LUMEN

LASER CENTER

ADVANCED VEIN AND SKIN HEALTH

919 Conestoga Road, Building Two, Suite 305, Bryn Mawr, PA 19010
610.525.0606, Fax: 610.525.5912, www.lumenlasercenter.com

Welcome to the LUMEN Laser Center – Vein Questionnaire

Name: ______________________________ Today's Date: ______________
First Middle Initial Last

Home Address: ____

City: ______________________ State: _______ Zip: __________

Home Telephone: ( ) ______________ Cell Phone: ( ) ________________

Work Telephone: ( ) ______________ *(Work number needed only to confirm appointments)*

Birthdate: ____________ Age: _____

Email Address: ________________________
We will not share your email address.

Your Pharmacy's Name and Phone Number: ______________________________

Social Security Number: __________________________

Your Primary Doctor's Name: ______________________ Phone: ______________
Office Location: ____
We will send a report to your primary doctor regarding your medical treatment here unless you check this box to indicate that you do not wish us to send a report: ☐

Your Obstetrician/Gynecologist's Name: ______________ Phone: ______________
Office Location: ____
We will send a report to your OB/GYN regarding your medical treatment here unless you check this box to indicate that you do not wish us to send a report: ☐

In case of emergency, contact: ________________Relationship: ______________

Home: ( ) ________________ Work: ( ) ________________

Cell: ( ) ________________

How did you learn about our practice?

- ◊ Referral from Dr. ___________________.
- ◊ My friend, ___________________ recommended you. ***Please ask us about our Referral Bonus Program.***
- ◊ The internet. Please specify ___________________________
- ◊ I saw your advertisement in a magazine: ____________________________
- ◊ I heard your advertisement on the radio.
- ◊ I read about you in an article.
- ◊ I came to one of your patient education events.
- ◊ I heard you speak at a seminar. (Given where? _______________________________)
- ◊ Other: ____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _______________________________ Relationship to Patient: _________________

Home Address if different ____

City: _________________________________ State: ___________ Zip: _____________

Telephone: (   ) _____________________ Birthdate: __________________

Employer: ____

Employer's Address: ____

City: _________________________________ State: _________ Zip: ____________

Work Phone: (   ) _______________________________

Would you be interested in having a free consultation for any of the following (please check):

- ☐ Cosmetic consultation for facial rejuvenation (BOTOX®, JUVÉDERM®, Restylane®, laser treatments)
- ☐ Non-invasive lipo treatment (SmartLipo™ and VASER®) for body contouring and fat removal
- ☐ Other cosmetic treatments (include any notes you would like to include below)

- Please see next page -

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OFFICE POLICIES AND AGREEMENT TO PAY

Please be advised of the following:

1. Your insurance is a contract between you, the insurance company and/or your employer. We are not a party to this contract. Not all services are covered benefits of all contracts. Cosmetic procedures are generally **not** considered a covered expense.
2. As a service to our vein patients, we will bill insurance carriers directly for visits and procedures, but please bear in mind that the patient is responsible for any outstanding balance. Should the insurance company for any reason not provide coverage for your procedures, you will be responsible for full payment.
3. **We require a copy of your Insurance ID card and Driver's License or other similar identification for insurance purposes.**
4. Co-payments, co-insurance and deductibles are due at the time of service. If balances are not paid within 30 days, a fee of $25 per month will be added to your account. We accept Visa/MasterCard, Discover, American Express, cash and personal checks. In the event of a returned check, a $25 returned check fee will be charged.
5. Patients with deductibles are asked to provide a credit card as backup for unpaid balances due beyond 30 days. We will contact you by phone to let you know that your card will be charged for the balance due unless you make payment arrangements with our office.
6. If a referral is required for your visit, it is the patient's responsibility to obtain this referral prior to any treatment at the center. If this is not obtained, you will be held financially responsible for all payments.
7. All charges, including deductibles, co-insurance and co-payments, any services that are not covered by your insurance plan, and any service that your insurance company has determined not to be "medically necessary," are the responsibility of the patient once services are administered. If financial issues do arise, please contact our staff for assistance as soon as possible.

Scheduling and Cancellation Policy

Your appointment time is very important to us. **For weekday appointments**, we ask that you notify us at least 48 hours in advance for an appointment change. **For Saturday appointments,** please kindly notify us 3-days in advance for an appointment change. Chronic short notices will have a $75 cancellation fee added to the account. If your appointment must be rescheduled or cancelled due to insurance authorization delays, no charge will be made to your account.

Late Arrival Policy

We respect the time of all of our patients. We strive to stay on schedule so that your wait time is minimal. If you arrive late for your appointment, every effort will be made to see you the same day. However, you may be required to wait, or your appointment will be rescheduled. Please call the office if you are running late.

Please ask any questions regarding the above information to a member of our staff.

Signature

I acknowledge that every billing effort will be made to my insurer for the reimbursement of my medical procedure, and in the event of insurance denial to pay I will be financially responsible for the full amount of the billed charges or the remaining balance after my insurer has paid.

I give valid consent for the release of all medical record documentation to any insurance company for determination of reimbursement for the treatment procedure. I also authorize all benefit information pertaining to my insurance be released to help in the reimbursement process. My consent is valid for whatever timeframe is necessary until further notice.

I have read, understand and accept all terms listed above. I will ask for a copy of this document if I would like to have one for my records.

Patient Signature ______________________________ Date ______________________

Patient Name (Printed) ____________________________

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Physician: Andrew Kwak, M.D.
919 Conestoga Road, Building Two, Suite 305, Bryn Mawr, PA 19010
Phone: 610.525.0606, Fax: 610.525.5912, www.lumenlasercenter.com

PATIENT VENOUS HISTORY

Name ______________________________ Date of Birth __________________

Today's Date _________________________

Please circle your responses below and provide as much information as possible. Thank you.

1. Have you had any prior treatment for varicose/spider veins? YES NO
   Date(s) of treatment ________________________________
   Type of agent(s) used, if known ________________________

2. Do you have any history of ulcerations, clots in veins, or deep vein thrombosis? YES NO

3. Do you have a family history of varicose/spider veins? YES NO

   If so, relationship(s) to you and treatments received:

   ____

4. Are you currently, or have you been on any hormone therapy or birth control pills? YES NO
   If so, please list type and dates taken:

   ____

5. Have you had any pregnancies? If so, how many? _________ YES NO

   If so, did your varicose/spider veins increase after your pregnancies? YES NO

   Are you currently pregnant, or are you planning to become pregnant in the next six months? YES NO

6. Are you presently employed and if so, type of job: YES NO

   ____

7 Do you sit or stand for long periods of time? YES NO

How many hours per day? ______

8 Have you ever taken any pain medications for your varicose/spider veins (Aspirin/Tylenol/Motrin)? YES NO

9 Have you ever elevated your legs to relieve your symptoms? YES NO

Please list all of your medications:

Comprehensive History Checklist

Please check all of the symptoms that apply to you.

	Right Leg	Left Leg
Edema (abnormal accumulation of fluid)		
Pain		
Tiredness		
Ulceration		
Skin Color Changes		
Spider Veins		
Varicose Veins		