



Vein Institute Of The Midwest

AN AFFILIATE OF VASCULAR SURGERY ASSOCIATES, P.A.

We offer a minimally invasive treatment for varicose veins using state-of-the-art technology.

All of our Doctors are Fellowship trained Vascular Surgeons.

To compliment this treatment, we also offer spider vein treatment, permanent laser hair removal and skin rejuvenation.

We have a comprehensive team of physicians, nurse practitioners, nurses and vascular technologists to provide a treatment plan that is best for you.

Our staff at the Vein Institute of the Midwest is committed to compassionate, professional, comprehensive treatment of all vascular patients in a comfortable, friendly office.

The Vein Institute of the Midwest participates with many insurance plans, including Medicare, most PPO's and HMO's.

Regretfully, we do not participate with Medicaid or any of its products.

We file your primary and secondary insurances for your convenience. If your insurance requires a referral please bring it with you or have your referring physician fax it to us at 913-322-2860.

We ask that co-payments, deductibles, co-insurance and non-covered charges be paid at the time of service.

For your convenience we accept Visa, MasterCard and Discover.



Dr. Richard Arnsperger II, M.D., FACS
Vascular Surgeon

Dr. Kirk Hance M.D., FACS
Vascular Surgeon

Dr. Jenny Grace Cho, M.D.
Vascular Surgeon

To schedule an appointment call
913.322.2211

Office Hours:

Monday - Friday • 8:00am - 4:30pm

www.veininstitutemidwest.com

7420 Switzer • Shawnee, KS 66203

Take I-35 to 75th Street Exit #227. Go west approx. 2 blocks.

We're located on the NW side of 75th & Switzer next to the bank.

An appointment has been scheduled for you:

Date: _____ **Time:** _____ **a.m/p.m**

Please complete the enclosed Patient Forms prior to your appointment:

- Patient Information Form
- Health History Form
- Patient Venous History
- Notice of Privacy Practices

Please bring the following items to your appointment:

- Completed New Patient Papers
- Insurance Card(s)
- Insurance Referral if applicable
- Test results &/or X-rays



Health History

Date: _____

Welcome to our practice. To help us in evaluating you, please fill out the information below to the best of your ability.

Name: _____
 Birthdate: _____ Age: _____
 Sex: Male Female

What is the reason for today's visit? _____
 How long have you been aware of this? _____

Major illnesses and hospitalizations:

- Hypertension Other: _____
 Diabetes _____
 Coronary Artery Disease _____

Previous surgeries:

- Open heart (CABG) Carotid endarterectomy (neck) Other: _____
 Gallbladder Which side? _____
 Hysterectomy Bypass on legs _____

Medications: (Prescription & Non-prescription) If you have a written list, we can make a copy. Otherwise, please list.

Medication	Dose (mg)	x per day	Medication	Dose (mg)	x per day

Allergies: (Please list drug, food, & environmental allergies with reaction.)

Cholesterol:

Has your cholesterol been checked? Yes No
 Last checked: Date _____ LDL: _____ HDL: _____

Patient Social History:

- Use of alcohol: Never Rarely Moderate Daily
 Use of tobacco: Never Previously, but quit. (How long ago? _____) Current (packs/day: _____)
 Use of drugs: Never Yes (Type / frequency: _____)

Occupation: _____

Weight: _____ (for medication dosing)

Do you have a living will or advanced directive? Yes No

Height: _____

Family History: (Do you have family members with the following problems?)

Please list relationship.)

- Peripheral vascular disease _____
 Coronary artery disease _____
 Stroke _____
 Varicose veins _____
 Venous thrombosis _____

Exercise routine: _____

If you have pain or breathlessness with walking, please list walking distance prior to onset of symptoms. _____

Symptoms: leg pain breathless chest pain

For office use

Vital Signs
BP -
P -

statin beta

**VASCULAR SURGERY
ASSOCIATES P.A.**



Vein Institute
of the Midwest

Dr. Beezley, Dr. Arnspiger, Dr. Connelly, Dr. Hance, Dr. Cho

7420 Switzer, Shawnee, KS 66203

Phone 913-262-9201 or 785-856-5075

Fax 913-262-3170

vascularsurgeryassoc.net

Patient Information

Name _____ Date of birth _____ Age ____ Sex: []Male []Female
Address _____

Are you presently in a nursing facility? []Yes []No If yes, what is the name? _____

Best contact number: _____ []home []cell []work []nursing home
Alternate contact number: _____ []home []cell []work []nursing home
email: _____

Your SSN: _____ Marital status: []single []married []divorced []widowed
Race: []Asian []Native Hawaiian []Black []White []Hispanic []Other Ethnicity: []Hispanic/Latin []non-Hispanic

Emergency contact _____ Relationship _____ Phone number _____

It is the policy of *Vascular Surgery Associates, P.A.* NOT to release confidential information regarding your medical care to any unauthorized person(s). Please designate below the individuals you would like to specify as "authorized" to receive your medical information.

AUTHORIZED PERSON(S):

Name: _____ Relationship: _____
Name: _____ Relationship: _____

Referred by _____ Primary Physician _____
Phone number _____ Phone number _____
Fax number _____ Fax number _____

Pharmacy of choice _____ Phone number _____

Hospital of choice: 1. _____ 2. _____

How did you hear about us? []Primary Physician []Friend []Advertisement []Insurance []Other: _____

Primary insurance _____ ID Number _____ Group Number _____

Is this an HMO? _____ Is a referral required? []Yes []No

Name of insured _____ Date of birth: _____ Relationship: _____

Secondary insurance _____ ID Number _____ Group Number _____

Name of insured _____ Date of birth: _____ Relationship: _____

Are you on dialysis? []Yes []No

Which dialysis center? _____

Phone number: _____

Dialysis days: []M/W/F []TThSat

Nephrologist: _____

Are you being seen by home health? []Yes []No

Agency: _____

VENOUS QUESTIONNAIRE

Name: _____

DOB: _____ Age: _____

Referral Source:

- Friend or relative Former patient of Vascular Surgery Web (veininstitutemidwest.com)
 Advertisement _____ Insurance Drive by Physician _____
(First & last name)MD/DO/DPM/PA/NP

Chief Complaint (check all that apply):

- varicose veins swelling of the legs/ankles
 spider veins sores that won't heal

Which leg? left leg right leg both legs

Symptoms include:

- pain burning throbbing heaviness achiness
 itching fatigue cramping swelling restless legs

1. How long have you had these symptoms?

- 6 months one year several years

2. Are they getting worse? yes no

3. Do your symptoms interfere to some degree with activities of daily living? yes no

4. Do you wear currently wear compression stockings or have you worn them in the past? yes no

Style: knee-high thigh-high pantyhose

Which leg? left leg right leg both legs

Worn how long? 3 months 6 months greater than 6 months

If you are wearing or have previously worn compression stockings for a period of 3 months or greater, has your pain (any degree) progressed despite wearing them? yes no

5. My symptoms are improved with:

- leg elevation compression stockings walking
 pain medication Motrin, Aleve, Advil, ext...

6. Do you have a venous ulcer? yes no

Which leg? left leg right leg both legs

If yes, what has your treatment included?

antibiotics external compression (stockings or tubigrips) no treatment

7. Do you require occasional pain medications for relief? yes no

8. Do your legs cramp (calf, thigh, and buttocks) as a result of walking? yes no

Which leg? left leg right leg both legs

9. My history of Vein treatment includes (please check those that apply):

Thermal ablation (laser or radiofrequency) Ligation and stripping Varicose vein excision

Sclerotherapy No prior history of vein treatment other _____

Which leg? left leg right leg both legs

10. My history includes (please check those that apply):

Family History: deep vein thrombosis cancer inherited blood clotting disorder

Personal History: deep vein thrombosis cancer inherited blood clotting disorder

pregnancy oral contraceptives or hormone use

obesity (greater than 50 lbs over ideal body wt.) recent major illness or surgery

11. Do you have a personal history of DVT? yes no

Which leg? left right both legs

Which vein segment did it involve? don't know common femoral vein popliteal vein
iliac vein inferior vena cava

12. Do you have a history of phlebitis? yes no

Which leg? left leg right leg both legs

13. Do you have a history of bleeding from your varicose veins? yes no

Which leg? left leg right leg both legs

14. Do you take blood thinners? yes no

If yes, please list: Warfarin/Coumadin Plavix Lovenox Aspirin



HIPAA PRIVACY POLICY

HIPAA is an acronym for the *Health Insurance Portability & Accountability Act of 1996* (a federal law). Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals, employers
- Healthcare Transactions & Code Sets for transmitting data electronically
- Privacy Regulations over disclosure and use of health information
- Security Regulations over protections of electronic health information

All of these rules have been developed by the *Department of Health & Human Services*.

I AUTHORIZE VASCULAR SURGERY ASSOCIATES TO CONTACT ME BY THE FOLLOWING METHODS:

Home Telephone/Answering Machine _____
Work Telephone _____
Cell Telephone _____
E-Mail _____
Other: _____

It is the policy of *Vascular Surgery Associates, P.A.* NOT to release confidential information regarding your medical care to any unauthorized person(s). Please designate below the individuals you would like to specify as "authorized".

IF YOU WOULD LIKE TO HAVE INFORMATION RELEASED TO SOMEONE OTHER THAN YOU, PLEASE COMPLETE THE FOLLOWING:

AUTHORIZED PERSON(S):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

MY SIGNATURE SERVES AS ACKNOWLEDGEMENT OF THE PRIVACY POLICY AND A COPY OF SUCH POLICY HAS BEEN OFFERED AND/OR GIVEN TO ME. I ASSUME THE RESPONSIBILITY OF NOTIFYING VASCULAR SURGERY ASSOCIATES WHENEVER BY CONTACT AND/OR AUTHORIZATION INFORMATION CHANGES.

X _____
Signature

Date

VASCULAR SURGERY ASSOCIATES, PA
VEIN INSTITUTE OF THE MIDWEST
7420 SWITZER
SHAWNEE, KS 66203
MICHAEL J. BEEZLEY, M.D. RICHARD C. ARNSPIGER, M.D.
DANIEL P. CONNELLY, M.D. KIRK A. HANCE, M.D.
JENNY GRACE CHO, M.D
PHONE: 913-262-9201 OR 913-322-2211

FINANCIAL POLICIES AND PROCEDURES

Insurance: As a courtesy to you (the patient), we will bill your insurance company. It is your responsibility to provide our office with a **current** copy of your insurance card and driver's license at the time of service. Failure to provide this information on a timely basis will delay your claims payment and full payment could potentially become your responsibility. Also it is your responsibility to obtain any necessary referrals and to verify your plan benefits with your insurance.

Please note that having insurance is **not a guarantee of coverage or payment** and it is your obligation to understand your plan benefits and coverage. This includes deductibles, copay/co-insurance and exclusions to your policy.

Please Note: Patients choosing to receive medical or cosmetic care for non-covered services as outlined by their insurance policy hereby agree to pay for said charges **prior** to receiving treatment.

Patient Balances: Copays are due at the time of service, we accept cash, check, Visa, MasterCard and Discover. All balances clearly stated as "patient responsibility" will be due and payable by the patient within 10 business days from receipt of their billing statement. Failure to pay your bill within the requested time frame may result in your account being assigned to an outside collection agency. The patient may incur additional collection agency fees and/or be dismissed from care with Vascular Surgery Associates, P.A. Please contact our office if special payment arrangements are needed.

When there is reasonable doubt about coverage benefits for potentially non-medically necessary treatment (as defined by your insurance plan), we will, as a courtesy to you (the patient) attempt to determine your financial responsibility for recommended treatment. **However**, our estimate of your financial responsibility **does not** constitute a contracted fee for services rendered. You will be responsible for all "patient responsibility" charges as defined by your insurance plan.

Returned Check Fee: There will be a \$30 charge for all returned checks.

Completing Insurance Forms: Vascular Surgery Associates, P.A. will complete one set of insurance forms out of courtesy. Any additional forms that you are requesting our staff to complete may incur a \$10/form charge.

I acknowledge and agree to the above financial policy.

Patient/Guardian Signature

Date