PITRODA MEDICAL

VARICOSE VEIN SELF ASSESSMENT

Patient Name: _____

HISTORY

Have you ever had varicose vein? ☐ Yes ☐No

(Varicose veins are large, bulging veins, as opposed to spider veins, which are thin, branching veins just beneath the skins surface.)

SIGNS AND SYMPTOMS

Do you experience any of the following signs and symptoms in your legs or ankles?

(Check all that apply)

☐ Leg pain, aching or cramping
☐ Leg or ankle swelling, especially at the end of the day
☐ Open wounds or sores, such as above the inner ankle
☐ Burning or itching of the skin
☐ "Heavy" feeling in legs
☐ Skin discolorations or texture changes
☐ Restless legs

RISK FACTORS

Has anyone in your blood-related family ever had varicose veins or been diagnosed with chronic venous insufficiency or venous reflux? ☐ yes ☐ no

Have you had any treatments or procedures for vein problems in the past? ☐ yes ☐ no

Do you stand for long periods of time? (ex: at work) ☐ yes ☐ no

Do you frequently engage in heavy lifting? ☐ yes ☐ no

The Patient Health Questionnaire-2 (PHQ-2)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

PATIENT REGISTRATION – PITRODA MEDICAL, LLC.

(PLEASE COMPLETE ALL FIELDS)

Patient Name (Full Legal Name): Last _____ First _____ Middle _____

Responsible Party (Parent, if minor): _____

Residing Address: _____ City, State, Zip: _____

Mailing Address: _____ City, State, Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Email: _____

Sex: Female/Male Birthdate: ____/____/____ Social Sec #: ____-____-____

Marital Status: Single/Married/Widowed/Other Please Circle All That Apply: Employed Full-Time Student Part-time Student Unemployed

Patient's Employer/School: Name _____ Address: _____ Phone: (____) _____

Spouse's Name: _____ Spouse's DOB: _____ Phone: (____) _____

Emergency Contact (full name & phone number): _____ (____) _____

Primary Insurance Co: _____ Secondary Insurance Co: _____

Insurance Address: _____ Insurance Address: _____

ID #: _____ Group/Claim #: _____ ID #: _____ Group/Claim #: _____

Co-pay Amount: _____ Co-pay Amount: _____

Policy Holder Name: _____ Policy Holder Name: _____

Policy Holder's Date of Birth: ____/____/____ Policy Holder's Date of Birth: ____/____/____

Policy Holder's Sex: Female/Male Policy Holder Sex: Female/Male

Relationship to Patient: (Self) (Spouse) (Other) Relationship to Patient: (Self) (Spouse) (Other)

Policy Holder's Employer: _____ Policy Holder's Employer: _____

Policy Holder's Social Security #: ____-____-____ Policy Holder's Social Security #: ____-____-____

If this visit is related to a WORK-related injury OR an AUTO accident please complete following information:

Industrial/Auto Insurance Carrier: _____ Address: _____

Telephone: _____ Claim No: _____ Adjuster's Name: _____

Date of Injury/MVA: _____

If Industrial Injury: Employer at Time of Injury: _____ Employer phone #:(____) _____

Is case Open? (Please circle) Yes No Supportive Care Award: (Please circle) Yes No

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Release of Medical Records and Assignments of Benefits

I hereby authorize PITRODA MEDICAL, LLC. to release any information acquired in the course of my examination or treatment to my insurance company, HMO, hospitals or referring Physician's office. I authorize assignment of benefits and payment directly to Pitroda Medical, LLC. and agree to pay any and all charges that exceed or that are not covered by insurance, including any attorney and collection fees incurred for collection purposes. Photocopy of this release and assignment is as valid as the original.

Signature: _____ Date: _____

If Signature is other than the patient's, relationship to patient: _____

PITRODA MEDICAL, LLC.

Patient Privacy. Our practice is committed to securing the privacy of your health information. Accordingly, we have posted our practice's Notice of Privacy Practices in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been notified that the practice has such a Notice of Privacy Practices.

Print Name: _____

Signature _____ Date _____

Please list names of your spouse/significant other and/or children that can receive and/or discuss your medical information with us.

NAME/RELATIONSHIP	PHONE
_____	_____
_____	_____
_____	_____

This notice authorizes us to leave messages concerning appointments, lab results, etc. at the numbers you listed on your registration form. This also authorizes us to release information concerning your health to the names listed above.

Print Name: _____

Signature _____ Date _____

PHARMACY INFORMATION:

Please provide your pharmacy information:

Your name: _____

Pharmacy Name: _____

Pharmacy phone number: _____ Fax: _____

Pharmacy address: _____

Prescription refills are provided only for medications prescribed by Pitroda Medical, LLC. If you need a refill, please call your pharmacy. If your prescription is a narcotic, please call our office 72 hours prior to running out of your prescription.

HEALTH SUMMARY

Patient's Name (PLEASE PRINT): _____

Today's Date: _____ **DOB:** _____ **SS#:** _____

REVIEW OF SYSTEMS: Are you currently experiencing any of the following? Please check ALL boxes that apply.

CONSTITUTIONAL
- ☐ Good heath lately
- ☐ Recent weight gain
- ☐ Recent weight loss
- ☐ Fever
- ☐ Fatigue
- ☐ Headaches
- ☐ Other_____

GENITOURINARY
- ☐ Frequent urination
- ☐ Burning or painful urination
- ☐ Blood in urine
- ☐ Change in force of stream
- ☐ Incontinence or dribbling
- ☐ Kidney stones
- ☐ Sexual difficulty
- ☐ Other_____

CARDIO/VASCULAR
- ☐ Heart trouble
- ☐ Chest pain
- ☐ Palpitations
- ☐ Varicose veins
- ☐ Other_____

ALLERGIES
- ☐ Runny/Stuffy nose
- ☐ Watery eyes
- ☐ Itchy nose, eyes and roof of mouth
- ☐ Sneezing
- ☐ Pressure in the nose and cheeks
- ☐ Ear fullness and popping
- ☐ Dark circles under the eyes
- ☐ Hives
- ☐ Other_____

SKIN
- ☐ Rash or itching
- ☐ Change in skin color
- ☐ Change in hair or nails
- ☐ Other_____

NEUROLOGICAL
- ☐ Frequent or recurrent headaches
- ☐ Light headed or dizziness
- ☐ Convulsions/seizures
- ☐ Numbness or tingling
- ☐ Extremity Weakness
- ☐ Other_____

ENDOCRINE
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Excessive thirst/urination
- ☐ Heat or cold intolerance
- ☐ Other_____

EAR, NOSE & THROAT
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Sore throat
- ☐ Other_____

SLEEP
- ☐ Snoring
- ☐ Stop breathing/ gasp for air at night
- ☐ Dry mouth/ Sore throat
- ☐ Wake up with headaches
- ☐ Often tired during the day/ while driving
- ☐ Often fall asleep while reading/ watching TV
- ☐ Other_____

EYES
- ☐ Eye disease or injury
- ☐ Wear glasses/contacts
- ☐ Glaucoma
- ☐ Blurred or double vision
- ☐ Other_____

HEMATOLOGIC / LYMPHATIC
- ☐ Slow to heal after cuts
- ☐ Easily bruise or bleed
- ☐ Anemia
- ☐ Past blood transfusion
- ☐ Enlarged glands
- ☐ Other_____

RESPIRATORY
- ☐ Frequent coughing
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Asthma/Wheezing
- ☐ Other_____

GASTROINTESTINAL
- ☐ Loss of appetite
- ☐ Change in bowel movements
- ☐ Blood in stool
- ☐ Stomach pain
- ☐ Hemorrhoids
- ☐ Nausea/Vomiting
- ☐ Heartburn
- ☐ Other_____

MENTAL WELLNESS
- ☐ Memory loss
- ☐ Nervousness
- ☐ Depression
- ☐ Other_____

☐ MUSCULOSKELETAL
- ☐ Joint pain
- ☐ Joint stiffness or swelling
- ☐ Muscle pain/cramps
- ☐ Back pain
- ☐ Other_____

HEALTH SUMMARY

DRUG ALLERGIES: Please list ALL medications you are allergic to.

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

CURRENT MEDICATIONS: Please list ALL meds you are currently taking. Include dosage and how often you take each med.

Current Pharmacy: _____ Address: _____ Phone: _____

Please list any additional medications on a separate sheet of paper

MEDICATION (including over-the-counter)	Strength	How often do you take?

PREVIOUS MEDICAL ILLNESSES: Please check any illnesses you have had in the past.

Please list the year the illness was diagnosed beside any checked box*

- ☐ Anemia / Low Blood
- ☐ Anxiety
- ☐ Asthma
- ☐ Bleeding from Bowels
- ☐ Bleeding Problems, Type: _____
- ☐ Blood Clot in Leg
- ☐ Blood Clot in Lung
- ☐ Blood Transfusion
- ☐ Cancer, Type: _____
- ☐ Communicable Diseases, Type: _____
- ☐ Congestive Heart Failure
- ☐ Depression
- ☐ Diabetes / High Blood Sugar
- ☐ Emphysema / Chronic Bronchitis
- ☐ Epilepsy / Seizures
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heart Beat
- ☐ Kidney Disease, Type: _____
- ☐ Kidney Stones
- ☐ Liver Disease, Type: _____
- ☐ Prostate Problems
- ☐ Rheumatic Fever
- ☐ Skin Disease, Type: _____
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers in Bowels / Stomach
- ☐ Varicose Veins or Spider Veins
- ☐ Other: _____

_____

HEALTH SUMMARY

CURRENT SPECIALISTS:

SPECIALTY	NAME	LOCATION	PHONE #

Females ONLY: Please write "N/A" on the lines that DO NOT apply to you or leave blank.

Are you pregnant or planning to be pregnant soon? ☐ Yes ☐ No **Currently breast feeding?** ☐ Yes ☐ No

Number of: Pregnancies? ____ Miscarriages? ____ Deliveries? ____ Abortions? ____

Current form of Birth Control: _____

Date of most recent: Pap smear? _____ Abnormal Pap(s)? _____

Mammogram? _____ Abnormal Mammogram(s)? _____

SURGERY HISTORY:

SURGERY	DATE
Appendectomy	
Joint Scope Surgery	
Biopsy of:	
Open Heart Surgery	
Neck Artery Surgery	
Cataract Surgery ☐ R ☐ L	
Gallbladder	
Broken Bone Repair	
Colonoscopy - Normal/Abnormal	

SURGERY	DATE
Joint Replacement	
Back Disc Surgery	
Abdominal Surgery	
Tonsils Removed	
Prostate Surgery	
Vasectomy	
Hysterectomy	
Other: _____	

FAMILY HISTORY: Check box for any disease that has affected your parents, children, and or sisters.

Please write which family member beside any box checked below

- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Epilepsy / Seizures
- ☐ Bleeding Problems
- ☐ Sickle Cell Anemia
- ☐ Diabetes / High Blood Sugar
- ☐ Thyroid Problems
- ☐ Cancer /Type:
- ☐ Alcohol Abuse
- ☐ Anxiety or Depression
- ☐ Glaucoma
- ☐ Other:

HEALTH SUMMARY

SOCIAL HISTORY:

- **Primary language if not English:** _____
- **Current Employment:** ☐ Full-time ☐ Part-time ☐ Not working ☐ Retired ☐ Student
- **Marital Status:** _____
- **Do you have a living will?** ☐ Yes ☐ No
- **Religion:** Describe any ethnic, religious or cultural beliefs you have that may/will influence your treatment. _____

_____.

CURRENT HEALTH HABITS:

☐ Never ☐ Rarely ☐ Daily	- Have you ever smoked? ☐ Yes ☐ No - Number of Years: _____	- How many packs currently smoked daily? _____ - Use of smokeless tobacco? ☐ Yes ☐ No - Do you currently smoke? ☐ Yes ☐ No

- **Alcohol consumption:** ☐ Rarely ☐ Socially ☐ Never Quantity? _____

Pitroda Medical, LLC.

Financial Policy

Thank you for choosing Pitroda Medical, LLC, for your medical needs. Our staff is committed to providing you with the best care possible. Your clear understanding of the Financial Policy, which is an agreement between the practice and the patient or guarantor, is important to our professional relationship. We require a signature to document that you have read and understand this policy.

INSURANCE/PAYMENT: Insurance plans vary considerably and we cannot predict or guarantee what part of our services will or will not be covered. On arrival, please sign in at the front desk and present your current insurance card and photo ID as well as any other forms that may assist us in processing your claims correctly at every visit. It is the responsibility of the patient to provide *accurate* and *timely* insurance information. Inaccurate or untimely information given to the staff that results in denial of non-coverage by your insurance company results in the guarantor being responsible for payment. IF the patient is not the policy holder on the insurance, we require the policy holder's full name, date of birth, social security number and relationship to the patient, to file all claims. If your plan requires, you must name Dr. Pitroda as your primary care physician (PCP) prior to your first appointment. If Dr. Pitroda is not named on your insurance as your primary care physician (PCP), your appointment will need to be rescheduled. According to your contractual agreement with your insurance plan, you are responsible for your co-payment, coinsurance, and/or deductible at the time of service. It is important for you to be an informed consumer who understands the specification of your insurance policy regarding doctor visit coverage, referral/authorization requirements for specialty care, imaging studies, laboratory tests, emergency hospital care, etc. You should refer to information from your insurance company or call them if you have questions about your coverage.

BILLING: We accept cash, checks, MasterCard, Visa American Express and Discover. Outstanding balances are due within thirty (30) days unless prior arrangements have been made with the billing department. For balances over sixty (60) days, you will receive a final request for payment letter. Balances not paid in full within ten (10) days of the date on the final request letter will be forwarded to a collection agency. You will be responsible for any costs incurred if your account is turned over to a collection agency, which will include collection agency fees and in addition, court costs and attorney fees. We reserve the right to refuse service due to unpaid balances.

The guarantor is responsible for full payment at the time of service. We recognize that temporary financial problems may affect timely payment on your account. If such problems arise, we encourage you to contact our billing dept promptly for payment arrangements and assistance in the management of your account.

Should your account balance become uncollectable due to bankruptcy, we will continue to see you on an emergency basis for only the next thirty (30) days, giving you time to find a new source of medical care.

Please call if you have a question about your bill. Most problems can be settled quickly and easily and your call will prevent any misunderstandings.

PAYMENT POLICY ON OUTSTANDING BALANCES: Pitroda Medical, LLC. Offers alternative arrangements to assist you if you are not able to meet your financial obligation on outstanding balances. We offer a financial agreement that allow you to pay your past due balance for a maximum of twelve (12) months. A signed agreement in addition to a 20% down payment is required on all outstanding balances. Credit/Debit card monthly draft are the preferred method of payment. If your agreement is unfulfilled, we will be unable to schedule further appointments.

Pitroda Medical, LLC.

Financial Policy

IF WE PARTICIPATE WITH YOUR INSURANCE COMPANY: All services performed in our office will be submitted as a courtesy to your insurance. All co-payments, deductibles, and coinsurance are due at the time of service. All insurance carriers have a fee schedule from which they will reimburse. Not all services provided by this office are covered benefits in all contracts. Therefore, any balance not covered by insurance becomes the responsibility of the patient.

IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE COMPANY: We are not able to bill your insurance and we cannot accept payment from them for the services performed. We will provide you with a bill so that you may submit the charges to your insurance company for reimbursement. Payment for service is due in FULL at the time of service.

IF YOU DO NOT HAVE INSURANCE: If you are not covered by insurance at the time of service, please be advised that you will be responsible for all charges incurred at the time of service.

NON-EMERGENCY APPOINTMENTS: We will reschedule non-emergency appointments if there us an overdue balance on your account with no financial agreement in place or if payment is not made at the time of service.

MISSED APPOINTMENTS/LATE CANCELLATIONS: Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. For cancellations, a 24-hour notice prior to the appointment is requested. However, we understand emergencies arise, so please call us if you must miss an appointment. We reserve the right to charge a $25.00 fee for missed appointments without proper notification ($100.00 for vein consults and procedures).

RETURNED CHECKS: A $35.00 fee will be charged for all returned checks. If you write a check that is returned, your account will be placed on a cash only basis, meaning we will only accept cash or credit card payments.

AFTER-HOURS PHONE TRIAGE SERVICES: Pitroda Medical, LLC. Provides ("on-call coverage") after regular business hours. Effective May 1, 2020, we may charge $25.00 if you chose to utilize our after-hour phone triage service. If you use our services, we will expect you to pay for them and reserve the right to charge accordingly.

AFFIDAVITS/LEGAL MATTERS: Pitroda Medical, LLC. Charges a fee for affidavits, letters or forms that we prepare for legal or employment matters. Those fees are not billable to your insurance company or employer and are due at the time of service.

ANTI-VIDEO & AUDIO RECORDING POLICY: Video and audio recording is strictly prohibited in the office for all patient, family and physician interactions.

Pitroda Medical, LLC.

Financial Policy

FORMS: We require at least one (1) week to complete all forms. An appointment may be required depending on the nature of the form and information requested.

MEDICAL RECORDS: If you request a copy of your medical records, you will be required to sign a medical record release form and pay a medical record fee prior to having your records copied (fee details stated on release form). Please allow up to fourteen (14) days for this request to be processed.

REFERRALS: If your insurance plan requires a written referral for you to see a specialist, for procedures, or laboratory tests, you must allow no less than 1 week to complete the appropriate form(s) prior to obtaining services. You may have to reschedule your appointment if enough notice is not given to prepare your referral. Emergency referrals will be completed on the same day. Retroactive referrals cannot be written and will not be honored. In general, we will not agree to a referral for a problem we have not been consulted about first.

DISMISSAL PROCESS: There are several reasons that a patient may be dismissed from our practice. A few reasons are, but not limited to:

- Failure to keep scheduled appointments
- Being verbally or physically abusive to staff or other patients
- Failure to meet financial obligations

A certified letter will be sent to your last known address notifying you that you are being dismissed from our practice. If you have a medical emergency within thirty (30) days of the date of the letter, Dr. Pitroda will be available for advice. After thirty (30) days, you will no longer be seen at our practice by any provider. A copy of your medical record may be forwarded to our new doctor after a formal request is made and applicable fee (if any) are paid.

PLEASE DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT COMPLETELY.

PATIENT ACKNOWLEDGEMENT: I, _____ (print name), have read, understand, and agree to the Pitroda Medical, LLC. Financial Policy. I agree to pay at the time of service. I also understand that Pitroda Medical, LLC. Reserves the right to dismiss patients that fail to keep their accounts current after reasonable attempts to collect payments have been made. I further agree to pay all reasonable costs and late fees should may account be turned over to collections. I also understand the terms of this Financial Policy may be amended by the practice without prior notification to the patient or guarantor.

_____

Patient's or Responsible party Signature Date

Pitroda Medical, LLC

Parol Pitroda, MD

Authorization For Release of Health Information

Patient's name (Please Print) _____ Date of Birth _____

Address (Street, City, State, and Zip code _____ Phone _____

I, the undersigned, authorize the disclosure/ use of the above named patient's health information.

From: _____
Full name of Individual Entity

_____
Address (Street, City, State, and Zip Code)

_____ _____
Phone (Area code and Number) Fax (Area code and Number)

To: Pitroda Medical, LLC
2260 W. Higgins Rd., Suite 201
224-353-6361(Phone) 847-278-5398 (Fax)

I request that the following health information be disclosed to/ used by Pitroda Medical, LLC:
Please check all that apply.

Complete Medical Record ____	Progress/Visit Notes ____	Imaging Reports ____
Complete Billing Record ____	Consultation Reports ____	Laboratory Results ____
History and Physical Exams ____	Operative/Procedure Reports ____	Pathology Results ____

Other (Please specify): _____

The authorization is effective for one year from the date on which it was signed. I understand that I may revoke this authorization except that such revocation will not apply to any uses and disclosures of my information that are described in the Notice of Privacy Practices or otherwise allowable under any Federal or State Laws. In the event of revocation, any prior use of any information up to the date of revocation may not be retracted. To revoke this information, write to the Director of Pitroda Medical, Governor's Square Office Centre, 2260 W Higgins Rd, Suite 201, Hoffman Estates, IL 60169. Include a copy of this authorization with your correspondence.

Patient/representative Signature: _____ Date: _____

What is your relationship to the patient, if the patient is unable to sign, or the authority you have to act on behalf of this patient? You must be able furnish proof of relationship or authority to act for the patient: _____