NORTHWEST
Vascular and Vein Specialists

1614 West Central Road, Suite 100, Arlington Heights, IL 60005
847-577-5814 Fax- 847-577-5914

Notice of Privacy Practices for Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services. This notice takes effect 1/15/03 and will remain in effect until we replace it.

Examples:

Treatment: We may use and disclose your protected health information in order to provide, coordinate or manage your care or related services. We may also disclose your protected health information to other dentists, physicians, healthcare service providers who are now or become involved in taking care of you.

Payment: We may use or disclose your protected health information in order to obtain payment for services we provide to you.

Healthcare Operations: We may use or disclose your health information as needed in connection with our healthcare operations, such as contacting you regarding an appointment, our practice's quality assessment and improvement, development of protocol and clinical guidelines, conducting training programs, credentialing, medical review, legal and insurance services.

Your Health Information Rights

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

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Obtain a paper copy of this Notice of Privacy Practices for Protected Health Information (ñNoticeò) by making a request at our office;
- Request that you be allowed to inspect and copy your health record and billing recordð you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information 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 office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;

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- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

Our Responsibilities

The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our ñNotice: or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Mary Ann Jackson.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to 1614 West Central Road, Ste 100, Arlington Heights, IL 60005. You may also file a complaint by mailing it or phoning the Secretary of Health and Human Services whose street address and phone number is 105 W. Adams Street, Chicago, Il 60603, 312-353-5160.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (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.

Other Disclosures and Uses

Notification

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

Communication with Family

Unless you object, we may disclose to a member of your family, a relative, close friend or other person you identify, your protected health information that directly relates to that personôs involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition.

Food and Drug Administration (FDA)

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

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Workers Compensation
If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health
As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect
We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

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

Law Enforcement
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses
Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Website
If we maintain a website that provides information about our entity, this Notice will be on the website.

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PATIENT REGISTRATION

Date:_____

Last Name:_____**First Name**:_____**M**:_____**Date of Birth:** _____

SS #:_____**Male**____**Female Marital Status:** ❒Single ❒Married ❒Separated ❒ Divorced ❒Widowed

Address:_____

City:_____ **State:**_____**Zip:** _____

Phone Numbers:

Home:_____**Business**:_____**Mobile**: _____

Preferred Language: ❒ English ❒Spanish ❒Other _____

Race: ❒American Indian or Alaska Native ❒Asian ❒Black or African American
❒Native Hawaiian or Pacific Islander❒Caucasian/White ❒Refused/Declined
Ethnicity: ❒Hispanic or Latino ❒Not Hispanic or Latino ❒Refused/Declined

Email Address:_____
(This is required so that we can give you access to you healthcare information)

If you do not have an email please initial below:
_____**(Initial) I decline access to my medical records. I understand the benefits and do not wish to have access to my health records.**

How did you hear about us? _____

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

Social History:
Marital Status: ❒Married ❒Widowed ❒Single ❒Divorced Occupation:_____
Do you have any children?_____ Age/Sex of Children:_____
Patient lives with: ❒Self ❒Spouse ❒Other (Parent/Child/Friend)
Employer:_____
Do you drive: ❒Yes ❒ No Do you have stairs in your home: ❒No ❒Yes, How Many?_____
Do you often sleep in a reclining chair? ❒No ❒yes, How often?_____
Do you use Tobacco? ❒No ❒ Yes -For how long?_____How much, Packs Per Day?_____
If you have quit smoking, when did you quit?_____How long did you smoke prior to quitting?_____
Do you use Alcohol ❒ Yes ❒No How much week?_____Weight:_____Height: _____
Patient Signature:_____ **Date:**_____

Patient History Form

Date:_____

Last Name:_____**First Name**:_____**MI**:_____**Birthdate**:_____

Referring Physician:_____**Primary Physician**:_____

Medical History: (check all that apply)

❒Aortic Aneurysm
❒Arthritis
❒Asthma
❒Cancer (Site_____)
❒Cerebrovascular Disease
❒Cervical Spine Disease (neck problems)
❒Claudication
❒COPD (Lung Disease)
❒Heart Disease-
Coronary Artery Disease- CAD
Congestive Heart Failure- CHF
Myocardial Infarction- Heart Attack
❒Neuropathy
❒Deep Vein Thrombosis (DVT)
❒Diabetes
❒High Blood Pressure
❒Migraines
❒Kidney Disease (Renal Failure)
❒Hepatitis
❒Leg Ulcers
❒Liver Disease (Cirrhosis)
❒Lymphedema/Leg Swelling
❒Thyroid Disease
❒Pacemaker/AICD
❒Peripheral Arterial Disease (PAD)
❒ Raynaud's Disease Syndrome
❒ Stroke/TIA
❒ History of Phlebitis
❒ Gastro-esophageal Reflux Disease (GERD)
❒Lumbar Spine Disease (Back Problems)
❒Other _____
❒Prostate Disease
❒High Cholesterol

Medications: **Dose:** **Start Date:**

_____

_____

_____

_____

Surgical History (check all that apply and list date):

❒Heart Bypass (CABG) _____
❒Appendectomy _____
❒Gallbladder Surgery_____
❒Colon Surgery_____
❒Hysterectomy_____
❒Breast Surgery_____
❒Cataracts _____
❒Back Surgery_____
❒Heart Angioplasty_____
❒Tonsillectomy_____
❒Foot Surgery_____
❒Varicose Vein Surgery_____

Have you had any recent Hospitalizations within the last 6 months? ❒No ❒Yes, Cause:_____

Allergies and Reactions (Include Latex):_____

	Age, If Living	If Deceased, Age and Cause	Health Problems
Father			
Mother			
Sister/Brother			
Sister/Brother			
Sister/Brother			

Patient Signature:_____**Date:**_____

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Susanne K. Woloson, MD, PhD, RPVI & Elizabeth T. Clark, MD, RVT, FACS
1614 West Central Road, Suite 100, Arlington Heights, IL 60005
900 Technology Way, Suite 230, Libertyville, IL 60048
847-577-5814 Fax- 847-577-5914

Financial/Insurance Acknowledgement

Financial
Complete billing information will be provided at the time of your appointment. Those patients who do not have insurance or are unable to provide adequate billing information are responsible for the total payment of their bills. **Initial**_____

Self Pay
I understand that I am financially responsible for services received and that I am eligible for a payment plan for my balance with my physician. Any payments that lapse over a 3 month period of time will be sent to a collection agency. **Initial**_____

No Show/Cancellation Policy
We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar **($50)** fee for a office visit and one hundred dollar **($100)** for procedures; this will not be covered by your insurance company. **Initial**_____

Insurance
As a courtesy, our billing department will bill your insurance on your behalf provided that you supply all of the necessary information at the time of service. Any services that are not paid by your insurance will become your financial responsibility. Due to the number of insurance plans that we work with and the different contracts our providers have as their own entities, it is not possible for us to know all the covered benefits your specific plan covers. We ask that our patients familiarize themselves with the different benefit levels available and whether certain services are covered, specifically any services or procedures Please notify our front desk staff if you are aware that certain services are not covered and be prepared to make payments for that service on the day of your appointment. Patients without coverage are eligible to receive a prompt pay discount if payment is received on the day the service is rendered. **Initial**_____

HIPAA – Patient Acknowledgement Form

I,_____, hereby acknowledge receipt of Northwest Vascular and Vein Specialists Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information. I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me.

I authorize Northwest Vascular and Vein Specialists to discuss my medical treatment with:

Only Myself:_____ Phone Numbers:_____

And/Or: Name:_____Relationship:_____Phone:_____

Messages may be left on my answering machine or voicemail: YES:_____ NO:_____
Messages may be left with one of the people listed above: YES:_____ NO:_____

Patient Signature:_____**Date:**_____

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Varicose Vein Form

1. When did you first notice varicose veins? _____
2. When did your varicose veins begin to bother you? _____
3. Have you ever had a Venous Reflux Ultrasound done to evaluate your veins? □ Yes □ No
   Where was test done and when? _____
4. Have you ever had any prior treatment of your varicose veins? □ Yes □ No
   If yes, what type of treatment?
   Vein stripping surgery? □ Yes □ No
   If yes, when and which leg? _____
   Laser therapy or radiofrequency ablation? □ Yes □ No
   If yes, when and which leg ? _____
   Injection /Sclerotherapy (vein injections)? □ Yes □ No
   If yes, when and which leg? _____
5. Have you ever had a blood clot (DVT)? □ Yes □ No
   If yes, which leg and when? _____
   How was this treated? Heparin Coumadin Aspirin No Treatment
6. Have you ever had phlebitis (redness/inflammation)? □ Yes □ No
   If yes, which leg and when? _____
7. Have you ever had a venous ulcer? □ Yes □ No
   If yes, which leg and when? _____
   How was this treated? □ UNNA boot □ Compression stocking/wrap □ Antibiotics □ No Treatment □ Other _____
8. Do you have any bleeding or clotting disorders? □ Yes □ No
9. Have your veins gotten worse in recent months? □ Yes □ No
   Describe: _____
10. Do you experience any of the following symptoms in your legs?

Aching/pain?	□ Yes	□ No	□ Left	□ Right	□ Both Legs
Heaviness?	□ Yes	□ No	□ Left	□ Right	□ Both Legs
Tiredness/fatigue?	□ Yes	□ No	□ Left	□ Right	□ Both Legs
Itching/burning?	□ Yes	□ No	□ Left	□ Right	□ Both Legs
Swollen ankles?	□ Yes	□ No	□ Left	□ Right	□ Both Legs
Night cramps?	□ Yes	□ No	□ Left	□ Right	□ Both Legs
Restless legs?	□ Yes	□ No	□ Left	□ Right	□ Both Legs
Throbbing?	□ Yes	□ No	□ Left	□ Right	□ Both Legs

11. Have you ever had bleeding from your leg veins before? □ Yes □ No
    If yes, explain: _____
12. Do your symptoms interfere with your work or daily activities? □ Yes □ No
    If yes, how? _____
13. Do you take any medication for your vein symptoms (i.e., Advil, Motrin) □ Yes □ No
    If yes, what medication(s) do you take and how many times/mgs per day? _____
14. Do you elevate your legs to relieve discomfort? □ Yes □ No
    If yes, how long per day do you elevate and does it provide relief? _____
15. Do you exercise? □ Yes □ No
    If yes, what kind of exercise and how often? _____
16. Do you wear prescription compression stockings? □ Yes □ No
    If yes, what type?_____How long have you worn them? _____
17. Do you wear light support hose (i.e., Sheer Energy)? □ Yes □ No
18. Do you have any problem walking? □ Yes □ No
    If yes, describe _____
19. What type of work do you do?_____How long do you stand (hours): _____

Patient Signature:_____ **Date:**_____