An AZ VEIN CLINIC
Medical Director: Alessandra Puggioni, MD

7331 E Osborn Dr. Ste 220
Scottsdale, AZ 85251
Tel.: (480)247-8662
FAX.: (480)247-8842
www.yourveins.com

New Patient Welcome Packet

The information contained/requested in this packet is intended to help you and us achieving the best medical care possible. After we finish gathering all pertinent information (this form, your history, any available labs/tests, a physical exam),

Dr. Puggioni will review with you all the findings and establish your treatment plan.

Please bring the following items to your first appointment:

- **Filled registration forms**
- **Insurance Card**
- **Photo ID**
- **List of current medications, including dosage and indication**
- **List of allergies and reaction**
- **Any pertinent medical documentation (labs, diagnostic tests)**
- **A pair of shorts or a skirt for leg exam**

This is a fragrance-free facility, and we ask our patients and their accompanying family members/friends not to wear any body fragrances (perfume, aftershave, hair spray, scented lotions) or smoke prior to their appointments.

Thank you!

Please do not hesitate to call the office if you have any questions at 480-247-8662. We look forward to meeting you and being part of your health care team.

MA ______________________________

DEMOGRAPHICS

LAST NAME: ________________________

FIRST NAME: ________________________ MI: ________

DATE OF BIRTH: _____/_____/________ GENDER: _ M _ F

RACE: _________ SOCIAL SECURITY #:______-_____-_______

ADDRESS : _________________CITY: _________________ STATE:______ ZIP:__________

CELL PHONE: ________________WORK PHONE: ________________ HOME PHONE: _______________

EMAIL (for portal): ______________________@______________________________

1st LANGUAGE: __________________2nd LANGUAGE__________________

MARITAL STATUS: _SINGLE _ MARRIED _ PARTNERED _ DIVORCED _ WIDOWED

PREGNANT_ (check if applicable), NURSING_ (check if applicable)

OCCUPATION (S):____________________________________

IF RETIRED, PRIOR OCCUPATION:_______________________

EMPLOYER:______________

Whom may we thank for referring you to our practice? ___________________________

EMERGENCY CONTACT INFORMATION

NAME: _______________________

CELL PHONE: ______________HOME/WORK PHONE: _________________

RELATIONSHIP TO PATIENT: _________________

PRIMARY CARE PHYSICIAN`s NAME: _______________________

PHONE: ______________FAX: _________________

PHARMACY NAME: ___________PHARMACY PHONE: ____________

PHARMACY LOCATION: ____

By signing below, I attest that the information provided above is true and accurate.

Signature of Patient / Guardian: ___________________________________

Date: _____/______/_________

MA

INSURANCE INFORMATION

Primary Insurance:_______________________ Policy No.:___________________

Group No.:_______________

Subscriber's Name (Last, First, Middle Initial):___________________,______________________,_________

Relationship:__________________________________

Subscriber`s Date of Birth:_______/________/________

Address:_________________________________ City:_____________________ State:______

Zip:___________

Occupation: _________________________ Employer:______________________

Work No.:________________

Secondary Insurance:_____________________ Policy No.:___________________ Group No.:_______________

Subscriber's Name (Last, First, Middle Initial):______________________,______________________,_________

Relationship:____________________________Date of Birth:_______/________/________

By signing below, I attest that the information provided above is true and accurate.

Signature of Patient / Guardian: _______________________________________

Date: _____/______/_________

DRUG ALLERGIES:

IODINE : NO YES: Reaction ________________ LIDOCAINE: NO YES: Reaction __________________

LATEX: NO YES: Reaction _________________ MORPHINE NO YES: Reaction ___________________

PENICILLIN: NO YES: Reaction ____________ BANDAID, TAPE, ADHESIVE ***NO YES: Reaction:___________***

List additional allergies and reactions: ____

____

MEDICATIONS

Current Medication List: (skip if a separate list was provided)

NAME	STRENGTH	FREQUENCY	PERSCRIBING Dr.	DURATION OF USAGE
___________________	_____________	_____________	________________	__________________
___________________	_____________	_____________	________________	__________________
___________________	_____________	_____________	________________	__________________
___________________	_____________	_____________	________________	_________________
___________________	_____________	_____________	________________	__________________
___________________	_____________	_____________	________________	__________________
___________________	_____________	_____________	________________	__________________
___________________	_____________	_____________	________________	__________________

ARE YOU CURRENTLY TAKING ANY SUPPLEMENTS/OVER THE COUNTER MEDICATIONS: FISH OIL, GARLIC, GINGER, ETC.? NO YES: LIST NAMES AND INCLUDE DOSAGE

____

____

____

ARE YOU CURRENTLY TAKING ANY HORMONES INCLUDING: DHEA, ESTROGEN,TESTOSTERONE, BIRTH CONTROL, IUD? NO YES: LIST EXACT NAME AND INCLUDE DOSAGE

____

____

MA ____

FAMILY MEDICAL HISTORY about your biological parents, siblings and children, if known.

Please *complete the family history in full*, as this information is very relevant to your medical care.

FAMILY RELATIONSHIP TO YOU	M-Male F-Female	L-Living D-Deceased	Age	Medical Conditions (include: diabetes, heart disease, varicose veins etc.)
1. MOTHER		L D		
2. FATHER		L D		
3.	M F	L D		
4.	M F	L D		
5.	M F	L D		
6.	M F	L D		
7.	M F	L D		
8.	M F	L D		
9.	M F	L D		

Comments:____

PERSONAL MEDICAL HISTORY

Anemia Yes ☐
Anxiety Yes ☐
Migraine Yes ☐
Depression Yes ☐
Dementia Yes ☐
Other Psychiatric dz Yes ☐
COPD Yes ☐
Asthma Yes ☐
Epilepsy Yes ☐
GERD Yes ☐
Dermatitis Yes ☐
Heart failure Yes ☐

Back problems Yes ☐
Aneurysms Yes ☐
Arterial clots Yes ☐
Arthritis Yes ☐
Gout Yes ☐
Glaucoma Yes ☐
HIV Yes ☐
Hepatitis Yes ☐
Hypothyroidism Yes ☐
Stroke Yes ☐
Heart attack Yes ☐
Hypertension Yes ☐

Pacemaker Yes ☐
Defibrillator Yes ☐
Heart murmur Yes ☐
Atrial Fibrillation Yes ☐
Stomach ulcer Yes ☐
Breast cancer Yes ☐
Prostate Cancer Yes ☐
Other cancer:__________
Diabetes Yes ☐
Arterial blockage Yes ☐
Coronary artery disease Yes ☐
High cholesterol Yes ☐

Other medical conditions:____

MA

PREGNANCY HISTORY

Number of Pregnancies: ______ Number of Children: ______ Age of Children:____,_____,_____,_____,____,___

Comments:____

SOCIAL HISTORY

Tobacco Use: 1) **No, never**. 2) **Yes, Current**. Amount cig./day? ___________

3) **Yes, but I quit**. When did you stop smoking cigarettes? _______________

Alcohol Use: No Yes. Type: Wine Beer Liquor__________________

If Yes, amount: n.____Glasses/servings Daily Weekly Monthly

Recreational Drugs: Never Quit / When? ____ Current: type/amount? __________________

PAST SURGERIES, INCLUDING COSMETIC PROCEDURES

SURGERY TYPE	REASON	HOSPITAL	YEAR
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Comments:____

REVIEW OF SYMPTOMS: PLEASE CROSS ALL OF YOUR CURRENT SYMPTOMS

Constitutional:	Chills	Y	□	Fatigue	Y	□	Fever	Y	□
	Weakness	Y	□	Weight Gain	Y	□	Weight Loss	Y	□
Head:	Dizziness	Y	□	Fainting	Y	□	Headaches	Y	□
EYE:	Blurry Vision	Y	□	Discharge from eye	Y	□	Double Vision	Y	□
	Eyeglass Use	Y	□	Vision Loss	Y	□	Eye pain	Y	□
ENT:									
Nose:	Nosebleeds	Y	□	Sinus Infection	Y	□			
Mouth/Throat:	Bleeding Gums	Y	□	Hoarseness	Y	□	Mouth infections	Y	□
Ears:	Hearing Aid	Y	□	Hearing Impairment	Y	□	Ringing in Ears	Y	□
Respiratory:	Asthma	Y	□	Cough	Y	□	Coughing blood	Y	□
	Shortness of breath	Y	□	Sputum	Y	□	Wheezing	Y	□
Cardiovascular:	Extremities Cool	Y	□	Extremity(s) Discolored	Y	□	Hair loss on legs	Y	□
	Heart Murmur	Y	□	High Blood Pressure	Y	□	Past heart attack	Y	□
	Leg Pain - Walking	Y	□	Chest Pain	Y	□	Palpitations	Y	□
	Rheumatic fever	Y	□	Short of Breath	Y	□	Blood clots	Y	□
Gastrointestinal:	Abdominal Pain	Y	□	Antacid Use	Y	□	Black Tarry Stools	Y	□
	Change in BM	Y	□	Constipation	Y	□	Decreased Appetite	Y	□
	Diarrhea	Y	□	Heartburn	Y	□	Hemorrhoids	Y	□
	Laxative Use	Y	□	Nausea	Y	□	Rectal Bleeding	Y	□
	Swallowing Problem	Y	□	Vomiting	Y	□	Vomiting Blood	Y	□
Musculoskeletal:	Back Problems	Y	□	Deformities	Y	□	Joint Pain	Y	□
	Paralysis	Y	□	Muscle cramps	Y	□	Muscle Stiffness	Y	□
	Behavioral change	Y	□	Disorientation	Y	□	Excessive Stress	Y	□
Psychiatric:	Feeling depressed	Y	□	Hallucinations	Y	□	Memory Loss	Y	□
	Mood changes	Y	□	Nervousness	Y	□	Psychiatric disorders	Y	□
	Nipple Discharge	Y	□	Breast Lumps	Y	□	Breast Tenderness	Y	□
Breast:	Dryness	Y	□	Easy bruisability	Y	□	Eczema	Y	□
Skin:	Hives	Y	□	Itching	Y	□	Lumps	Y	□
	Nail texture change	Y	□	Rashes	Y	□	Skin Color Change	Y	□

MA ______________________________

Neurological:	Toes burning sensation	Y	☐	Dizziness	Y	☐	Fainting	Y	☐
	Migraines	Y	☐	Loss of consciousness	Y	☐	Memory Loss	Y	☐
	Numbness	Y	☐	Paralysis	Y	☐	Speech disorders	Y	☐
	Tingling	Y	☐	Tremors	Y	☐	Unsteady gait	Y	☐
Endocrine:	Cold Intolerance	Y	☐	Heat Intolerance	Y	☐	Sweats	Y	☐
	Weakness	Y	☐	Weight Gain	Y	☐	Weight Loss	Y	☐
Hematologic:	Anemia	Y	☐	Bleeding Easily	Y	☐	Easy Bruising	Y	☐
Allergic/Immune	Frequent infections	Y	☐	Swollen glands	Y	☐			
	Sneezing	Y	☐	Stuffy Nose	Y	☐	Wheezing	Y	☐
Genitourinary:	Awakening to Urinate	Y	☐	Blood in Urine	Y	☐	Burning during urination	Y	☐
	Frequent urination	Y	☐	Kidney stones	Y	☐	Urgency to urinate	Y	☐
	Urinary incontinence	Y	☐	Urinary infections	Y	☐	Urinary Retention	Y	☐
Males Only:	Hernias	Y	☐	Impotence	Y	☐	Prostate problems	Y	☐
Females Only	Heavy periods	Y	☐	Menopause	Y	☐	Pain on Intercourse	Y	☐
	Pelvic pain/pressure	Y	☐	Fertility Problems	Y	☐	Vaginal discharge	Y	☐

PLEASE LIST ALL OF YOUR CURRENT PHYSICIANS

Physician's name____Speciality_____________________

Address: _______________________________ City:____________________ State:______ Zip:__________

Phone Number: ______________________________Fax Number:_________________________________

Physician's name____Speciality_____________________

Address:_______________________________ City:____________________ State:______ Zip:__________

Phone Number: ______________________________Fax Number:_________________________________

Physician's name____Speciality_____________________

Address:_______________________________ City:____________________ State:______ Zip:__________

Phone Number: ______________________________Fax Number:_________________________________

Physician's name____Speciality_____________________

Address:_______________________________ City:____________________ State:______ Zip:__________

Phone Number: ______________________________Fax Number:_________________________________

Pharmacy:____ Location:______________________________

Address:____

Phone:____ Fax:____________________________________

REASON(s) FOR TODAY'S VISIT:____

____

PLEASE ANSWER THE FOLLOWING QUESTIONS ACCURATELY, AND TO THE BEST OF YOUR KNOWLEDGE.
THIS IS A NECESSARY STEP FOR OPTIMAL MEDICAL CARE, AS WELL AS INSURANCE COVERAGE OF TESTS/THERAPIES.

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS/SYMPTOMS?

Varicose Veins	□	**Hair loss on legs**	□	**Cellulitis and leg infections**	□
Spider Veins	□	**Restless legs**	□	**Did you experience a leg blood clot in the past?**	yes □ no □
Leg Swelling	□	**Have you tried leg elevation?**	yes □ no □	When?	__________
Night cramps	□	Does leg elevation eliminate the symptoms?	yes □ no □	Which leg?	R □ L □
Leg Heaviness	□	**Have you tried compression stockings?**	yes □ no □	**Do you exercise regularly?**	yes □ no □
Leg burning	□	When did you start wearing compression stockings?	__________	**Are you on a weight loss diet?**	yes □ no □
Ulcers (sores) on Legs	□	How many hours a day do you wear them?	__________	**Do you take pain medication for leg pain?**	yes □ no □
Leg dermatitis	□	How many days/week?	__________	What pain medication?	__________
Extremity(s) Discolored	□	What is the strength of compression?	__________	How many pills a week?	__________
Foot numbness	□	a) 8-15 mmHg	□	**What activities are limited by leg symptoms?**	
Leg numbness	□	b) 15-20 mmHg	□	c) Feeding	□
Leg Pain	□	d) 20-30 mmHg	□	e) Bathing	□
What leg is the worst?	R □ L □	f) Other:	__________	g) Dressing	□
Pain intensity (0-10)	0-1-2-3-4-5-6-7-8-9-10	Are you currently wearing compression stockings?	yes □ no □	h) Grooming	□
What triggers leg pain?		Do compression stockings eliminate the symptoms?	yes □ no □	i) Meal Preparation	□
1- pain walking	□	**Did you experience phlebitis?**	yes □ no □	j) Household chores	□
2- pain exercising	□	How many times?	1□ 2□ >2□	k) Occupational tasks	□
3- pain sitting	□	**Any bleeding from veins**?	yes □ no □	l) Prolonged standing	□
4- pain standing	□	How many times?	1□ 2□ >2□	m) Walking	□
5- pain is always present	□	Required blood transfusion?	yes □ no □	n) Other	__________

Please describe how your leg symptoms affect your life:

Sign and date:____

MA ____

Any prior vein treatments?	yes □ no □		
How many times?	1□ 2□ >3□		
Stripping?	yes □	Dates:	Surgeon:
Vein ablation?	yes □	Dates:	Surgeon:
Sclerotherapy:	yes □	Dates:	Surgeon:
Other?		Dates:	Surgeon:
Any prior leg vein ultrasounds?	yes □ no □		
Dates:	1. ____ 2. ____ 3. ____ 4. ____	Location:	1. ____ 2. ____ 3. ____ 4. ____
Any other test for your veins?	yes □ no □	Date and type/location: ____	

ALESSANDRA PUGGIONI, M.D.
7331 E. OSBORN DR. SUITE 220
SCOTTSDALE, AZ 85251
(480) 247-8662

Patient Authorization for Release of Insurance Benefits

I, ______________________________, hereby authorize Alessandra Puggioni, MD, PLLC to apply for benefits from (Insurance Co.)_______________________and that these benefits may be paid directly to Dr. Puggioni, (or in case of Medicare Part B benefits, to myself or the party who accepts assignments).

I certify that the information I have reported with regard to my insurance is correct, and further authorize the release of any necessary information, including medical information for this or any related claim, to the above billing agent (or in the case of Medicare Part B benefits, to the Social Security Administration and Centers for Medicare and Medicaid Services and/or (other Insurance Co.) to:

Insurance name: ______________________ in order to determine benefits to which I may be entitled.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me or the above carrier at any time in writing.

Signature:____ Date:______________________________

Authorization to Pay Benefits to Physician

I hereby authorize payment directly to Alessandra Puggioni, MD of the surgical and/or medical benefits, if any, otherwise payable to me for service described by the Attending Physician's Statement and Billing. It is understood that any monies received from the insurance company named above, over and above my indebtedness, will be refunded to me when my bill is paid in full.

I understand that I am financially responsible for all charges not covered by this authorization.

I also understand should this matter be placed in the hands of an attorney for collection, I am financially responsible for additional charges (attorney fees and court costs).

Signature of Patient:_____________________________________ Date: ________________

All services, including any cosmetic visits, diagnostic tests and follow-ups are subject to a financial charge. Please discuss any financial concerns prior to seeking medical treatment in this private office. Payments are due as services are rendered.

MA ______________________________

YOURVEINS of AZ
ALESSANDRA PUGGIONI, M.D.
7331 E. OSBORN DR. SUITE 220
SCOTTSDALE, AZ 85251
TEL: (480) 247-8662 FAX: (480) 247-8842

Patient Authorization to Release/ Restrict Disclosures or Use of Protected Health Information

Patient Name:____________________________________ Date of Birth:_______/________/_______

Previous Name(s) (if applicable):____

A) I authorize this health care provider and facility to receive all/some of my past health information from all /some of my treating physicians/labs/radiology reports:

Yourveins of AZ, Alessandra Puggioni, M.D. P.L.L.C. Phone: (480) 247-8662 Fax:(480) 247-8842
Address: 7331 E Osborn Drive Ste 220 Scottsdale, AZ 85251.

Specify any restriction of time period or type of report:____

Patient/ Legally Authorized Individual Signature:___________________________Date:_______________

Printed Name of Individual if Signed on Patent's Behalf:____

Relationship to Patient (e.g. parent, legal guardian):____

B) I request that this office transmits my Protected Health Information (PHI) to certain individuals/physicians, or for certain purposes (indicate which doctors you would like us to fax notes/labs/tests to):

1- ALL MY DOCTORS:___ yes □ no □__________INITIAL:___________

2- ONLY CERTAIN DOCTORS/INDIVIDUALS_ yes □ __________INITIAL:___________

LIST OF DOCTORS/INDIVIDUALS WHO MAY RECEIVE MY RECORDS FROM DR PUGGIONI`s OFFICE:_

__1)____2)____

__3)____4)____

I understand that any restrictions agreed to by this office do not apply to use or disclosure of my PHI by this office for emergency medical care or as otherwise provide by law. I may revoke this authorization at any time, but I must do so in writing and submit it to this office. I understand that I do not have to sign this authorization and that my treatment, payment, enrollment, or eligibility for benefits at Dr Puggioni`s office will not be denied if I do not sign this authorization.

Patient/ Legally Authorized Individual Signature:__________________________Date:_______________

Printed Name of Individual if Signed on Patent's Behalf:__________________________

Relationship to Patient (e.g. parent, legal guardian):____

MA

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Patient Financial Responsibility Policy Statement

Yourveins is pleased to provide you, our patient, with the highest level of care for your health and quality of life. We strive to employ the most professional staff and deliver services to you with the latest technology and education available each day. You and Yourveins, together, will combine our energies to bring positive results to your healthcare needs.

Yourveins, in its continuous efforts to deliver the best in care, requires payment of all known patient responsible balances at time of service. These balances may include but are not limited to: co-pays, deductibles, co-insurance (amounts as stated in the benefits coverage contract with your insurance carrier), self-pay, balance from previous dates of service, or out-of pocket amounts for services that may provided during your current visit.

We appreciate your understanding and cooperation to ensure that Yourveins is able to continue its provision of the highest level of services to all in need by our staff and facilities.

Payment Policy:

Payment is expected at time of service for any applicable co-pay, co-insurance, balances and/or deductible. Yourveins accepts Checks, Visa, or MasterCard, American express or Discover as forms of payment for your convenience. **WE DO NOT ACCEPT CASH AS A METHOD OF PAYMENT.**

If your check is returned to Yourveins for insufficient funds, a thirty-five dollar ($35.00) returned check fee would be applied to your outstanding balance.

As a courtesy to our patients we will bill your insurance. If your insurance company does not pay in a timely manner (90 days) the balance will become your responsibility. It is your responsibility to verify that Dr. Alessandra Puggioni is a contracted provider within your insurance network and that desired services are covered by your plan. Please check with your insurance prior to all of your appointments to discover any changes made to your policy. Please notify our staff if any changes have occurred in your insurance policy, address or phone number.

Delinquent Accounts Policy:

Any unpaid bills over 90 days will be reported to a collection agency following standard collection procedures to resolve any outstanding balances. If an account is reported to a collection agency, a collection fee will be added to any outstanding balance. Please inform our billing staff if you know your payment will be late in arriving or if you require payment arrangements. Patients who fail to honor this agreement will be dismissed as a patient after 90 days of unpaid outstanding balance.

I will ask questions about fees and expected payments to my insurance and Yourveins office staff prior to obtaining any medical services in this office. By signing, I understand and agree to all of the above statements/policies.

Patient Name and Signature: ______________________________ **Date:**____________________

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Notice of privacy practice (1)

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures: our practice collects personal health information on you that may be used for three primary purposes.

TREATMENT- For example, we will prepare a record of information each time we see you in our office while you are under our care. This medical records is used to keep track of changes in your condition as well as remind us of your past care, treatment, allergies, and other facts relevant to your overall health. This information may be passed on to other providers as part of a coordinate health care program for you.

PAYMENT- We must report elements of your personal health information, such as specific treatments, visits, tests and operations along with related diagnosis to third party payers to properly determine benefits payable on your behalf for the services we render. We only report the minimum necessary information to process the claim.

HEALTH CARE OPERATIONS- In order to provide you with high-quality health care, we often need to be able to use your personal health information for purposes such as pre-registering you at the hospital if you need to be admitted to providing your pharmacy with prescription so that it is ready to be picked up when you arrive. Again, we are committed to using the minimum necessary information to achieve these purposes.

In addition, we will use your personal health information under the following circumstances:

When we receive a valid authorization from you

If you give us an oral authorization

If we are required by law to disclose your personal health information to others such as public health agencies

Required Disclosures: We are required to disclose the information to you if you request it and we are required to disclose the information to the US Department of Health and Human Services for compliance determinations of the practice. We may disclose information about you without your authorization for the following reasons:

When required by law, for judicial proceedings or law enforcement

For workers compensation

For uses and disclosures about decedents

Uses and disclosures for cadaveric tissue donation

To avert a serious threat to health or safety

For disclosures about abuse, neglect, or domestic violence.

Other uses and disclosures will be made only with your written authorization and you may revoke such authorization by writing to us at our practice address or delivering a written revocation to us in person. We may periodically call you to remind you of appointments and we may advise you of treatment alternatives and benefits that may be of interest to you based on your health condition or status.

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Notice of privacy practice (2)

Your Rights:

You have the right to request restrictions on the use and disclosures of your personal health information. Our practice is not obligate to accept your restrictions. However, if we for accept your request, it must be complied with fully on our part.

You have a right to inspect and have a copy of your personal health information. If you would like a copy please request the information in writing or use a form available in our office for the request. If you would like to have all records printed, there is an office fee of $35 that needs to be collected beforehand before you are able to receive those records.

You have the right to request amendments to your personal health information. We will not amend any information we did not create. We are not obligated to make an amendment to your personal health information, but we will include your request for the amendment as part of your personal health information.

You have a right for accounting for the prior six years (but no earlier than the effective date of this notification) for uses and disclosure for purposes other than treatment, payment and health care operations of our practice.

You have a right to a paper copy of this notification. The current version will be provided to you at your request.

OUR DUTIES:

We are obligated by law to protect your privacy and we will do our best to fulfill that duty to you. We will abide by all the terms in this notification but we reserve the right to change the terms of this notice and the personal health information it protects. You are entitled to a copy of those changes.

We will do our very best to make certain your rights are protected and we carry out our responsibilities to you. If you have any compliant, we encourage you to contact us. It is our sincere desire to preserve your privacy and fulfill our duties. We will take no retaliatory action against any person exercising their right to resolution of grievance. To the contrary, we encourage your comments and criticisms. If we cannot resolve the issue for you, you have the right to file a grievance with the US Department of Health and Human Services.

I hereby acknowledge that I have been presented with a copy of the Notice of Privacy Practices for the office of Dr. Puggioni.

Patient Name and Signature: ______________________________Date:_________________________

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MEDICATION HISTORY CONSENT FORM

By signing below I give permission for **Yourveins of AZ** to access my pharmacy benefits data electronically through Healthfusion.

This consent will enable us to:

- Determine the pharmacy benefits and drug co pays 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 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. Check drug to drug interactions between medications you have been prescribed here and elsewhere.

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

Patient Name and Signature: ____

Date:_________________________