Fox Valley Plastic Surgery, S.C.
2400 Witzel Avenue, Suite A
Oshkosh, WI 54904
920-233-1540
920-651-6951 Fax

www.fvpsurgery.com
2500 E Capitol Drive, Suite 1500
Appleton, WI 54911
920-358-1810
920-358-1819 Fax

Name: <PersonalInfo.FullName>

DOB: <PersonalInfo.DOB>

VEIN QUESTIONNAIRE

☐ Yes ☐ No Have you ever had a **vein surgery** or **vein procedure?**
Right Leg: ☐ RFA ☐ EVLA ☐ HTL ☐ ECHO ☐ Varithena ☐ Other:_____ Year:_____
Left leg: ☐ RFA ☐ EVLA ☐ HTL ☐ ECHO ☐ Varithena ☐ Other:_____ Year:_____

☐ Yes ☐ No Have you ever had a **blood clot** in your leg(s)? ☐ Right - Year:_____ ☐ Left - Year: :_____

☐ Yes ☐ No Is there a family or personal history of **Factor V**? ☐ Personal ☐ Family

☐ Yes ☐ No Have you ever had an **ulcer** in your leg(s)? ☐ Right - Year:_____ ☐ Left - Year: :_____

☐ Yes ☐ No Have you ever had a **hemorrhage** in your leg(s)? ☐ Right - Year:_____ ☐ Left - Year:_____

☐ Yes ☐ No Do you have a **family history** of varicose veins, spider veins, or vein disease?

Have you ever had **tests,** such as ultrasound performed on your veins? If yes, what type of tests & results?

☐ Yes ☐ No	Right Leg Test: Test Results:	☐ Venous Duplex Ultrasound ☐ Venous Insufficiency ☐ Blood Clots	Left Leg Test: Test Results:	☐ Venous Duplex Ultrasound ☐ Venous Insufficiency ☐ Blood Clots

Please read this section carefully and respond appropriately.
It is very important for determining insurance coverage that current symptoms are checked.
Do you experience ANY of the following in your leg(s)?

Aching	☐ Right ☐ Left ☐ Both	Swollen Ankles	☐ Right ☐ Left ☐ Both
Heaviness	☐ Right ☐ Left ☐ Both	Leg Cramps	☐ Right ☐ Left ☐ Both
Tiredness/Fatigue	☐ Right ☐ Left ☐ Both	Restless Legs	☐ Right ☐ Left ☐ Both
Itching	☐ Right ☐ Left ☐ Both	Throbbing	☐ Right ☐ Left ☐ Both
Burning	☐ Right ☐ Left ☐ Both	Leg Pain	☐ Right ☐ Left ☐ Both
Leg Edema	☐ Right ☐ Left ☐ Both		

Conservative Therapy (Required for Insurance)

☐ Yes ☐ No Do you take pain medication for your vein related symptoms?
If yes, what medications? How often?

☐ Yes ☐ No Does the pain functionally impair you from activities for daily living and/or employment?
If yes, what activities are affected? Examples: getting dressed, driving, housekeeping (such as doing dishes), yard work, grocery shopping, preparing meals, sleeping, or ability to function at work, etc.

☐ Yes ☐ No Have you worn compression stockings?
If yes, for how long have you worn stockings? ☐ > 8wks. ☐ > 3mos. ☐ > 6 mos.

☐ Yes ☐ No Does elevating the leg(s) relieve the symptoms? How often?

☐ Yes ☐ No Have the veins or symptoms become worse recently?

☐ Yes ☐ No Do you have problems walking or running because of the leg pain?

☐ Yes ☐ No Do you have problems standing, walking or running because of leg pain?

What type of work do you do?

How many hours do you stand per day at work? At home?

Additional Comments:

Signature: **Date:**

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FOX VALLEY PLASTIC SURGERY
VEIN CANCELLATION POLICY

Fox Valley Plastic Surgery reserves a specific time for your visit. Your appointment time is in high demand, and can easily be filled if we are given notice of any impending cancellation. Therefore, we would appreciate a timely cancellation call, if you are not able to keep your scheduled appointment.

If you must cancel or change your appointment, please notify us at least 24 hours prior to your appointment time in order to avoid being charged a $75 service fee. No shows will be charged the same amount. The office may ask for your credit card information to have on record, or may send you a bill for the cancellation fee.

When you miss an appointment, the office will attempt to reschedule your appointment. Your appointments have a sequential and cumulative sequence that must be followed. If one appointment is missed, the rest are timed incorrectly and must be rescheduled. If the office cannot contact you, or you do not contact us, then all your remaining appointments will be cancelled.

If there is any part of the Cancellation Policy that you do not understand, please address it with the staff before you sign.

I have read, understand, and agree to the Vein Cancellation Policy

Patient's or Responsible Party's Signature Date

Witness Signature Date

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Name: _____

DOB: _____

Demographics ~ <Appointment.Date>

First Name: _____ MI: _____ Last Name: _____ Former Name: _____

Address: _____ City: _____ State: _____ Zip: _____

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

DOB & Age: _____ Race: _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Sex: _____ SSN: _____ Email Address: _____

Who is your primary care physician? _____
First Name Last Name

Preferred Pharmacy (name & location): _____

How did you hear about our practice?

☐ Patient: _____ ☐ Dr. Referral: _____
First Name Last Name

☐ Friend: _____

☐ Other: _____

Emergency Contact

Name: _____ Relationship: _____

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

HIPAA Notice of Privacy Practices

I have been given the opportunity to read, review, obtain a hard copy and ask questions about Fox Valley Plastic Surgery's **HIPAA Notice of Privacy Practices**, and how Fox Valley Plastic Surgery uses and discloses my information and my rights concerning my information. I consent and acknowledge my agreement to the terms set forth in the HIPAA information form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Patient Signature: _____ Date: _____

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Consent to Communicate including Transmission of Protected Health Information by Non Secure Means (Email & Text Message)

In order to secure your Protected Health Information (PHI), it is always best to personally go to the office and talk to a representative of Fox Valley Plastic Surgery (FVPS). If this is not possible, the next best methods are to communicate by phone, fax, or U.S. mail. All these methods are secure means of transmitting PHI.

In spite of these secure options, it sometimes may become useful for during the course of treatment for the patient to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with FVPS, there is a reasonable chance that a third party may be able to intercept those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

FVPS has found that some patients prefer to message or email the office with photos or questions. These are not secure avenues of communication. If you wish the office to respond in kind to your inquiries, you must expressly give FVPS permission to communicate with you with these insecure methods instead of phoning, faxing, or writing you. Please mark the ways that you consent to us communicating with you.

Communication Method	OK to Leave Voicemail?	OK to Leave Message with Another Person?	Preferred Method(s)	Best Time to Call
☐ Call Work Phone	☐ Yes	☐ Yes	☐	
☐ Call Cell Phone	☐ Yes	☐ Yes	☐	
☐ Call Home Phone	☐ Yes	☐ Yes	☐	
☐ Send Email	☐ Okay for appt reminder? ☐ Okay for medical/schedule information? ☐ Okay for special offers including patient surveys and newsletter? No spam. We do not sell our lists.			
☐ Send US Mail to	Mail to ☐ present address, ☐ permanent address, ☐ employer address, ☐ emergency contact, ☐ responsible party			
☐ Send Text Message Cell Phone Carrier:	☐ Okay for appt reminder? ☐ Okay for medical/schedule information? ☐ Okay for special offers?			

FAMILY MEMBERS				
Name	Date of Birth	Relationship	Release Results	Expiration or Comments

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my PHI by unsecured means. I understand that message and data rates may apply. I understand that I am not required to opt into emails or texting, or sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

Patient Signature: _____ Date: _____

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Health History

Section I: Surgery and Anesthesia History

1. List and date your surgical history.

_____

_____

2. Do you have a blood relative who had anesthesia complications of any kind? ☐ No ☐ Yes, please describe:

_____

Section II: Specific Medical History

HEIGHT & WEIGHT: _____

Do you have a history of the following?	No	Yes	Description
1. Anemia	☐	☐	
2. Anxiety	☐	☐	
3. Asthma	☐	☐	
4. Emphysema	☐	☐	
5. Bleeding tendency	☐	☐	
6. Blood clots	☐	☐	
7. Cancer	☐	☐	
8. CHF	☐	☐	
9. COPD	☐	☐	
10. Depression	☐	☐	
11. Diabetes	☐	☐	
12. High Blood Pressure	☐	☐	
13. Heart disease	☐	☐	
14. Hepatitis	☐	☐	
15. Herpes/Cold Sores	☐	☐	
16. Kidney disease	☐	☐	
17. Melanoma	☐	☐	
18. Migraine headaches	☐	☐	
19. Multiple Endocrine Neoplasia (MEN)	☐	☐	
20. Pancreatitis	☐	☐	
21. Periodontal disease – currently being treated	☐	☐	
22. Stroke	☐	☐	
23. Thyroid Cancer	☐	☐	
24. Thyroid disease	☐	☐	
25. Problem Scarring	☐	☐	
26. Have you been advised to or had psychiatric care?	☐	☐	
27. Vein problems, such as venous reflux disease	☐	☐	
28. Others Not Listed			

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Section III: Social History

1. Do you smoke? ☐ No ☐ Current Every Day Smoker ☐ Current Some Day Smoker ☐ Former Smoker---Quit date_____ ☐ Tobacco user
2. Do you Vape? ☐ No ☐ Yes If yes does it contain nicotine ☐ No ☐ Yes
3. How often do you drink alcohol? ☐ Never ☐ Monthly ☐ Weekly ☐ Daily ☐ Socially
4. Number of children given birth to? ☐ No ☐ Yes, how many? _____
5. Do you drink caffeine? ☐ Never ☐ Occasionally ☐ Daily
6. Illicit drug use? ☐ No ☐ Yes
7. Do you exercise? ☐ Never ☐ Weekly ☐ Daily

Section IV: Family History

Do your blood relatives have any of the following?		Brother	Daughter	Father	Maternal Aunt	Maternal Grandfather	Maternal Grandmother	Maternal Uncle	Mother	Paternal Aunt	Paternal Grandfather	Paternal Grandmother	Paternal Uncle	Sister	Son
1.	Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2.	Bleeding Tendency	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.	Blood Clots	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4.	Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.	Chronic Lung Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.	Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7.	Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8.	Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9.	High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10.	Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11.	Melanoma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12.	Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
13.	Migraine Headaches	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
14.	Multiple Endocrine Neoplasia (MEN)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
15.	Obesity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
16.	Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
17.	Thyroid Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Section V: Medications

List any medications, and oral or topical vitamins or herbal supplements you are taking.

Name of Medication	Strength (mg)	How many times a day?

Do you have a Pain Contract with another physician? ☐ **No** ☐ **Yes**

Section VI: Allergies and Sensitivities

List all allergies and sensitivities:

Allergy:	Severity:	Reaction: (list #'s from bottom)
	☐ Mild, ☐ Moderate, ☐ Severe, ☐ Unknown	
	☐ Mild, ☐ Moderate, ☐ Severe, ☐ Unknown	
	☐ Mild, ☐ Moderate, ☐ Severe, ☐ Unknown	
	☐ Mild, ☐ Moderate, ☐ Severe, ☐ Unknown	
	☐ Mild, ☐ Moderate, ☐ Severe, ☐ Unknown	
	☐ Mild, ☐ Moderate, ☐ Severe, ☐ Unknown	
	☐ Mild, ☐ Moderate, ☐ Severe, ☐ Unknown	
	☐ Mild, ☐ Moderate, ☐ Severe, ☐ Unknown	

Reaction List: 1) Arthralgia, 2) Chills, 3) Cough, 4) Fever, 5) Headache, 6) Hives, 7) Malaise/Fatigue, 8) Myalgia, 9) Nasal Congestion, 10) Other, 11) Pain/Soreness at injection site, 12) Rash, 13) Rhinorrhea, 14) Shortness of breath/Difficulty breathing, 15) Sore Throat, 16) Swelling, 17) Unknown

Are you allergic to medical adhesives such as tape, steri-strips, bandaids? ☐ No ☐ Yes, please list:
Are you allergic to any medications or local anesthesia? ☐ No ☐ Yes, please list:

Section VII: Women Only

Date of last mammogram: ______________________ Number of pregnancies: ______________

Do you do regular breast self-exams?	☐ Yes	☐ No
Do you breast feed?	☐ Yes	☐ No
Breast lump or discharge?	☐ Yes	☐ No
Are you pregnant or trying to get pregnant?	☐ Yes	☐ No
Are you on birth control pills or hormone replacement therapy?	☐ Yes	☐ No

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature: ______________________________ Date: ____________________

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Financial Policy

Appointment scheduling requires careful planning and coordination between our office, surgery centers and contracted staff. Special medical instrumentation and supplies may be ordered and are sterilized for each individual procedure. Please consider the importance of this policy before scheduling a procedure.

SURGERY SCHEDULING

A $1,000 down payment is required to secure a scheduled surgery time. **Full payment is due 21 days prior to a scheduled surgery date.** This includes complete payment of deductibles, co-insurance and copays for insurance cases. Immediately upon scheduling, patients have a **24-hour grace period** to make changes including cancelling the surgery without incurring a rescheduling/cancellation charge.

SURGERY RESCHEDULING / CANCELLATION FEES

Patients who wish to change the surgery date or cancel surgeries, will incur a fee. Patients, who **fail a cotinine test**, are considered patient cancellations. Adequate notice of cotinine testing is always given, so there is no reason for a failed test. A rescheduling/cancellation fee will be assessed on failed cotinine tests. Fees are first withheld from any down payments already paid before invoicing the patient. The fee schedule is as follows:

Days Prior to Surgery	Rescheduling Fee	Cancellation Fee
Over 21 days	$200.00	$300.00
15-21 days	$400.00	$500.00
8-14 days	$600.00	$700.00
1-7 days	$800.00	$900.00
24 hours or less	$1000.00	$1000.00

NON-SURGERY RESCHEDULING / CANCELLATION FEES

Generally, full payment is due on the day of service for non-surgical procedures such as those in the Renaissance Medispa and the Laser Institute of Wisconsin™. Some procedures have a non-refundable $250 fee payable at the time of booking. The booking fee will be applied to the cost of the actual procedure, or used to cover the cost of consumables and room setup, if the patient cancels the appointment without adequate notice. You will be notified if your service requires a booking fee.

If you must cancel or change your non-surgical appointment, please notify us at least **24 hours** prior to your appointment time so that we can try to fill your slot with another patient. Without this advance notice, you will either forfeit your $250 booking fee, if applicable, or be charged a **$50 service fee**. This also applies to **no-shows**.

It is your responsibility to call us if you wish to reschedule. Your appointments, such as in veins, may have a sequential and cumulative sequence that must be followed. If one appointment is missed, the rest are timed incorrectly and must be rescheduled. If we cannot contact you, or you do not contact us, then all your remaining appointments will be cancelled.

If you arrive late for your treatment, you may be asked to reschedule, so as not to delay the next scheduled client.

ALLOWABLE FORMS OF PAYMENT

Our office accepts payment by cash, check, money order and credit cards from Visa, Mastercard, Discover and American Express. We also offer patient financing through Care Credit and Alphaeon Credit. Not all patients will qualify for financing, and not all procedures are eligible to be financed.

INSURANCE: CO-PAYS, DEDUCTIBLES, CO-INSURANCE, DENIALS

Our office is happy to file claims with your insurance company as a courtesy. However, your insurance policy is a contract between you and your insurance company. Verification of benefits is not a guarantee of payment. You are responsible for understanding your coverage. You are financially responsible for 1) co-pays, deductibles, and co-insurance, 2) services not covered by your insurance, 3) services your insurance denies for any reason, and 4) charges not paid by your insurance plan. If your insurance does not pay for a service, you agree to be responsible for the remaining balance. Some services require prior authorizations or referrals. While we may assist in obtaining them,

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payment is not guaranteed by authorization approval. If your insurance denies payment, you are responsible for the balance.

The patient or his/her legal representative is ultimately responsible for all charges incurred. Our office accepts assignment of benefits for many insurance companies. However, we are not preferred providers with all of them. It is your responsibility to **contact your insurance as to whether we are in your plan**, obtain your individual benefits and to be prepared to pay for any out-of-pocket expenses such as co-pays, deductibles and co-insurance before any surgery or office procedure is done. **Co-pays, estimated patient balances, and past due balances are due at time of check-in**.

Medicare does not have a pre-authorization process for most procedures. If it is determined that your surgery was not medically necessary, you will then be billed for the surgery. It is ultimately **your responsibility to pay for all services** provided by Fox Valley Plastic Surgery.

BILLING

Statements are mailed monthly and expected to be paid in full within 60 days after your insurance has settled your claim. If you have financial difficulties, please contact our Financial Supervisor as soon as you are aware of the situation. The worst thing that you can do is to ignore the bill. Doing so will make you ineligible for any further service. Payment plans may be available upon request. If payment is not received within 90 days, your account may be sent to a collection agency.

DISPUTES

Performed services that are paid with a credit card, debit card or with financing, are not eligible for post-care payment challenges. Fox Valley Plastic Surgery encourages a complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy. I agree that this credit, debit card or financing challenge agreement is irrevocable.

I have read the above Financial Policy. I understand and agree to this.

Patient Signature: _____ Date: _____