



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

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.

A pink, rectangular sticky note with a white border and a slight shadow, tilted at an angle. It contains the handwritten text "Thank you!" in a dark pink, cursive font.

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.

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: ____/____/____



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

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		<input type="checkbox"/> L <input type="checkbox"/> D		
2. FATHER		<input type="checkbox"/> L <input type="checkbox"/> D		
3.	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> L <input type="checkbox"/> D		
4.	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> L <input type="checkbox"/> D		
5.	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> L <input type="checkbox"/> D		
6.	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> L <input type="checkbox"/> D		
7.	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> L <input type="checkbox"/> D		
8.	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> L <input type="checkbox"/> D		
9.	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> L <input type="checkbox"/> D		

Comments: _____

PERSONAL MEDICAL HISTORY

Anemia	Yes	<input type="checkbox"/>	Back problems	Yes	<input type="checkbox"/>	Pacemaker	Yes	<input type="checkbox"/>
Anxiety	Yes	<input type="checkbox"/>	Aneurysms	Yes	<input type="checkbox"/>	Defibrillator	Yes	<input type="checkbox"/>
Migraine	Yes	<input type="checkbox"/>	Arterial clots	Yes	<input type="checkbox"/>	Heart murmur	Yes	<input type="checkbox"/>
Depression	Yes	<input type="checkbox"/>	Arthritis	Yes	<input type="checkbox"/>	Atrial Fibrillation	Yes	<input type="checkbox"/>
Dementia	Yes	<input type="checkbox"/>	Gout	Yes	<input type="checkbox"/>	Stomach ulcer	Yes	<input type="checkbox"/>
Other Psychiatric dz	Yes	<input type="checkbox"/>	Glaucoma	Yes	<input type="checkbox"/>	Breast cancer	Yes	<input type="checkbox"/>
COPD	Yes	<input type="checkbox"/>	HIV	Yes	<input type="checkbox"/>	Prostate Cancer	Yes	<input type="checkbox"/>
Asthma	Yes	<input type="checkbox"/>	Hepatitis	Yes	<input type="checkbox"/>	Other cancer: _____		
Epilepsy	Yes	<input type="checkbox"/>	Hypothyroidism	Yes	<input type="checkbox"/>	Diabetes	Yes	<input type="checkbox"/>
GERD	Yes	<input type="checkbox"/>	Stroke	Yes	<input type="checkbox"/>	Arterial blockage	Yes	<input type="checkbox"/>
Dermatitis	Yes	<input type="checkbox"/>	Heart attack	Yes	<input type="checkbox"/>	Coronary artery disease	Yes	<input type="checkbox"/>
Heart failure	Yes	<input type="checkbox"/>	Hypertension	Yes	<input type="checkbox"/>	High cholesterol	Yes	<input type="checkbox"/>

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

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

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

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 (pain, swelling etc): _____

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

When did your leg symptoms start? _____

Please describe how your leg symptoms affect your life (i.e. unable to walk, exercise, etc). *We will not be able to send claims to your insurance without a detailed and accurate description on how much your varicose veins affect your life.*

If left blank treatments may be considered cosmetic.

Sign and date: _____

Any prior vein treatments?	yes <input type="checkbox"/> no <input type="checkbox"/>		
How many times?	1 <input type="checkbox"/> 2 <input type="checkbox"/> >3 <input type="checkbox"/>		
Stripping?	yes <input type="checkbox"/>	Dates:	Surgeon:
Vein ablation?	yes <input type="checkbox"/>	Dates:	Surgeon:
Sclerotherapy:	yes <input type="checkbox"/>	Dates:	Surgeon:
Other?		Dates:	Surgeon:
Any prior leg vein ultrasounds?	yes <input type="checkbox"/> no <input type="checkbox"/>		
Dates:	1. _____ 2. _____ 3. _____ 4. _____	Location:	1. _____ 2. _____ 3. _____ 4. _____
Any other test for your veins?	yes <input type="checkbox"/> no <input type="checkbox"/>	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.

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 Patient'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 THIS 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 Patient's Behalf: _____

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

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 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 be provided during your current visit.

A \$80 no-show fee will be charged to your account for all no-shows, or if an appointment is not canceled by phone call within 48h prior, or for any 15 min tardiness that requires rescheduling. Monday appointments need to be rescheduled by 5pm the prior Thursday by phone call. Web cancellations are not available at this time.

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:** _____

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

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.

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

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 obligated to accept your restrictions. However, if we do 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 complaint, 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:** _____

MA

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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: _____
