Patient Registration Form

Patient Information

Name_____ _____/_____/_____ _____
Last First Middle Initial Date of Birth Age

_____ Gender: ☐ Male ☐ Female _____/_____/_____
Address City, State Zip Social Security #

( ) _____-_____ ( ) _____-_____ **Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Cellular Telephone Home Telephone

Please list your preferred contact method_____

☐ Check here if detailed messages can be left on an answering machine or voice mail

Email address: _____

Emergency Contact _____ ( ) _____-_____ _____
Last First Telephone Relationship to Patient

☐ Check here if you allow disclosure of medical information to your emergency contact

Primary Care Physician: _____ **Telephone Number:** _____

Who may we thank for referring you? _____

Preferred pharmacy name: _____ **Address:**_____

Telephone Number: ( )_____-_____

Primary Insurance

Insurance Company _____ ( ) _____-_____ Effective Date _____
Telephone

_____ Policy # _____ Group #_____
Claim Address City, State Zip

Policy Holder Name _____ Relationship to Patient _____

_____ _____/_____/_____ Gender □ **Male** □ **Female**
Address City, State Zip Date of Birth

Additional Insurance

Insurance Company _____ ( ) _____-_____ Effective Date _____
Telephone

_____ Policy # _____ Group #_____
Claim Address City, State Zip

Policy Holder Name _____ Relationship to Patient _____

_____ _____/_____/_____ Gender □ **Male** □ **Female**
Address City, State Zip Date of Birth

Patient Signature: _____ Date: _____

Utah Vein Specialists

Veins matter.

Confidential Health History

Patient Name: _____ **DOB:**_____

Who's your primary care physician? _____ **Referred by:**_____

Please check the symptoms you are currently experiencing. **(Please Circle)**

☐	Varicose Veins, Spider Veins, Purple (Reticular) Veins at the Ankles	Left	Right
☐	Leg Pain: Aching, Tired, Heavy Legs, Tender Varicosities, Painful Calves	Left	Right
☐	Leg Cramps: Night Cramps, "Charley Horses", Nocturnal Cramping	Left	Right
☐	Swollen Ankles: Swelling at day's end or when traveling (w/o CHF, renal issues)	Left	Right
☐	Skin Changes: Red/Brown Discoloration, Ulceration, Eczema, Itching & Burning	Left	Right
☐	'Secondary' Restless leg syndrome	Left	Right

Your insurance will ask how your vein symptoms affect your daily life? Please explain specific examples: (*keeps you up at night, ways it makes it hard to take care of your self or your family or if it interferes with your employment*)

_____

_____

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

__Warm Soak __Exercise __Pain Meds __Wrap __Leg Elevation __Cold Packs __Walking __Flexion/Extension of your feet

Other Method: _____

Many insurance companies require conservative treatment of Compression Stockings before they will consider coverage for any venous treatment. Have you previously worn Compression Stockings? If so, please provide the length of time worn and check mark style used?

_____ Thigh High _____ Knee High _____Full Length for _____Years _____ Months

Insurance companies also need to know the details of medications you have tried to relieve pain and swelling:

____Asprin _____Tylenol _____ Ibuprofen _____Dosage _____Frequency Other: _____

Do you have a history of serious skin, staph or bacterial infections? ***Yes No***

Please Explain:

Do you have a history of HIV, AIDS, Hepatitis or other blood-borne disease or illnesses? ***Yes No***

Please Explain:

Does walking/exercise relieve your discomfort? **Yes** **No** **Which?** **Walking / Exercise**

Have you ever been treated for your veins before? **Yes** **No** **When?**_____

What Method:

__Cosmetic Injection __Ultrasound-Guided Injections __Radiofrequency Closure __Ambulatory Phlebectomy

__Ligation __Stripping __Laser for Spider Veins __Laser Catheter Ablation

__Other_____ **What were your results?**_____

CURRENT MEDICAL - REVIEW OF SYSTEMS: *(Please check all that apply to your CURRENT health)*

__ *Weight Loss*	__ *Weight Gain*	__ *Fever*	__ *Chills*
__*Night Sweats*	__ *Fatique*	__ *Dizziness*	__ *Chest Pain*
__ *Heart Palpitations*	__ *Tachycardia*	__ *Shortness of Breath*	__ *Cough*
__ *Wheezing*	__ *Vision Loss*	__ *Loss of Taste*	__*Loss of Balance*
__ *Bleeding Disorder*	__ *Cough of blood/sputum*	__ *Headaches*	__ *Painful Respiration*
__ *Blood in urine*	__ *Blood in Stool/Tarry Stool*	__*Frequent Fainting*	

ALLERGIES:

Do you have any allergies or sensitivities to medications, latex or tape? Yes No * If yes please list and include reactions

Date of last Flu Vaccine_____ ***Date of last Pneumoccoccal Vaccine:_____***

Have you received the COVID-19 vaccine? *__Started __Completed __ Boosted __N/A*

MEDICATION LIST: *(Prescription, Non-Prescription, Vitamins and Herbal Suppliments)*

****List dosage and how it's administered***

PAST MEDICAL HISTORY: *(Please check all that apply to your PAST Medical History)*

__ *Acid Reflux*	__ *Diabetes: Insulin Dependent*	__ *Liver Disease*
__ *Anemia*	__ *Deep Vein Thrombosis*	__ *Peripheral Vascular Disease*
__ *Asthma*	__ *Excessive Bleeding/Easy Bruising*	__ *Pulmonary Embolism*
__ *Atherosclerosis*	__ *Heart Valve Problems*	__ *Stomach Ulcers*
__ *Bleeding Disorder*	__ *High Blood Pressure*	__ *Stroke or TIA*
__ *Carotid Disease*	__ *Intolerant of NSAIDS*	__ *Thyroid Disease*
__ *Coranary Heart Disease*	__ *Kidney/Bladder Disease*	__ *Trauma to your Legs*

PAST SURGICAL HISTORY & HOSPITALIZATIONS: *(Please include childbirths & pregnancies)*

	YEAR

FAMILY HISTORY:

Family History of spider and /or varicose veins? Yes No Mother/Father/Grandparent/Other

Please list and describe:_____

Family History of deep blood clot, stroke, or clotting disorder? Yes No Mother/Father/Grandparent/Other

Please list and describe:_____

SOCIAL HISTORY:

Do you smoke? Yes No How much and how often?_____

Do you consume alcohol? Yes No How much and how often?_____

OCCUPATION: _____

Are you being treated for any current medical conditions? Yes No

Please list:

Patient Signature _____ Date _____

Utah Vein Specialists

Veins matter.

HIPAA & PHI Disclosure Consent

Patient Name: _____ **Patient date of birth:** _____

Please list the individuals who are allowed to receive personal health information and what type of information you are authorizing Utah Vein Specialists to disclose.

Name: _____ Relation: _____

□ All information □ Appointments □ Accounts & Payments □ Prescriptions □ Diagnosis

□ Diagnostic reports □ Treatment □ Operative Report □ Other: _____

Authorization void after: □ Date: _____ □ Completion of treatment □ Other:

_____

Name: _____ Relation: _____

□ All information □ Appointments □ Accounts & Payments □ Prescriptions □ Diagnosis

□ Diagnostic reports □ Treatment □ Operative Report □ other: _____

Authorization void after: □ Date: _____ □ Completion of treatment □ Other:

_____

Name: _____ Relation: _____

□ All information □ Appointments □ Accounts & Payments □ Prescriptions □ Diagnosis

□ Diagnostic reports □ Treatment □ Operative Report □ Other: _____

Authorization void after: □ Date: _____ □ Completion of treatment □ Other:

_____

I understand I have the right to revoke this authorization, in writing, at any time. Unless otherwise revoked this authorization shall be in forced and in effect one year from today's date at which this authorization expires.

Patient Signature: _____ **Date:** _____

COVID-19 Patient Disclosures

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma COPD, cancer treatment, radiation, chemotherapy and any prior or current disease or medical condition), can put you at greater risk for contracting COVD-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus within the last fourteen days.

	Yes	**No**
Do you have a fever or temperature above normal?		
Have you experienced shortness of breath or had trouble breathing		
Do you have a dry cough?		
Do you have a runny nose?		
Do you have a sore throat?		
Have you recently lost or had a reduction in your sense of smell or taste?		
Have you recently experienced vomiting, diarrhea, or other GI issues?		
Have you been in contact with someone who has tested positive for COVID-19?		
Have you tested positive for COVID-19? If yes, when?		
Have you been tested for COVID-19 and are awaiting results?		
Have you traveled outside the United States by air or cruise ship in the past 14 days?		
Have you traveled within the United States by air, bus or train within the past 14 days?		

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____ _____

Signature Date

_____ _____

Witness Temperature

Patient Service Agreement

Consent for Services

By signing this agreement I give consent to the physicians, medical staff and employees of Utah Vein Specialists to provide health care services to _____, _____ (Date of Birth).
Patient Name

Financial Responsibility and Assignment of Benefits

I agree that all benefits from insurance companies or any other third party payer will be paid directly to Utah Vein Specialists for services rendered by the health care providers employed by Utah Vein Specialists. I authorize the use of my signature and any records pertaining to my services to all insurance companies, or third party payers to secure payment.

I understand that I am financially responsible for all charges whether or not paid by insurance or any other third party payer. I agree to pay all co-payments at the time of service, all deductibles, co-insurance, and all non-covered services regardless of the amount paid by my insurance or any other third party payer. I agree to pay all attorney fees, court costs, filing fees, including charges or commissions that may be assessed by any collection agency retained to pursue collection on outstanding balances, with or without suit. The cost of collection is 30% of the total balance owed. I further agree to pay interest fees at the rate of 1 ½% per month (18% annually) for any outstanding balance.

I agree to pay a return processing fee of $25.00 for any check, or other payment method, that is returned unpaid to Utah Vein Specialists.

Release of Information and Privacy Notice

The law requires Utah Vein Specialists to make and keep records of the patient's medical treatment. Utah Vein Specialists safeguards those records and it uses and discloses such records and any information they contain only in accordance with Utah State and Federal privacy laws. Such uses and disclosures are described in detail in the Notice of Privacy Practices. The Notice of Privacy Practices is available for the patient to review at anytime.

Acknowledgement

I acknowledge I have received or been offered the Notice of Privacy Practices by Utah Vein Specialists. As the patient, or the representative of the patient, I have read the above information and give consent and agree to the terms. All of my questions regarding privacy and this agreement have been answered and a copy has been offered.

Date:

Patient or Legal Representative Signature:_____

Legal Representative Name: _____

Witness Signature: _____

Utah Vein Specialists

Veins matter.

Dear Valued Patient,

We thank you for choosing Utah Vein Specialists for your medical care; we look forward to building a relationship with you throughout your treatment. As part of our service to you, we will be providing an imaging study on your legs at the time of your new patient visit. This ultrasound is required in order for Dr. Jensen to properly diagnose your potential venous disease. *This is important for you to know as we will be billing your health insurance for the new patient consultation in addition to the ultrasound on your legs.*

It is important that the information you provide to us on your initial visit be correct and current to facilitate our efforts. This information includes your full legal name, address, date of birth, policy/ID number, phone number of the subscriber, as well as address and telephone number of the insurance carrier. This information should be on your insurance card, a copy of which we will obtain upon your initial visit.

Insurance policies vary from company to company and from patient to patient. Because it is your insurance policy, you are ultimately responsible for knowing and executing its particular requirements. *We strongly suggest that you contact your insurance company to confirm that our physician(s) participate with your plan and to better understand how your benefits will apply to this visit.* This information may include:

- Your policy's effective date
- Your coinsurance (e.g., 70-30%, 80-20%, 100%)
- Your deductible amount
- Your maximum out-of-pocket amount
- The need for pre-certification or authorization
- Specialist co-payment requirements

No insurance company guarantees payment. We will do everything we can to assist you in obtaining the maximum benefit according to your insurance plan; however, your insurance policy is a contract between you and your insurance carrier. *You are ultimately responsible for the payment of your bill.*

After your treatment plan is communicated to you by Dr. Jensen, our staff will contact your insurance to verify specific benefits for the procedures that you may need in addition to obtaining necessary prior authorization(s). We will contact you with a cost estimate of the procedures and authorization details prior to any procedure scheduling. We thank you for your compliance and understanding and are happy to answer any questions or concerns.

Acknowledgement:
*I understand that this is a specialist consultation visit and **NOT** a free screening. My insurance will be billed for this visit. An ultrasound study will be performed and I am responsible for my co-pay, coinsurance and deductible payments that may apply.*

Patient or Legal Guardian Signature: _____

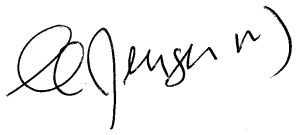
Witness Signature: _____
Utah Vein Specialists
Date:

Photograph Consent

I agree to have Dr. Jensen or his assistants take photographs of my legs and my face for medical records purposes. These photographs will be held in confidentiality according to HIPPA regulations. Photographs of my name and face will only be used for purpose of my chart at Utah Vein Specialists, Inc. in order for the staff to better recognize each patient and to confirm correct patient when they arrive in the office. I do consent to the future use of my leg photographs, both before and after proposed procedures, at Dr. Jensen's discretion for the purpose of insurance authorization, and patient and physician education.

Patient or Patient's Representative Signature: _____

Utah Vein Specialists



By: _____

Signature of Physician Or Authorized Representative

Utah Vein Specialists

Veins matter.

FORMULARY BENEFITS DATA CONSENT FORM

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing below I give Utah Vein Specialists permission to access my pharmacy benefits date electronically through RxHub. This consent will enable Utah Vein Specialists to:

- Determine the pharmacy benefits and drug copays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

Patient Name Print:_____ Date of Birth:_____

Patient or Patient's Representative Signature:_____ Date:_____

Peter E. Jensen, MD FACS RVT
Diplomate of the American Board of Surgery • Diplomate of the American Board of Thoracic Surgery • Diplomate of the American Board of Phlebology
7410 South Creek Road, Suite 104 • Salt Lake City, UT 84093 • 801-501-VEIN (8346) • Fax 801-501-2627
www.VeinsMatter.com

ARBITRATION AGREEMENT

Patient Name: **Date:**

Article 1 Dispute Resolution

By signing this Agreement ("Agreement") we are agreeing to resolve any Claim for medical malpractice by the dispute resolution process described in this Agreement. Under this Agreement, you can pursue your Claim and seek damages, but you are waiving your right to have it decided by a judge or jury.

Article 2 Definition

A. The term "we," "parties" or "us" means you, (the Patient), and the Provider.

B. The term "Claim" means one or more Malpractice Actions defined in the Utah Health Care Malpractice Act (Utah Code 78-14-3(15). Each party may use any legal process to resolve non-medical malpractice claims.

C. The term "Provider" means the physician, group or clinic and their employees, partners, associates, agents, successors and estates.

D. The term "Patient" or "you" means:

(1) You and any person who makes a Claim for care given to YOU, such as your heirs, your spouse, children, parents or legal representatives, AND

(2) Your unborn child or newborn child for care provided during the 12 months immediately following the date you sign this Agreement, or any person who makes a Claim for care given to the unborn or newborn child.

Article 3 Dispute Resolution Options

A. Methods Available for Dispute Resolution. We agree to resolve any claim by:

(1) Working directly with each other to try and find a solution that resolves the Claim, OR

(2) using non-binding mediation (each of us will bear one-half of the costs); OR

(3) Using binding arbitration as described in this Agreement.

You may choose to use any or all of these methods to resolve your Claim.

B. Legal counsel. Each of us may choose to be represented by legal counsel during any stage of the dispute resolution process, but each of us will pay the fees and costs of our own attorney.

C. Arbitration – Final Resolution. If working with the Provider of using non-binding mediation does not resolve your Claim, we agree that your Claim will be resolved through binding arbitration. We both agree that the decision reached in binding arbitration will be final.

Article 4 How to Arbitrate a Claim

A. Notice. To make a Claim under this Agreement, mail a written notice to the Provider by certified mail that briefly describes the nature of you Claim (the "Notice"). If the Notice is sent to the Provider by certified mail it will suspend(toll) the applicable statute of limitations during the dispute resolution process described in the Agreement.

B. Arbitrators. Within 30 days of receiving the Notice, the Provider will contact you. If you and the Provider cannot resolve the Claim by working together or through mediation, we will start the process of choosing arbitrators. There will be three arbitrators, unless we agree that a single arbitrator may resolve the Claim.

(1) Appointed Arbitrators. You will appoint an arbitrator of your choosing and all Providers will jointly appoint an arbitrator of their choosing.

(2) Jointly-Selected Arbitrator. You and the Provider(s) will then jointly appoint an arbitrator (the "Jointly-Selected Arbitrator"). If you and the Provider(s) cannot agree upon a Jointly-Selected Arbitrator, the arbitrators appointed by each of the parties will choose the Jointly-Selected Arbitrator from a list of individuals approved as arbitrators by the state or federal courts of Utah. If the arbitrators cannot agree on a Jointly-Selected Arbitrator, either or both of us may request that a Utah court select an individual from the lists described above. Each party will pay their own fees and costs in such an action. The Jointly-Selected Arbitrator will preside over the arbitration hearing and have all other powers of an arbitrator as set forth in the Utah Uniform Arbitration Act.

C. Arbitration Expenses. You will pay the fees and costs of the arbitrator you appoint and the Provider(s) will pay thefees and costs of the arbitrator the Provider(s) appoints. Each of us will also pay one-half of the fees and expenses of the Jointly-Selected Arbitrator and any other expenses of the arbitration panel.

D. Final and Binding Decision. A majority of the three arbitrators will make a final decision on the Claim. The decision shall be consistent with the Utah Uniform Arbitration Act.

E. All Claims May be Joined. Any person or entity that could be appropriately named in a court proceeding ("Joined Party") is entitled to participate in this arbitration as long as that person or entity agrees to be bound by the arbitration decision ("Joinder"). Joinder may also include Claims against persons or entities that provided care prior to the signing date of this Agreement. A "Joined Party" does not participate in the selection of the arbitrators but is considered a "Provider" for all other purposes of this Agreement.

Article 5 Liability and Damages May Be Arbitrated Separately

At the request of either party, the issues of liability and damages will be arbitrated separately. If the arbitration of panel finds liability, the parties may agree to either continue to arbitrate damages with the initial panel or either party may cause that a second panel be selected for considering damages. However, if a second panel is selected the Jointly Selected arbitrator will remain the same and will continue to preside over the arbitration unless the parties agree otherwise.

Article 6 Venue/Governing Law

The arbitration hearings will be held in a place agreed to by the parties. If the parties cannot agree, the hearings will be held in Salt Lake City, Utah. Arbitration proceedings are private and shall be kept confidential. The provisions of the Utah Uniform Arbitration Act and Federal Arbitration Act govern this Agreement. We hereby waive the prelitigation panel review requirements. The arbitrators will apportion fault to all persons or entities that contributed to the injury claimed by the Patient, whether or not those persons or entities are parties to the arbitration.

Article 7 Terms/Rescission/Termination

A. Term. This Agreement is binding on both of us for one year from the date you sign it unless you rescind it. If it is not rescinded, it will automatically renew every year unless either party notifies the other in writing of a decision to terminate it.

B. Rescission. You may rescind the Agreement within 10 days of signing it by sending written notice by registered or certified mail to the Provider. The effective date of the rescission notice will be the date the rescission is postmarked.If not rescinded, this Agreement will govern all medical services received by the Patient from Provider after the date of signing, except in the case of Joined Party that provided care prior to the signing of this agreement (see Article 4(E)).

C. Termination. If the Agreement has not been rescinded, either party may still terminate it at any time, but termination will not take effect until the next anniversary of the signing of the Agreement. To terminate this Agreement, send written notice by registered or certified mail to the Provider. This Agreement applies to any Claim that arises while it is in effect, even if you file a Claim or request arbitration after the Agreement has been terminated.

Article 8 Severability

If any part of the Agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and will not be affected by the invalidity of any other provision.

Article 9 Acknowledgement of Written Explanation of Arbitration

I have received a written explanation of the terms of this Agreement and I have been verbally encouraged to read it andthis Agreement. I have had the right to ask questions, I have been verbally encouraged to ask any questions, and I havehad all my questions answered. I understand that any Claim I might have must be resolved through the dispute resolutionprocess in this Agreement instead of having them heard by a judge or jury. I understand the role of the arbitrators and themanner in which they are selected. I understand the responsibility for arbitration related costs. I understand that this Agreement renews each year unless cancelled before the renewal date. I understand that I can decline to enter into the Agreement and still receive health care. I understand that I can rescind this Agreement within 10 days of signing it.

Article 10 Receipt of Copy I have received a copy of this document.

_____

Patient or Patient's Representative Signature:_____

Utah Vein Specialists

By: _____

Signature of Physician
Or Authorized Representative