O'DONNELL
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## PATIENT INFORMATION

Name: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Home Address: _____ City: _____ State_____ ZIP: _____

Social Security #: _____ Marital Status: Single Married Divorced Widowed

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

How did you hear about us?: _____

HIPPA Choices:

Did you receive a copy of the HIPAA notice? YES _____ NO _____ Allow Voice Msg? YES _____ NO _____

Allow SMS (text message)? YES _____ NO _____ Allow postal mail? YES _____ NO _____

Occupation: _____ Employer: _____

Language: _____ Race/Ethnicity: _____

Primary Health Insurance Name: _____ ID#: _____

Group #: _____ Subscriber: Self _____ Spouse _____ Other _____

Subscriber's Name: _____ DOB: _____

Secondary Health Insurance Name: _____ ID#: _____

Group #: _____ Subscriber: Self _____ Spouse _____ Other _____

Subscriber's Name: _____ DOB: _____

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Patient Name: _____

Height: ____' ____" Weight: _____ Gender: Male Female

Reason for Visit: _____

_____

Chief Complaint:

| | | |
|---|---|---|
| ____Aching | ____Fatigue | ____Ulcers |
| ____Awakened at night | ____Heaviness | ____Varicose veins |
| ____Bleeding from veins | ____Itching | ____Spider veins |
| ____Burning | ____Pain | ____Skin discoloration |
| ____Cramping | ____Restless legs | Other: _____ |
| ____Diff. healing wounds | ____Swelling | _____ |

Which Leg: Right Left Both How long: _____

Ulcer on Leg: No Yes: which leg? _____ for how long? _____

Timing of Symptoms: ____Intermittently ____Mostly at night ____Only during daytime

____All day ____While laying down ____Bedtime ____Other: _____

How do these symptoms affect your activities of daily living?

Work: _____
Daily Chores: _____
Care for Family: _____
Travel: _____
Walking/Exercising: _____
Other: _____

Symptoms made worse by:
____Walking ____Exercise ____Prolonged Standing ____Prolonged Sitting ____Leg Elevation ____Heat
____Premenstrual ____Pregnancy ____Travel ____Other: _____

Symptoms made better by:
____Resting: how often? _____ ____Leg Elevation ____Standing ____Sitting
____Walking ____Exercise ____ Heat ____Other: _____

Conservative Therapy: (please check any of the conservative therapy measures you have tried)
____Compression Stockings ____Elevation ____Weight Reduction ____Exercise
____Avoiding Prolonged Sitting/Standing ____Tylenol/Motrin ____Other: _____

How long have you been using conservative measures? _____

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**Vein History**

**Past Vein Procedures:**

_____

_____

**Past Vein History:** ____DVT ____PAD ____Leg Ulcers Other: _____

**Are you on any blood thinners?** YES NO If yes, what? _____

**Past Medical History:**

____CAD ____High Cholesterol ____High Blood Pressure ____Gout ____Diabetes ____CHF
____HIV/AIDs ____Hepatitis ____Mental Health Disorder ____Neuropathy (Peripheral) ____Heart Defect
____Hypothyroidism ____Peripheral Vascular Disease Other: _____

**Past Surgeries:**

_____

_____

_____

**Family History:**____Venous Disease ____Clotting Disorder ____Stroke
____Diabetes ____Hypertension ____Cancer Other: _____

**Social History:** Alcohol: ____Never ____Rare ____Occasional ____Daily
Smoking: ____Never ____Current Smoker
____Quit >1 year ____Quit 1-10 years ____Quit 10+ years

**Female History:** ____#pregnancies ____planning for pregnancy

**Allergies:**

_____

_____

_____

**Current Medications:**

_____

_____

_____

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**Review of Systems:** (please check all that apply)

Constitutional:
____ Fatigue
____ Fever
____Recent weight loss
____Recent weight gain

Cardiovascular:
____Chest pain
____Palpitations
____Shortness of Breath
____with walking
____while lying flat
____Swelling legs/ankles
____Varicose veins

Respiratory:
____Chronic/Freq cough
____Cough/spit up blood
____Wheezing
____Asthma

Gastrointestinal:
____Abdominal Pain
____Black tarry stools
____Changes in bowel habits
____Difficulty/Pain swallowing
____Heartburn
____Hemorrhoids
____Indigestion
____Jaundice
____Pain on defecation
____Rectal bleeding
____Vomiting of blood

Genitourinary:
____ Blood in urine
____ Difficulty urinating
____Irregular/abnormal periods
____Pain or burning with urination
____Pain with intercourse
____Pain with menstruation
____Pelvic pain
____Vulvar veins

Musculoskeletal:
____Ankle pain
____Back pain
____Foot pain
____Hip pain
____Knee pain
____Leg cramps

Integumentary:
____Easy skin bruising
____Eczema
____Hair loss
____Heavy sweating
____Itching
____Rashes
____Skin lesions
____Ulcers

Endocrine:
____Cold intolerance
____Excessive thirst
____Excessive urination
____Heatintolerance
____Incontinence

Hematologic/Lymphatic:
____Bleeding tendencies
____Enlarged lymph nodes

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# For Patients Aged 65 Years and Older

**Name:** _____ **Date:** _____

| | | | |
|---|---|---|---|
| 1) Have you relied on people for any of the following? bathing, dressing, shopping, banking, or meals? | **YES** | **NO** | **DID NOT ANSWER** |
| 2) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids or medical care, or from being with people you wanted to be with? | **YES** | **NO** | **DID NOT ANSWER** |
| 3) Have you been upset because someone talked to you in a way that made you feel shamed or threatened? | **YES** | **NO** | **DID NOT ANSWER** |
| 4) Has anyone tried to force you to sign papers or to use your money against your will? | **YES** | **NO** | **DID NOT ANSWER** |
| 5) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically? | **YES** | **NO** | **DID NOT ANSWER** |
| 6) For Doctor: Elder abuse **may** be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. **Did you notice any of these today or in the last 12 months?** | **YES** | **NO** | **DID NOT ANSWER** |

| | | |
|---|---|---|
| 7) Do you have an Advance Care Plan or surrogate decision maker? Name: | **Yes** | **No** |
| 8) **For Female Patients Only:** Have you experienced urinary incontinence within the past twelve months? | **Yes** | **No** |

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# HIPAA Compliance Patient Consent Form

Our notice of privacy provides information about how we may use or disclose protected health information. You have a right to restrict how your protected health information is used and disclosed for treatment, payment or health care operations. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations. By signing this consent form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

- My we phone, email or send a text to you to confirm appointments? **YES** **NO**
- May we leave a voice mail on your home or cell phone? **YES** **NO**
- May we discuss your medical condition with any family member? **YES** **NO**

If YES, please name the members allowed?

_____

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

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## ASSIGNMENT OF BENEFITS FORM

I, _____, understand that services rendered to me by O'Donnell Vein and Laser/Kelly O'Donnell, M.D. are my financial responsibility and that the provider will bill my insurance company. I authorize my insurance company to pay my benefit directly to O'Donnell Vein and Laser/Kelly O'Donnell, M.D. and I understand that I will be responsible for any amount allowed and not paid by my insurance company. I am also responsible for any Deductible, Copay and/or Co-insurance.

I authorize the provider to release any information necessary to adjudicate my claims.

I also understand that should my insurance company send payment directly to me, I will forward the payment to the office in a timely manner.

I certify that the information I have provided with regard to my insurance coverage is current and correct. I agree to continually provide current and accurate health insurance information should any changes occur. I agree to notify the office of any updated insurance information prior to any services being rendered.

I authorize O'Donnell Vein and Laser/Kelly O'Donnell, M.D. to initiate a complaint or file an appeal to my insurance company and/or the insurance commissioner on my behalf and I personally will be active in the resolution of any claim delays, unjustified reductions or denials.

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

## COLLECTION AGREEMENT

If payment is not made as agreed, I will be responsible for all court costs, 35% collection fees and attorney fees.

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

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## Optional Cosmetic Interest Form

Please select any skin concerns you are interested in learning more about:

- ☐ Fine Lines/Wrinkles
- ☐ Sun Damage (Hands/Arms)
- ☐ Brown Spots/Pigmentation
- ☐ Red Spots/Facial Veins
- ☐ Uneven Skin Tone
- ☐ Unwanted Facial/Body Hair
- ☐ Spider Veins
- ☐ Scars
- ☐ Double Chin
- ☐ Acne
- ☐ Flat Cheeks/Mid-face Volume Loss
- ☐ Lips: Shape/Fullness
- ☐ Skin Texture
- ☐ Large Pores
- ☐ Loose Skin
- ☐ Permanent Fat Reduction/ Body Contouring

Share with us any other areas of concerns:

_____

_____

_____

_____

_____

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### Patient Photograph Consent & Release Form

**Name:** _____ **DOB:** ____ ____ ____

I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after procedures. The photographs will be taken by one of the members of O'Donnell Vein and Laser, medical staff I hereby give my consent for O'Donnell Vein and Laser to use any and all photographs under one of the following circumstances.

**Please initial one of the following options:**

_____ **All Media:** Photographs taken of me or parts of my body as well as details regarding services that I have received at O'Donnell Vein and Laser can be used in any print or broadcast media including, but not necessarily limited to social media, interne, newspapers and pamphlets. Further, I release and discharge O'Donnell Vein and Laser, any employees of O'Donnell Vein and Laser and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

_____ **Medical Care Only:** Photographs taken of me or parts of my body can be used solely for the purpose of my care with O'Donnell Vein and Laser. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal history file at O'Donnell Vein and Laser. By signing this form, I acknowledge my consent as initialed above, and I further recognize that this consent form will supersede any other photo consent forms with a date prior to the date written below. This consent may be revoked at any time by written request or by completion of a new form.

Signature: _____ Date: _____

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## ***Cancellation and Refund Policy***

O'Donnell Vein and Laser requires a 24-hour notice from the patient when canceling any appointment. For cancellations, please call the office at 410-224-3390. **Please DO NOT email us to cancel any appointments.** If you have opted in for text message reminders, you will receive your appointment reminder 48 hours in advance. Otherwise, our office will call you to confirm your scheduled appointment 24-48 hours in advance.

Any appointment, no-show, or arriving more than 15 minutes late is subject to a $50 no-show fee. Please call us if you cannot make it to your scheduled appointment as we understand ***sometimes*** there are circumstance beyond your control, and we try to be accommodating.

## ***Refund Policy***

We do not offer refunds for any services provided for any reason.

I, _____, understand and agree to O'Donnell Vein and Laser's cancellation and refund policy. I also agree that I will may be billed for any missed appointment, no-show, or if I arrive more than 15 minutes late for my schedule appointment.

Client Name: _____

Client Signature: _____ Date: _____