leg ulcers (who?)

Child Rearing History (Females Only):

☐ Are you pregnant? (Yes/No)
☐ Do you intend to become pregnant in the next year? (Yes/No)
☐ Are you currently breastfeeding? (Yes/No)
☐ How many pregnancies have you had?
☐ How many births?

Venous Review of Symptoms:

☐ Which leg is affected?	☐ left	☐ right	☐ both			
☐ Types of veins:	☐ bulging veins	☐ spider veins	☐ blue surface veins			
☐ Symptoms:	☐ pain	☐ aching	☐ throbbing	☐ cramping	☐ itching	☐ burning
	☐ heaviness	☐ leg swelling	☐ fatigue	☐ restless legs		

Venous Symptomatic Management:

☐ Do you wear or have you worn compression stockings? When? For how long? Did they help?
☐ Do you take medicine for pain? If yes, what do you take? How often?
☐ Does anything else relieve your symptoms?

Please state your personal priority and goal for vein treatment:

Signature: **Date:**

THE NEW JERSEY
VEIN AND VASCULAR CENTER
390 Route 10 West, North Building Suite 102
Randolph, NJ 07869
Stuart H. Miller, M.D.

ACKNOWLEDGEMENT OF PRIVACY PROCEDURES

Please Print Patient Name **Date of Birth** **Social Security Number**

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND ANSWER ALL OF THE QUESTIONS.

This Notice of Privacy Procedures describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment and/or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

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, and any other use required by law.

TREATMENT:
We will use 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, to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you, and/or to review your health information with a case manager who is coordinating your care.

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.

HEALHCARE OPERATIONS (TPO):
We may 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/arranging for other business activities. For example, we may disclose your protected health information to:

- Medical school students that see patients at our office;
- We may use a sign-in sheet at the registration desk where you are asked to sign your name and indicate your physician;
- We may 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;
- With your specific approval, leave information at your home on an answering machine or to a duly authorized person acting on your behalf.

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, criminal activity, inmates;
- Coroners, Funeral Directors and Organ Donation;
- Research;
- Military Activity, National Security; and
- Workers' Compensation

Under the law, we must make disclosures to you and when required by the 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 of the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS:

The following is a statement of your rights with respect to your protected health information:

- You have the right to inspect and receive a copy of your protected health information. Under federal law, however, you may not inspect or copy Psychotherapy notes;
- Information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding;
- 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 your family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Procedures. Your request must state the specific restrictions(s) requested and to whom you want the restriction(s) to apply. Your physician is not required to agree to a restriction that you may request. If the 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 communication from us by alternative means or at an alternative location. You have the right to obtain a copy of this notice, upon request;
- 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; and
- 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 have the right to object or withdraw as provided in this notice.

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 any supervisor, a member of our administration, or our designated Privacy Officer.

This notice was published and becomes effective January 31, 2015.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy procedures with respect to your protected health information. If you have any objections to this form, please notify our administration at (862) 251-7111.

Please answer the questions below and affix your signature acknowledging that you have received this Notice of our Privacy Policy and Procedures and have provided specific direction and authorization in protection gy9our health information.

****

Who may we provide with your personal health information:

Check all that apply

☐ Spouse ☐ Children ☐ Parent ☐ Other, specify _____

Give name & phone number _____

May we leave personal health information on your answering machine at home?

☐ Yes ☐ No

_____ _____ _____

Patient's Signature (A parent or guardian must sign for patient if under 18 years of age) Print Patient's Name Today's Date

THE NEW JERSEY
VEIN AND VASCULAR CENTER
390 Route 10 West, North Building Suite 102
Randolph, NJ 07869
Stuart H. Miller, M.D.

INFORMED CONSENT TO PERFORM HEALTH SCREENING

This Informed Consent gives the New Jersey Vein and Vascular Center (the "**Center**") permission to conduct the health screening listed below. Please read this Informed Consent carefully.

I voluntarily and willing consent to have the **Center** administer and conduct the following health screening: **varicose veins of the legs**. I understand I may be touched on my leg(s) and consent to such touching. I understand that there are possible risks associated this health screening, including, without limitation: (1) pain from touching my legs, and (2) a worsening of my varicose vein condition, and (3) other injury such as pulmonary embolism or death.

I understand that:

☐ I am entitled to receive a copy of this Informed Consent, my health screening results, and any other protected health information that is collected by the **Center** in connection with my health screening.

☐ A diagnosis can only be made by a qualified physician or licensed healthcare professional;

☐ The health screening results collected here by the **Center** will be held securely and confidentially by the **Center.**

☐ The health screening results will not be shared with anybody, unless I sign additional documents.

☐ I understand that I will not receive any compensation and that the value of this health screening is nominal. understand there is no fee for providing this health screening. I believe this health screening complies with all laws, regulations and rules relating to this health screening.

☐ I will not be permitted to participate in any other health screening offered by the **Center** for the twelve (12) month period following this health screening.

☐ I understand I am not obligated to use the service of the Center and should it be determined that follow up medical care is suggested I am free to select the health care provider of my choice, which may be the Center or any other health care provider.

☐ The health screening results will not be used by the **Center** unless I voluntarily choose to do so.

☐ I am responsible for contacting my primary care doctor for questions about any specific medical needs that may be indicated by this health screening. I will not hold the **Center** responsible for providing information, diagnosis or treatment as a substitute for the care I receive from my physician or any other qualified health care provider.

☐ If I have an abnormal health screening result, I am responsible for following up with my primary care physician.

☐ I may revoke this Informed Consent by sending a written revocation to: **New Jersey Vein and Vascular Center**, **390 Route 10 West North Building Suite 102, Randolph, New Jersey 07869**. Revocation of this Informed Consent will not affect actions the **Center** takes in reliance on this Consent before the **Center** receives your written revocation.

I recognize that if I do not sign this Informed Consent, the **Center** cannot administer the health screening.

I have had full opportunity to read and considered the contents of this form.

_____ _____

Printed Name Date of Birth (mm/dd/yy)

_____ _____

Signature Date

390 Route 10 West, North Building Suite 102
Randolph, NJ 07869
Stuart H. Miller, M.D.

PATIENT INFORMATION

Patient Name: Last First: MI Nickname
Address: Street Apt #
City State Zip Code
Date of Birth: Home Phone #
Social Security # Work Phone #
Email Address Cell Phone #

- Please Indicate: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Domestic Partner
- Race: ☐ African/American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Native Hawaiian ☐ Other ☐ Refuse to Answer
- What is your preferred language?
- Please Indicate Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Refuse to Answer
- Height: Weight:
- Referring Physician:
- Allergies or reactions:
- Please state your personal priority and goal for vein treatment:
- **Your Primary Doctor's Name**:
  Group Name:
  Address:
  Phone:
- **Your Pharmacy**
  Address:
  Phone:
- **Your Employer**
  Address:

Primary Insurance Information

Insurance Company
Patient ID # Group # Effective Date
Subscriber/Cardholder Name Subscriber DOB
Subscriber SS# Relationship to Patient
Address (if different from patient)
Phone #

Secondary Insurance Information

Insurance Company
Patient ID # Group # Effective Date
Subscriber/Cardholder Name Subscriber DOB
Subscriber SS# Relationship to Patient
Address (if different from patient)
Phone #

It is the policy of this practice that any fees or co-payments are due and payable at the time of each visit. By signing below, you agree to be financially responsible for all bills incurred that are not covered or paid by insurance, as determined by your insurance company, while receiving care at this office. As a courtesy, insurance billing is provided for all plans in which the practice is a participating member. We do not participate in NJ Medicaid and you will be balance billed for all costs after payment from primary insurance. By signing below, you agree that all insurance payments be made directly to Dr. Stuart H. Miller. It is the patient's responsibility to provide his/her current insurance card and obtain and keep current referrals for each visit and to notify us of all changes in coverage. There will be an additional $50 collection fee for all outstanding balances sent to an outside collection agency. The entire balance is the responsibility of the guarantor and delinquent accounts will be assessed at an interest rate of 1.5% monthly. If your account is turned over to collections, all costs incurred for collection, attorney, court, etc. will be your responsibility. By signing below, you authorize the use of this signature on all insurance submissions and on all legal submissions/medical records to an attorney, law enforcement representative and doctors or facilities that may also be involved in your medical care.

Signature Date
(if under 18 years of age, a parent or guardian must sign for patient)

OVER

Patient Responsibility
For Follow-Up Care Pledge

I, (please print name), hereby acknowledge and understand that even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations by doctors are followed completely in order to increase the likelihood of a positive and healthy treatment and/or outcome. I acknowledge and understand that if any physician in this office prescribes medicine to me that the proper taking of any such medication shall by my sole responsibility (or my guardian who has attending this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my doctor.

I understand that if a doctor in this office refers me to another doctor or receive another test including, but not limited to: blood test, MRI, CT scan, this timely recommendation is important and essential to the ultimate success of my treatment and/or outcome. I understand that is not possible for any person in this office to constantly follow-up to ensure that I have followed these recommendations. Therefore, I understand that if I fail to see that specialist or obtain the test for which I was referred immediately, this can risk my current health or increase future health risks.

I understand that it is solely my responsibility to follow the medical advice given by any medical person in this office. I also understand that any bad health outcome from my failure to follow the advice of my doctors should be expected.

Patient or Guardian Signature Today's Date

****

MEDICARE PATIENTS ONLY

"I request that payment of all authorized Medicare benefits be made either to me or on my behalf to this office for any services furnished by that physician to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services."

Patient (or authorized) Name

Patient (or authorized) Signature

Health Insurance Claim Number (Medicare ID)

Date

390 Route 10 West, North Building Suite 102
Randolph, NJ 07869
Stuart H. Miller, M.D.

PAYMENT AGREEMENT

Thank you for choosing our practice! First and foremost, we are committed to the success of your medical treatment and plan of care. Please understand that payment of your bill is part of this treatment and care.

OFFICE VISITS & OFFICE SERVICES
Patient's health insurance plans state that payment for copays is to be collected for office visits at time of service. If you do not have your copay for your visit, we can reschedule your appointment.

DO YOU NEED A REFERRAL?
Current referrals are necessary for ongoing care. If you have a plan that requires referrals, it is your responsibility to contact your Primary Care Physician and have referral sent to our office. If a referral is needed for your appointment, you may contact your PCP to request the referral be faxed to our office or you can bring the hardcopy provided by your primary doctor. We will not be able to keep your appointment if the required referral is not received and will need to reschedule your appointment.

PATIENT CANCELLATION AGREEMENT
This office requires twenty-four (24) hours notice for all patients cancelling office visits, new patient appointments and consults. If our office does not receive a minimum of twenty-four (24) hours notice, you will be charged $25 for the missed appointment or consult. This charge is not eligible to be submitted to your insurance. It will be billed directly to your account.

SURGERY
Our office will complete any pre-certification or authorization that may be required by your insurance company. We will review any deductibles and out of pocket expenses you will be responsible for as outlined by your insurance plan. We cannot assume that your deductible has been met. We will submit all charges to insurance for payment. However, please keep in mind that any calculated amount is an estimated cost. Unfortunately, there is always the possibility that after your insurance pays its portion, you may have a balance due towards copay, coinsurance or deductible. If your insurance denies payment on a surgical procedure, a flat rate fee will be applied and will be your responsibility.

DURABLE MEDICAL EQUIPMENT
At the time of your visit, the doctor may suggest a brace or support. If you purchase durable medical equipment from our office, all sales are final. There can be no returns or exchanges.

HOW MAY I PAY?
We accept payment by Cash, Cashier's Check, Visa, MasterCard, Discover, American Express or Diner's Club

ACKNOWLEDGEMENT
I have read, understand and agree to the above Payment Agreement. I understand that my co-payment is due and payable at the time of service. I understand that charges not covered by my insurance company as well as applicable copayments, coinsurances and deductibles are my responsibility.

- In the event that outside collection and/or legal costs are incurred by this office to obtain payment due, responsible party agrees that they will be liable for any costs incurred.
- I authorize my insurance benefits to be paid directly to **The New Jersey Vein and Vascular Center**

_____	_____	_____
Printed Name of Patient	Signature of Patient or Guardian	Date