

Dear Patient,

You have recently scheduled a consultation with Dr. Kass at the Twin Cities Vein & Laser Clinic. Enclosed are the Varicose & Spider Vein Information Packet, which you might have previously received, and other forms for you to complete prior to your visit.

We encourage you to read the Varicose & Spider Vein Information Packet since it contains most, if not all, of your questions and concerns and is a pertinent part of your consultation.

You must complete the Demographics & Patient Questionnaire prior to your visit as completely as possible or arrive 30 minutes early.

Failure to do so will shorten the time of your consultation and will not provide Dr. Kass with the information he needs to evaluate you.

In addition, you will need to bring a pair of loose fitting shorts to change into for the examination. The shorts should enable examination in the groin area.

At this consultation Dr. Kass will determine the severity of your problem and will then inform you of your treatment options and whether or not you will need a more extensive workup and/or diagnostics. Most will not require the additional workup and will be able to begin treatment at their next appointment. Please do not bring children to this exam.

If you have any further questions, feel free to contact the office at 952-926-3311.

Thank you,

Twin Cities Vein & Laser Clinic

Appointment Date: _____, _____

Appointment Time: _____

IMPORTANT: Our introductory consultation is complimentary. A valid credit card to secure your appointment is required. **A missed appointment or cancellation/rescheduling without 72 hours notification will incur a \$25 charge to your credit card.** If one wishes to reschedule their appointment and did not provide 72 hours notice, there is a \$75 non-refundable charge for the consultation.

Twin Cities Vein & Laser Clinic

Patient Information

| | | | | |
|---|--|-----------------------|--------------------------------------|-----------------------|
| Patient Name (Last - First - Middle) Mr. Dr. Ms. Mrs. | | Gender M F | Date of Birth | Social Security No. |
| Address (street - City - State - Zip) | | Home Phone No. () | | Work Phone No. () |
| City, State, Zip | | Employer | | Occupation |
| In Case of Emergency, Notify | | | Emergency Contact's Phone No. () | |
| Family Physician | | | Physician's Phone No. () | |
| How Did You Hear About Us? NEWSPAPER ___ INTERNET ___ BILLBOARD ___ YELLOW PAGES ___ DOCTOR ___ Patient ___ Other _____ | | | E-Mail _____ | |

Insurance Information

| | | | | |
|--|--|-------------------------|---------------|-----------------------|
| We cannot guarantee insurance coverage by your insurance carrier. The information below will assist us in determining if some of the expenses are reimbursable by your HMO or insurance carrier. Please give your insurance card to our receptionist to be copied. | | | | |
| Primary Insurance Carrier | | ID # | Group # | Social Security No. |
| Name of Insured | | Relationship to Insured | Date of Birth | Gender M F |
| Address (street - City - State - Zip) | | Home Phone No. () | | Work Phone No. () |
| City, State, Zip | | Employer | | Occupation |
| Secondary Insurance Carrier | | ID # | Group # | Social Security No. |
| Name of Insured | | Relationship to Insured | Date of Birth | Gender M F |
| Address (street - City - State - Zip) | | Home Phone No. () | | Work Phone No. () |
| City, State, Zip | | Employer | | Occupation |

Authorizations & Releases

| | |
|--|--|
| Initial | |
| | I certify the above information is true and correct to the best of my knowledge. I certify that I (or my dependent) have insurance coverage and assign directly to Twin Cities Vein & Laser Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand and agree that I am ultimately responsible for payment – and that at this time services rendered may not be covered by my insurance. I understand that I am financially responsible for all charges whether or not paid by insurance. |
| | I authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. |
| | I have received a copy of the Payment/Cancellation Policy. |
| <div style="display: flex; justify-content: space-between; margin-top: 10px;"> _____ _____ _____ </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> Patient / Responsible Party Signature Relationship Date </div> | |

Demographics



VARICOSE & SPIDER VEIN PATIENT QUESTIONNAIRE

(PLEASE FILL OUT AS COMPLETELY AS POSSIBLE)

NAME _____ DATE _____
AGE _____ GENDER _____

How Did You Hear About Us:

NEWSPAPER _____ INTERNET _____ BILLBOARD _____
YELLOW PAGES _____ DOCTOR _____ PATIENT _____
OTHER _____

HPI:

1. AT WHAT AGE DID YOUR VEINS OCCUR? _____

BEFORE PREGNANCY _____ DURING PREGNANCY _____
AFTER BIRTH CONTROL OR ESTROGEN THERAPY _____ AFTER TRAUMA _____
OTHER (PLEASE EXPLAIN) _____

2. HAVE YOU EVER BEEN EVALUATED FOR THIS PROBLEM? _____ IF SO, WHEN? _____ BY WHOM? _____

3. HAVE YOU HAD TESTS DONE FOR THIS PROBLEM? _____ IF SO, WHEN? _____ BY WHOM? _____

WHAT TESTS: _____

4. HAVE YOU EVER BEEN TREATED FOR THIS PROBLEM (YES/NO) ? _____ WITH WHAT METHOD?
INJECTION _____ # TIMES? _____ WHEN? _____
ELECTROCAUTERY _____ # TIMES? _____ WHEN? _____
LASER _____ # TIMES? _____ WHEN? _____
VEIN SURGERY _____ # TIMES? _____ WHEN? _____
WERE YOU SATISFIED WITH RESULTS (YES/NO)? _____

DESCRIBE PROCEDURE: _____

5. ARE YOU DEVELOPING NEW VEINS (YES/NO)? _____ ARE YOUR VEINS GETTING BIGGER/LONGER (YES/NO)? _____

6. INDICATE WHICH OF THE FOLLOWING PROBLEMS YOU HAVE EXPERIENCED:

| A) PAIN OR TENDERNESS IN YOUR: | L LEG | R LEG | # OF YEARS |
|--------------------------------|-------|-------|------------|
| • THIGH | _____ | _____ | _____ |
| • CALF | _____ | _____ | _____ |
| • LOWER LEG (BELOW KNEE) | _____ | _____ | _____ |
| • FOOT | _____ | _____ | _____ |
| B) SWELLING OF THE LEGS | _____ | _____ | _____ |
| C) SKIN OR ULCER PROBLEMS | _____ | _____ | _____ |
| D) OTHER: _____ | _____ | _____ | _____ |

7. IF YOU EXPERIENCE PAIN IN YOUR LOWER LIMBS: **(VERY IMPORTANT TO BE ACCURATE)**

| A) INDICATE THE TYPE OF PAIN | L LEG | R LEG |
|------------------------------|-------|-------|
| • ACHING | _____ | _____ |
| • AGONIZING | _____ | _____ |
| • BURNING SENSATION | _____ | _____ |

- | | L LEG | R LEG |
|-----------------------------------|-------|-------|
| • CONSTANT | _____ | _____ |
| • DULL | _____ | _____ |
| • GNAWING | _____ | _____ |
| • HEAVINESS IN LEGS | _____ | _____ |
| • INTERFERES WITH NORMAL FUNCTION | _____ | _____ |
| • ITCHING | _____ | _____ |
| • NIGHT CRAMPS | _____ | _____ |
| • NUMBNESS | _____ | _____ |
| • RESTING CRAMPS | _____ | _____ |
| • RESTING PAIN | _____ | _____ |
| • RESTLESS LEGS | _____ | _____ |
| • TENDER | _____ | _____ |
| • THROBBING | _____ | _____ |
| • TIREDNESS/FATIGUE | _____ | _____ |
| • ADDITIONAL COMMENTS: | _____ | |

- | B) DESCRIBE THE CONDITIONS BELOW: | IMPROVES | WORSENS | DOESN'T CHANGE |
|---|----------|---------|----------------|
| • EXTENDED PERIODS IN STANDING POSITION | _____ | _____ | _____ |
| • WARM WEATHER | _____ | _____ | _____ |
| • COLD WEATHER | _____ | _____ | _____ |
| • MENSTRUAL PERIODS | _____ | _____ | _____ |
| • EXERCISING AND /OR WALKING | _____ | _____ | _____ |
| • ELEVATION OF LIMBS | _____ | _____ | _____ |
| • ELASTIC STOCKINGS | _____ | _____ | _____ |
| • OTHER: | _____ | | |

- | 8. IN THE COURSE OF A NORMAL DAY, HOW MUCH TIME IS SPENT: | STANDING | SITTING |
|---|----------|---------|
| A) 10% OF THE DAY | _____ | _____ |
| B) 20% OF THE DAY | _____ | _____ |
| C) 30% TO 50% OF THE DAY | _____ | _____ |
| D) MORE THAN 50% | _____ | _____ |

- | 9. DOES YOUR WORK REQUIRE: | Yes |
|----------------------------|-------|
| A) PROLONGED STANDING | _____ |
| B) PROLONGED SITTING | _____ |

10. DO YOU EXERCISE REGULARLY? (Yes/No) _____

11. DO YOU WEAR ELASTIC SUPPORT STOCKINGS? (Yes/No) _____

IF SO, WHAT KIND? _____ HOW OFTEN? _____ DO THEY HELP? _____

12. OVERALL, DO YOU FEEL YOUR CONDITION IS (CIRCLE ONE): **IMPROVING** **WORSENING** **NO CHANGE**

13. INDICATE THE DATE OF YOUR LAST PHYSICAL EXAM _____

14. HEIGHT _____ WEIGHT _____

ALLERGIES:

1. DO YOU HAVE ANY ALLERGIES TO **MEDICATIONS OR OTHER** (PLEASE LIST)?
- | | PLEASE DESCRIBE REACTION |
|---|--------------------------|
| A) _____ | _____ |
| _____ | _____ |
| b) ALLERGY TO ADHESIVE TAPE | _____ |
| c) ALLERGY TO LATEX | _____ |
| d) ALLERGY TO POLIDOCANOL (AETHOXYSCLEROL) | _____ |
| e) ALLERGY TO ALCOHOL | _____ |

| | YES | WHEN? |
|------------------------------------|------------|--------------|
| NEUROLOGIC DISORDERS | _____ | _____ |
| PARALYSIS | _____ | _____ |
| PERIPHERAL VASCULAR DISEASE | _____ | _____ |
| PULMONARY DISORDERS | _____ | _____ |
| RAYNAUD'S | _____ | _____ |
| RHEUMATIC HEART DISEASE OR FEVER | _____ | _____ |
| SEIZURES OR CONVULSIONS (EPILEPSY) | _____ | _____ |
| SKIN DISEASE | _____ | _____ |
| STROKE | _____ | _____ |
| THYROID DISEASE | _____ | _____ |

PLEASE DESCRIBE ANY OF THE ABOVE "YES" ANSWERS _____

4. DO YOU HAVE ANY OTHER PRESENT ILLNESS WE SHOULD BE AWARE OF? (Yes/No) _____
 IF SO, WHAT? _____

5. HAVE YOU EVER HAD ANY MISCARRIAGES (NOT ABORTIONS)? (Yes/No) _____ IF SO, HOW MANY? _____

SURGIAL HISTORY:

HAVE YOU EVER HAD ANY SURGERY? (Yes/No) _____ IF SO, WHAT & WHEN? _____

FAMILY HISTORY:

DOES ANYONE IN YOUR FAMILY HAVE? (PLEASE INDICATE FAMILY MEMBER)

| | YES | FAMILY MEMBERS |
|--------------------------------------|------------|-----------------------|
| • VARICOSE VEIN PROBLEMS | _____ | _____ |
| • PHLEBITIS (INFLAMMATION OF A VEIN) | _____ | _____ |
| • BLOOD CLOTS | _____ | _____ |
| • LEG ULCERS | _____ | _____ |

SOCIAL HISTORY:

1. DO YOU SMOKE? (Yes/No) _____ IF SO, HOW MUCH? _____
2. ARE YOU PREGNANT? (Yes/No) _____
3. ARE YOU PLANNING A PREGNANCY SOON? (Yes/No) _____ IF SO, WHEN? _____
4. ARE YOU PRESENTLY BREASTFEEDING? (Yes/No) _____

OTHER HISTORY:

| DO YOU CURRENTLY HAVE OR ARE EXPERIENCING: | YES | WHEN? |
|--|------------|--------------|
| ANEMIA | _____ | _____ |
| ASTHMA ATTACK RECENTLY | _____ | _____ |
| BLEEDING PROBLEMS, TENDENCIES | _____ | _____ |
| BRUISE EASILY | _____ | _____ |
| CALF PAIN | _____ | _____ |
| CHEST PAIN OR PRESSURE | _____ | _____ |
| CLOTTING DISORDERS | _____ | _____ |
| PAIN OR CRAMPING WHEN WALKING | _____ | _____ |
| CONVULSIONS | _____ | _____ |
| DIFFICULTY HEALING | _____ | _____ |
| ELEVATED BLOOD PRESSURE | _____ | _____ |

| | YES | WHEN? |
|--|------------|--------------|
| FAINTING OR DIZZY SPELLS | _____ | _____ |
| FATIGUE | _____ | _____ |
| HEART PALPITATIONS | _____ | _____ |
| HEPATITIS B CARRIER | _____ | _____ |
| LEG SWELLING | _____ | _____ |
| NUMBNESS | _____ | _____ |
| PACEMAKER | _____ | _____ |
| PARALYSIS | _____ | _____ |
| RACING HEART | _____ | _____ |
| RASH | _____ | _____ |
| SHORTNESS OF BREATH AT REST OR ON EXERTION | _____ | _____ |
| SORES | _____ | _____ |
| WHEEZING | _____ | _____ |

9. ARE YOU PRESENTLY UNDER THE CARE OF A PHYSICIAN BESIDES ROUTINE VISITS? (YES/NO) _____
 IF YES, PLEASE EXPLAIN: _____

MISCELLANEOUS

IS THERE ANY ADDITIONAL INFORMATION THAT YOU WOULD CONSIDER PERTINENT?

FOR DOCTOR USE ONLY:

PLAN:

- ROUTINE SCLERO APPROX. 1-2 Tx's 2-3 Tx's 2-4 Tx's 3-4 Tx's 3-5 Tx's 4-6 Tx's >5 Tx's
- FULL WORKUP
- ULTRASOUND
- D-PPG
- PHLEBECTOMY
- REFERRED OUT

FINDINGS:

- OUT-OF-NETWORK STATUS DISCUSSED
- PROCEDURE FEES DISCUSSED
- INSURANCE REIMBURSEMENT CHARGE SHEET GIVEN



PAYMENT/CANCELLATION POLICY*

Effective (7/1/2005)

The following is the Payment/Cancellation Policy for our clinic. Time, staff and great expense have been invested to provide you with the personal care one does not typically receive in today's healthcare environment. Missed appointments or appointments cancelled/rescheduled on short notice (regardless of the reason) cause a significant expense to our practice and inconvenience to other patients who could have been scheduled. We hope you understand the need for such a policy.

Introductory Consultation:

Our introductory consultation is complimentary. A valid credit card to secure your appointment is required. **A missed appointment or cancellation/rescheduling without 72 hours notification will incur a \$25 charge to your credit card.** If one wishes to reschedule their appointment and did not provide 72 hours notice, there is a \$75 non-refundable charge for the consultation.

Complete Consultation + Diagnostics:

A deposit of \$350 is taken at the time of scheduling to secure your appointment. The remainder of payment is made at the conclusion of your exam. **Failure to show for your appointment or cancellation/rescheduling without 72 hours notification will forfeit your deposit.**

Ultrasound:

A deposit of \$75 is taken at the time of scheduling. **Failure to show for your appointment or cancellation/rescheduling without 72 hours notification will forfeit your deposit.**

Sclerotherapy:

A deposit of \$75 is taken at the time of scheduling. **Failure to show for your appointment or cancellation/rescheduling without 72 hours notification will forfeit your deposit.**

VNUS™ Closure:

A deposit is typically taken which may vary depending on your deductible and/or copay. Several hours is reserved for you. **Failure to show for your appointment or cancellation/rescheduling without 72 hours notification will forfeit your deposit.**

Other Procedures:

These costs may vary and require a deposit to reserve your appointment. **Failure to show for your appointment or cancellation/rescheduling without 72 hours notification will forfeit your deposit.**

*MN Care Tax is added. These policies might differ for Blue Cross patients. These rates and policies may change.

over

Payment Cancellation Policy.doc

Late Arrivals:

We strive to be timely with our appointments, rarely there is a slight delay. Please plan your arrival accordingly to allow for weather, traffic, etc. If you show up late for your appointment or your paperwork is not completed prior to your arrival it will most likely result in your appointment being shortened or cancelled.

Appointment Reminders:

As a courtesy we will give you a reminder call unless notified otherwise. Regardless, this is a courtesy call and your appointment is your responsibility.

Payment:

We accept cash, check, VISA, Mastercard or Discover.

Late Payment:

Any outstanding balance will incur a 1.5% monthly late charge that will be added to your bill. Typically we do not begin billing you until all insurance payments have been received.

Insurance:

In many cases your insurance may cover all or a portion of the consultation, diagnostics and procedures, however we cannot guarantee this and you are responsible for payment at the time of service. As a courtesy, we will file a claim to your carrier for any visit that may be reimbursable. Since **we are out of network**, except for Blue Cross, we do not have access to your carrier to determine your benefits, but will provide you with the necessary information to determine them yourself. Most policies allow for out-of-network visits, but typically have slightly higher copays. Deductibles vary between policies and are always the patient’s responsibility. **We are also not a Medicare participant and therefore cannot accept patients if Medicare is their primary insurance.**

We hope your experience at the Clinic is favorable. We have made many efforts to provide you with a quality of care not seen in today’s healthcare environment. If you have any concerns, do not hesitate to bring them to our attention.

Dr. Kass and Staff
Twin Cities Vein & Laser Clinic

Signature:

Date:

I have received a copy of this policy.

*MN Care Tax is added. These policies might differ for Blue Cross patients. These rates and policies may change.

over