Gilvydis Vein Clinic
GENEVA • NAPERVILLE • SYCAMORE • ROCKFORD

Northern Illinois Vein Clinic
POWERED BY GILVYDIS VEIN CLINIC

Patient Information

Patient Legal Name _____

Patient Preferred Name _____ Birthdate _____

Street Address _____

City _____ State _____ Zip Code _____

Email Address _____

Cell Phone # _____ Home Phone # _____

Preferred method of communication (check all that apply) ☐ Call ☐ Text ☐ Email

Referred By _____

Emergency Contact Name _____

Relation to the Patient _____ Phone # _____

Insurance Provider _____

Name of Policy Holder _____

Birthdate _____ Marital Status _____

Race
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other _____
- ☐ Decline to Report

Ethnicity
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Other _____
- ☐ Decline to Report

Exam Questionnaire

Today's Date: _____ /_____ /_____

Patient Legal Name: _____

Birthdate: _____ /_____ /_____ Age: _____ Sex: M / F Weight: _____ lbs. Height: _____' _____"

Primary Care Physician: _____

Gynecologist: _____ # of pregnancies: _____

General Medical History

List past and present medical conditions you have been treated for and year diagnosed:

_____

_____

List any surgeries and year performed: _____

_____

List any allergies and reaction you may have: _____

Are you allergic to: Latex ☐ Yes ☐ No Reaction: _____

Iodine ☐ Yes ☐ No Reaction: _____

Adhesive ☐ Yes ☐ No Reaction: _____

Lidocaine ☐ Yes ☐ No Reaction: _____

Medications (RX and Supplements, including dose and how often you take the medication):

_____

_____

_____

Smoking history: ☐ Never ☐ Former Smoker – Year Quit _____ ☐ Current smoker – PPD _____

Vein History

Are the problems you are having with your legs interfering with your daily activities? (circle ***all*** that apply)

Both Legs **Right leg only** **Left Leg Only**

Walking Work Exercise Stairs Kneeling Social Activities Sleeping

Other: _____

Do your symptoms interfere with daily lifestyle activities? (circle ***one*** of the following)

Not at all Mildly Moderately Severely Unable to work

Exam Questionnaire

Do any of the following cause discomfort for you? (circle ***all*** that apply)

Prolonged Standing/Sitting | Hot weather/ Hot baths | Menstrual Cycle | Pregnancy | Walking

Do any of the following temporarily relieve your symptoms? (circle ***all*** that apply)

Elevating | Walking | Compression Stockings* | Medication | Warm/cold packs | Resting

*Have you ever worn compression stockings? ☐ Yes ☐ No When: _____ (knee-high or thigh-high)

Do you experience any of the following symptoms? (Occasional or Frequent – circle ***all*** that apply)

Leg Swelling	Right	Left	Ulcer	Right	Left
Tiredness/Fatigue	Right	Left	Rash on Leg	Right	Left
Burning	Right	Left	Skin Color Change	Right	Left
Itching	Right	Left	Bulging Vein	Right	Left
Cramps	Right	Left	Bleeding	Right	Left
Restless Leg	Right	Left	Aching or Pain	Right	Left
Fullness	Right	Left	Throbbing	Right	Left

On a scale of 1-10, (with 10 being the worst), where would you rate your LEG pain/discomfort? (circle ***one*** of the following)

1 2 3 4 5 6 7 8 9 10

Quality of pain (circle ***all*** that apply): Sharp Dull Pulling Achy Throbbing Tightness

Have you had any treatment on your varicose veins or spider veins? ☐ Yes ☐ No

If yes, explain treatment and leg treated: _____

Family History

	Venous Ulcer	Varicose Veins	Deep Vein Thrombus	Pulmonary Embolism	Phlebitis	Peripheral Vascular Disease	Leg Swelling	Heart Murmur
Father	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐
Sibling	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandparent	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandparent	☐	☐	☐	☐	☐	☐	☐	☐

☐ No known family history of varicose vein disease

Exam Questionnaire

Are you currently being treated for these medical conditions?

Cardiovascular

Heart Attack	☐ Yes	☐ No
ASD/VSD/PFO (Heart defects)	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Blood Clots	☐ Yes	☐ No
Atrial Fibrillation	☐ Yes	☐ No
Congestive Heart Failure	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Migraines	☐ Yes	☐ No

Peripheral Vascular

Peripheral Artery Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No

Respiratory

Shortness of breath	☐ Yes	☐ No
Sleep Apnea	☐ Yes	☐ No
CPAP/BiPAP Use	☐ Yes	☐ No
COPD	☐ Yes	☐ No

Answer the following if you are 65 years old or above

Do you have an advance directive (Healthcare living will/Power of Attorney)? ☐ Yes ☐ No ☐ Decline to respond

If yes, name of Medical Power of Attorney: _____

Steadi Fall Screening

1. Feels unsteady when standing or walking? ☐ Yes ☐ No
2. Worries about falling? ☐ Yes ☐ No
3. Has fallen in the past year? ☐ Yes ☐ No How many times? _____ Injured? ☐ Yes ☐ No

BELOW TO BE COMPLETED BY MEDICAL STAFF

Leg Measurements

Right Leg		**Left Leg**	
Ankle	_____"	Ankle	_____"
Calf	_____"	Calf	_____"
Thigh	_____"	Thigh	_____"
Leg length	_____"	Leg length	_____"
Calf length	_____"	Calf length	_____"

Today's Date: _____ /_____ /_____

BP _____/_____ Pulse _____

☐ Stockings Given
☐ RX Given
☐ Insurance
☐ Self-Pay

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Release of Medical Information for Payments of Claims

Privacy Notice

I consent and request Gilvydis Vein Clinic to furnish my insurance company or other party payor the following specific information contained in my medical records for review, examination and/or photocopies: insurance claim form and documentation related to billed services which may include chart notes, ancillary test results and procedures.

The purpose of this disclosure is for my insurance company or other third-party payor to process payment for my medical services. I understand that the information provided pursuant to this release of information may contain mental health, developmental disabilities, alcohol/drug abuse and/or acquired immune deficiency syndrome (AIDS) information. I understand that I may inspect and/or arrange for photocopies of the information that is to be disclosed. I understand that this authorization allows the aforementioned information to be released orally or through copies of medical records.

I understand that if I refuse to sign this release of information, the information will not be furnished (except as required by law), and my insurance company or other third party payor cannot be billed. In such a case, I will be financially responsible for all charges incurred.

This release will remain in effect for one (1) year from the date of signature below. I understand that this release may be revoked by me at any time. Any revocation must be in writing, signed by me and my signature must be witnessed by a person who can attest to my identity. Nor written revocation of consent shall be effective to prevent disclosure of records and communications, until it is received by Gilvydis Vein Clinic and no revocation will be effective to the extent Gilvydis Vein Clinic has already acted in reliance on it.

_____ *I acknowledge that I have received and understood the information provided*
(Initials)
Patient or Parent/Legal Guardian

Assignment of Benefits

I assign payment of medical benefits to Gilvydis Vein Clinic for services described. I understand that I am financially responsible for charges not covered plus all costs incurred in or related to the collection of such charges including but not limited to reasonable collection agency charges not to exceed 50% of the principal, attorney's fees, and costs of suit.

_____ *I acknowledge that I have received and understood the information provided*
(Initials)
Patient or Parent/Legal Guardian

Release of Medical Information for Payments of Claims

Medication History Authority

The purpose of this consent is for permission to obtain your medication history. Patient medication history is a list of prescription medicines that our providers or other providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribution to the collection of this history.

The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illnesses properly and in avoiding potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history may not include drugs purchased without using your health insurance. Also, over-the-counter drugs, supplements and/or herbal remedies that patients take on their own may not be included.

By signing this consent form you are giving your healthcare provider permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan.

_____ *I consent*
(Initials)
Patient or Parent/Legal Guardian

_____ ***OR** I decline to consent*
(Initials)
Patient or Parent/Legal Guardian

By signing below, I acknowledge that I have read, understand and accept the policies above.

_____
(Print)
Patient or Parent/Legal Guardian

_____
(Sign) **(Date)**
Patient or Parent/Legal Guardian

_____
(Print)
Office Administration

_____
(Sign) **(Date)**
Office Administration

Financial Policy

Thank you for choosing Gilvydis Vein Clinic. Please understand that payment of your bill is part of your treatment and care. For your convenience, we have answered a few commonly asked financial and office policy questions below.

What is my financial responsibility for services?

You will be financially responsible for all copays, coinsurance and deductibles at the time of service, depending on the type of insurance plan you have. If you do not have insurance, payment in full is due at the time of service unless prior payment arrangements have been discussed with our office. We accept payment by Cash, Check, VISA, MasterCard, Discover and American Express. It is your responsibility to know what is covered by your insurance plan and you will be responsible for the balance your insurance does not cover. We encourage you to contact your insurance company for an estimate of costs.

_____ *I acknowledge that I have received and understood the information provided*
(Initials)
Patient or Parent/Legal Guardian

What if my account becomes delinquent?

Patients will be sent a monthly statement detailing any amount owed to Gilvydis Vein Clinic, please make sure that we have your current mailing address AND email address. ***Balances must be paid in full within 12 months of the date of service.*** If our office receives no payment for 2 consecutive months, then your remaining balance will be due in full.

_____ *I acknowledge that I have received and understood the information provided*
(Initials)
Patient or Parent/Legal Guardian

What if the patient is a Minor?

A parent or legal guardian must accompany patients who are minors during their visit. This accompanying adult is responsible for payment of the account, according to the policy outlined on the previous page(s).

_____ *I acknowledge that I have received and understood the information provided*
(Initials)
Patient or Parent/Legal Guardian

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Financial Policy

Cancellation/No Show Policy

It is expected that I will show up for my scheduled appointment on time. I understand that if I show up late for my appointment that I may be required to reschedule for another day. I understand that I need to notify the office within 48 hours of a scheduled procedure. In the event of an emergency where prior notice cannot be given, the practice will give consideration.

_____ *I acknowledge that I have received and understood the information provided*

(Initials)
Patient or Parent/Legal Guardian

By signing below, I acknowledge that I have read, understand and accept the policies above.

_____	_____
(Print)	***(Sign)*** **(Date)**
Patient or Parent/Legal Guardian	Patient or Parent/Legal Guardian
_____	_____
(Print)	***(Sign)*** **(Date)**
Office Administration	Office Administration

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Social Media & Marketing Consent

I hereby authorize Gilvydis Vein Clinic (GVC), including its physicians, nurses, staff, and other employees, to use my name, photograph(s), and video taken of me, and written statements provided by me on its social media platforms, solely for the purpose of creating and publishing marketing materials and/or ads about my treatment experience and results as a Gilvydis Vein Clinic patient (any of which are referred to herein as my testimonials, treatment results, and experience.) I hereby authorize Gilvydis Vein Clinic to use and publish my testimony in or on GVC-associated printed materials, photos, videos, publications, social media platforms, website, and any other form of media or form of communication now existing or hereafter developed. I acknowledge and agree that the information described above may be received by or viewed by members of the general public, as well as current and future patients of GVC.

I have voluntarily chosen to provide or allow for the use or disclosure by Gilvydis Vein Clinic of the following vein health information. I understand that Gilvydis Vein Clinic uses this information to demonstrate how vein treatments can change and transform the quality of life of people who have vein disease and understand that I will not receive compensation for the use of this information. Gilvydis Vein Clinic may use these materials for marketing their services, and show their positive clinical outcomes.

Please *initial* all of those that apply:

____ Written or Verbal Testimonials, Comments or Quotes (first name only or initials)
____ Name/Treatment Status/Location
____ Before/After Photograph(s)/Likeness
____ Audio Recordings (either recorded in private or during a public presentation for example during an Event / Class/ provider session)
____ Video Recordings

I understand that I may revoke this Authorization at any time by notifying the Privacy Office of Gilvydis Vein Clinic in writing. If I revoke this Authorization, Gilvydis Vein Clinic will not make any new use or publication of the information described above but my revocation will not have any effect on actions taken and information published or disseminated prior to my revocation. I understand that information disclosed pursuant to this Authorization may be redisclosed by the recipient and may no longer be protected by federal privacy regulations. This Authorization expires upon the earlier of my revocation of this Authorization or ten (10) years from the date of my execution of this Authorization. I understand that I do not have to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from GVC, nor will it affect my eligibility to obtain payment for such health care.

By signing below, I acknowledge that I have read, understand and accept the policies above.

_____	_____
(Print) Patient or Parent/Legal Guardian	***(Sign)*** Patient or Parent/Legal Guardian **(Date)**
_____	_____
(Print) Office Administration	***(Sign)*** Office Administration **(Date)**

- C I V I Q -14 -

SELF-QUESTIONNAIRE PATIENTS

English for the USA

Many people complain of leg pain. We would like to find out how often these leg problems occur and to what extent they affect the everyday life of those who have them.

Below is a list of symptoms, sensations and types of discomfort that you may or may not be experiencing and which might make everyday life hard to bear to a greater or lesser extent. **For each symptom, sensation or type of discomfort listed, we would like you to answer in the following way:**

Please consider whether you have experienced what is described in each sentence, and if the answer is 'yes', how **intense** it was. There are five response options. Please circle the one which best describes your situation.

Circle 1	if the symptom, sensation of discomfort described does not apply to you
Circle 2, 3, 4 or 5	if you have felt it to a greater or lesser extent

- C I V I Q -14 -

SELF-QUESTIONNAIRE PATIENTS

English for the USA

1) During the past four weeks, have you had any **pain** in your **ankles** or **legs**, and how severe has this pain been?
Circle the number that applies to you.

No pain	Slight pain	Moderate pain	Considerable pain	Severe pain
1	2	3	4	5

2) During the past four weeks, how much trouble have you had at **work** or with your **usual daily activities because of your leg problems**?
Circle the number that applies to you.

No trouble	Slight trouble	Moderate trouble	Considerable trouble	Severe trouble
1	2	3	4	5

3) During the past four weeks, have you **slept poorly** because of your leg problems, and how often?
Circle the number that applies to you.

Never	Rarely	Fairly often	Very often	Every night
1	2	3	4	5

- C I V I Q -14 -

SELF-QUESTIONNAIRE PATIENTS

English for the USA

	During the past four weeks, how much **trouble** have you had **carrying out the actions and activities** listed below b**ecause of your leg problems**? *For each statement in the table below, indicate how much trouble you have had by circling the number that applies to you.*				
	No trouble	Slight trouble	Moderate trouble	Considerable trouble	Could not do it
4) Climbing several flights of stairs	1	2	3	4	5
5) Crouching / Kneeling down	1	2	3	4	5
6) Walking at a brisk pace	1	2	3	4	5
7) Going out for the evening, going to a wedding, a party, a cocktail party...	1	2	3	4	5
8) Playing a sport, exerting yourself	1	2	3	4	5

- C I V I Q -14 -

SELF-QUESTIONNAIRE PATIENTS

English for the USA

	Leg problems can also affect your spirits. How closely do the following statements correspond to how you have felt during the past four weeks? *For each statement in the table below, circle the number that applies to you.*				
	Not at all	A little	Moderately	A lot	Completely
9) I felt nervous/tense	1	2	3	4	5
10) I felt I was a burden	1	2	3	4	5
11) I felt embarrassed about showing my legs	1	2	3	4	5
12) I got irritated easily	1	2	3	4	5
13) I felt as if I was handicapped	1	2	3	4	5
14) I did not feel like going out	1	2	3	4	5

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Elder Abuse Suspicion Index

The EASI was developed to raise a physician's suspicion about elder abuse to a level at which it might be reasonable to propose a referral for further evaluation by social services, Adult Protective Services, or the equivalent. Although all six questions should be asked, a response of "yes" on one or more of questions 2 through 6 may establish concern. The EASI was validated for family physicians to administer to older persons with a Mini-Mental State Examination score of 24 or greater who are seen in ambulatory settings.

1. Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?

☐ Yes ☐ No ☐ Decline to 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 ☐ Decline to answer

3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?

☐ Yes ☐ No ☐ Decline to answer

4. Has anyone tried to force you to sign papers or to use your money against your will?

☐ Yes ☐ No ☐ Decline to answer

5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?

☐ Yes ☐ No ☐ Decline to answer

To be answered by Medical Provider

6. 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 past 12 months?

☐ Yes ☐ No ☐ Not Sure