HAMILTON VEIN CENTER

A LEADER IN VEIN TREATMENT

How did you hear about us?

- ☐ Physician referral:_____
- ☐ Magazine ad: _____
- ☐ Friend/ Family:_____
- ☐ Radio ad:_____
- ☐ Other:_____
- ☐ Newspaper ad:_____
- ☐ Television News Show:_____
- ☐ Website:_____
- ☐ Facebook:_____
- ☐ Television ad:_____

I. PATIENT INFORMATION:

Name:_____ Date of Birth:_____Sex:_____

Language:_____ Race:_____ Ethnicity: _____

Home Address:_____

City:_____ State:_____ Zip:_____ Marital Status_____

Home Phone #:_____ SS #:_____

Employer:_____ Work #:_____

Work Address:_____ City:_____ State:_____ Zip:_____

Cell Phone #:_____ Voice Mail: Y - N

Best Contact: Home / Work / Cell / Email Email:_____

Emergency Contact:_____**Relationship:**_____**Phone#**_____

By providing an email you agree to receive updates, news, and general information from Hamilton Vein Center. We respect your right to privacy and will not share your information.

II. INSURANCE INFORMATION:

(Primary) **Please complete if other than self**

Insurance Co.:_____

Policy#:_____

Group #:_____

Name of Guarantor:_____

Insured's Date of Birth:_____

Insured's ID or SS:_____

Employer(if group policy)_____

(Secondary)**Please complete if other than self**

Insurance Co.:_____

Policy#:_____

Group #:_____

Name of Guarantor:_____

Insured's Date of Birth:_____

Insured's ID or SS:_____

Employer(if group policy)_____

PAYMENT OF BENEFITS

I direct payment to Dr. Carlos R. Hamilton III of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described, but not to exceed the reasonable and customary charges for those services.

_____ _____

Signed (Insured Person) Date

RELEASE OF INFORMATION

I hereby authorize Hamilton Vein Center to release any information acquired in the course of my examination or treatment.

_____ _____

Signed (Patient) Date

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Patient Name:_____Referring Physician: _____

Primary Care Doctor: _____Primary Care Clinic Name: _____

Pharmacy: _____Pharmacy Phone: (_____) _____-_____

Vascular History

Place an "x" if you have any of the following:

__Red/purple spider veins __Skin discoloration below knee

__Abdominal veins __Bulging veins __Other:_____

__Leg ulcers/Open wounds __Diagnosed with vein disease _____

Years with varicose veins/spider veins____

Years with venous ulcers/open wounds____

Place an "x" if you have any of the following:

__Ache or hurt __Swelling __Itching

__Become restless __Heaviness __Pelvic Pain

__Ankle skin changes __Cramping __Tiredness/fatigue in leg

__Bleeding from veins __Burning __Other_____

Please check any factors that **aggravate** your leg discomfort:

__Prolonged standing __Exercise __Sexual Intercourse

__ Prolonged sitting __Tender to touch __Other: _____

__Around/during Menstrual Cycle __ Pregnancy _____

Please check any methods you have used to **relieve** your leg discomfort:

__No discomfort __Cold packs

__Compression hose/Leg wraps __Massage

__Exercise __Pain medications

__Leg elevation __ Other: _____

__Warm soaks/heating pad

Have you ever worn compression stockings? Yes ☐ No☐

If so, Stockings prescribed by: _____When? _____How long? _____

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Have you been treated for your leg veins before? Yes ☐ No ☐
By whom? _____When? _____

- If so, By which of the following methods :

__Cosmetic injections
__Radiofrequency closure
__Laser for spider vein
__Stripping
__Ambulatory Phlebotomy
__Ultrasound guided injections
__Laser catheter ablation
__Ligation:
__Other:_____
__Unknown

What was the outcome? _____
What would you like to correct most about your legs? _____
_____

Are you currently on or have been prescribed blood thinners? Yes ☐ No ☐

- **If yes, for how long? _____**

Current Medication(s) (no need to record dosage)

Allergies to medications ☐ No ☐ Yes (if yes please cite below) Reaction

Past Medical History

Place an "x" if you have any of the following medical illnesses:

__COPD
__HIV or AIDS
__Arthritis
__Asthma
__Patent Foramen Ovale (Hole in heart)
__Bleeding disorder
__Cancer
__Pace Maker
__Atrial Fibrillation (irregular heartbeat)
__Blood transfusions
__Clot in lungs (PE)
__Clot in legs (DVT)
__Depression
__Diabetes
__Dialysis
__Heart attack (MI)
__High blood pressure
__High cholesterol
__Stroke
__Kidney problems
__Lupus
__Hepatitis B
__Hepatitis C
__Thyroid disease
__Migraines

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Please list any surgeries that you have had:

Please indicate if you have a **FAMILY** history of varicose or spider veins?

__Mother __Father __Maternal Grandmother __Maternal Grandfather
__Brother __Sister __Children __Paternal Grandmother __Paternal Grandfather

FAMILY history of blood clots? Yes ☐ No ☐

Females Only

Are you pregnant or planning on becoming pregnant soon? Yes ☐ No ☐

Are you currently breastfeeding? Yes ☐ No ☐

Do you have more leg discomfort on or around your menstrual cycle? Yes ☐ No ☐

Number of children_____ Number of miscarriages_____

Social History

Occupation: _____

Do your daily activities require prolonged periods of standing/sitting? Yes ☐ No ☐

- If yes, what activity requires prolonged periods of standing/sitting?
  _____

Do you now or have your ever used tobacco? Yes ☐ No ☐ Packs per week_____

- Quit date, if applicable_____

Average number of alcoholic beverages per week:

None ☐ 1-5☐ 6-10☐ 10+☐

Notice of Privacy Practices for Protected Health Information (PHI)

HAMILTON VEIN CENTER

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

Effective date: September 23, 2013

The Practice of Hamilton Vein Center is required by applicable federal and state laws to maintain the privacy of your health information. Protected health information (PHI) is the information we create and maintain in the course of providing our services to you. Such information may include documentation of your symptoms, examination and test results, diagnoses and treatment protocols. It also may include billing documents for those services. We are permitted by federal privacy law (the Health Insurance Portability & Accountability Act of 1996 (HIPAA)), to use and disclose your PHI, without your written authorization, for purposes of treatment, payment, and health care operations.

Examples of Using Your Health Information for Treatment Purposes:

- Our nurse obtains treatment information about you and records it in your medical record.
- During the course of your treatment, the physician determines he will need to consult with a specialist. He will share the information with the specialist and obtain his/her input.
- We may contact you by phone, at your home, if we need to speak with you about a medical condition or to remind you of medical appointments.

Example of Using Your Health Information for Payment Purposes:

- We submit requests for payment to your health insurance company. We will respond to health insurance company requests for information about the medical care we provided to you.

Example of Using Your Information for Health Care Operations:

- We may use or disclose your PHI in order to conduct certain business and operational activities, such as quality assessments, employee reviews, or student training. We may share information about you with our Business Associates, third parties who perform these functions on our behalf, as necessary to obtain their services. Your health information is also subject to electronic disclosure for treatment, payment and health care operations.

Your Health Information Rights

The health and billing records we maintain are the physical property of the Practice. The information in them, however, belongs to you. You have a right to:

- Obtain a paper copy of our current Notice of Privacy Practices for PHI ("the Notice");
- Receive Notification of a breach of your unsecured PHI (i.e., PHI that is not electronically encrypted);
- Request restrictions on certain uses and disclosures of your health information. We are not required to grant most requests, but we will comply with any request with which we agree. We will, however, agree to your request to refrain from sending your PHI to your health plan for payment or operations purposes if at the time an item or service is provided to you, you pay in full and out-of-pocket and the disclosure is not otherwise required by law;
- Request inspection and copying the information about you that we maintain in the Practice's designated record set. You may exercise this right by delivering your request, in writing, to our Practice;
- Appeal a denial of access to your PHI, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our Practice. We may deny your request if you ask us to amend information that (a) was not created by us (unless the person or entity that created the information is no longer available to make the amendment), (b) is not part of the health information kept by the Practice, (c) is not part of the information that you would be permitted to inspect and copy, or (d) is accurate and complete. If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be placed in your record;
- Request that communication of your health information be made by alternative means or at alternative locations by delivering a written request to our Practice;
- To opt-out of any future fundraising communications if we engage in fundraising activities and contact you to raise funds for our Practice;
- Obtain a list of instances in which we have shared your health information with outside parties, as required by the HIPAA Rules;
- Revoke any of your prior authorizations to use or disclose information by delivering a written revocation to our Practice (except to the extent action has already been taken based on a prior authorization).

Our Responsibilities

The Practice is required to:

- Maintain the privacy of your health information as required by law;
- Notify you of a breach of your unsecured PHI;
- Provide you with a notice ('Notice') describing our duties and privacy practices with respect to the information we collect and maintain about you and abide by the terms of the Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,

- Accommodate your reasonable requests regarding methods for communicating with you about your health information and comply with your written request to refrain from disclosing your PHI to your health plan if you pay for an item or service we have provided in full and out-of-pocket at the time of service.

We reserve the right to amend, change, or eliminate provisions of our privacy practices and to enact new provisions regarding the PHI we maintain about you. If our information practices change, we will amend our Notice. You are entitled to receive a copy of the revised Notice upon request by phone, by visiting our website or Practice.

Other Uses and Disclosures of your PHI

Communication with Family

- Using our best judgment, we may disclose health information to a family member, other relative, close personal friend, or any other person you identify, relevant to that person's involvement in your care or payment for your care (if you do not object) or in an emergency. We may also do this after your death, unless you tell us before you die that you do not consent to our communication with certain individuals.

Notification

- Unless you object, we may use or disclose your PHI to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care about your location, your general condition or your death.

Research

- We may disclose information to researchers if an institutional review board has reviewed the research proposal and established protocols to ensure the privacy of your PHI. We may also disclose your information if the researchers require only a limited portion of your information.

Disaster Relief

- We may use and disclose your PHI to assist in disaster relief efforts.

Organ Procurement Organizations

- Consistent with applicable law, we may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation/transplant.

Food and Drug Administration (FDA)

- We may disclose to the FDA your PHI relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers' Compensation

- If you are seeking compensation from Workers Compensation, we may disclose your PHI to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

- We may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury or disability; to report reactions to medications or problems with products; to notify people of recalls; or to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

As Required by Law

- We may disclose your PHI as required by law, or to appropriate public authorities as allowed by law to report abuse or neglect.

Employers

- We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of the release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of information to your employer.

Law Enforcement

- We may disclose your PHI to law enforcement officials (a) in response to a court order, court subpoena, warrant or similar judicial process; (b) to identify or locate a suspect, fugitive, material witness, or missing person; (c) if you are a victim of a crime and we are unable to obtain your consent; (d) about criminal conduct on our premises; and (e) in other limited emergency circumstances where we need to report a crime.

Health Oversight

- Federal law allows us to release your PHI to appropriate health oversight agencies or for health oversight activities such as state and federal auditors.

Judicial/Administrative Proceedings

- We may disclose your PHI in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

For Specialized Governmental Functions or Serious Threat

- We may disclose your PHI for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, to public assistance program personnel or to avert a serious threat to health or safety. We may disclose your PHI consistent with applicable law to prevent or diminish a serious, imminent threat to the health or safety of a person or the public.

Correctional Institutions

- If you are an inmate of a correctional institution, we may disclose to the institution or its agents the PHI necessary for your health and the health and safety of other individuals.

Coroners, Medical Examiners, and Funeral Directors

- We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about our patients to funeral directors as necessary for them to carry out their duties.

Website

- You may access a copy of this Notice electronically on our website.

Other uses and disclosures of your PHI not described in this Notice will only be made with your authorization, unless otherwise permitted or required by law. Most uses and disclosure of psychotherapy notes, uses and disclosures of your PHI for marketing purposes, and disclosures of your PHI that constitute a sale of PHI will require your authorization. You may revoke any authorization at any time by submitting a written revocation request to the Practice (as previously provided in this Notice under "Your Health Information Rights.")

To Request Information, Exercise a Patient Right, or File a Complaint

If you have questions, would like additional information, want to exercise a Patient Right described above, or believe your (or someone else's) privacy rights have been violated, you may contact the Practice's Privacy Officer at (281) 565-0033, or in writing to us at:

Privacy Officer
Hamilton Vein Center
4690 Sweetwater Blvd, Suite 113
Sugarland, TX 77479

Please note that all complaints must be submitted in writing to the Privacy Officer at the above address. You may also file a complaint with the Secretary of Health and Human Services (HHS), Office for Civil Rights (OCR). Your complaint must:

1. Be filed in writing, either electronically via the OCR Complaint Portal, or on paper by mail, fax, or e-mail (OCRComplaint@hhs.gov);
2. Name the covered entity or business associate involved and describe the acts or omissions you believe violated the requirements of the Privacy, Security, or Breach Notification Rules; and
3. Be filed within 180 days of when you knew that the act or omission complained of occurred.

The address for the Texas regional office is: Office for Civil Rights, U.S. Department of Health and Human Services, 1301 Young Street, Suite 1169, Dallas, TX 75202; or call (800) 368-1019. More information regarding the steps to file a complaint can be found at: www.hhs.gov/ocr/privacy/hipaa/complaints.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of HHS as a condition of receiving treatment from the Practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of HHS.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with a copy of the Practice's Notice of Privacy Practices.

_____

Print Name

_____ _____

Patient (or Patient Representative*) Signature Date

For Practice Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify):

*If Patient Representative is signing, legal documentation must be included designating authority to sign or receive information. This form must be maintained for 6 years.