GENERAL CONSENT FORM TO THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that **VeinSolutions, a division of Cardiothoracic and Vascular Surgeons** creates and maintains medical and related records that include personal healthcare information, including my health records, symptoms, demographic information, diagnoses, examination and test results, treatment, and any plans for future care or treatment. This is my "protected health information".

I understand and consent to the use and disclosure of my Health Information by **VeinSolutions** a division of **Cardiothoracic and Vascular Surgeons** for the following purposes:

My treatment: This includes the provision, coordination, or supervision of my healthcare and related services, including the coordination or management of my care and consultation between healthcare professionals related to my treatment, or my referral to another healthcare professional and participation in SureScripts Pharmacy database.

Payment for healthcare services provided to me: This includes actions undertaken by a health plan to decide coverage of the provision of benefits to me, by my Provider or a health plan to obtain or provide compensation for my care, or otherwise related to me.

My Provider's internal operations: This includes quality assessment and improvement activities; reviewing provider performance and training; activities relating to health insurance and benefits; conducting or arranging for medical review, legal services, and audits; business planning and development; and business management and general administrative activities including customer service, resolution of internal grievances, due diligence, and creating de-identified healthcare information.

My personal release: I authorize the release of my protected healthcare information to myself at any time.

I understand and agree that:

I have the right to review **VeinSolutions**, a division of **Cardiothoracic and Vascular Surgeons** *Notice of Privacy Practices for Protected Health Information,* which provides a much more detailed description of information uses and disclosures, prior to signing the consent.

VeinSolutions, a division of **Cardiothoracic and Vascular Surgeons** may change or modify it *Notice of Privacy Practices for Protected Health Information* at any time and I have the right to obtain a revised notice of privacy practices by accessing the **Cardiothoracic and Vascular Surgeon's** website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I have the right to request restrictions as to how my Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations. I understand and agree that my Provider is not required to agree to any restrictions that I may request, but if my Provider agrees, it will be bound by that restriction.

I have the right to revoke this consent by notifying my Provider *in writing* that I revoke this consent unless my Provider has used or disclosed my Health Information in reliance on this consent.

My Provider has the right to disclose relevant Health Information to my family member, other relative, close personal friend, or anyone identified by me.

VeinSolutions General Consent Form to the Use and Disclosure of Protected Health Information

_____

Signature of Patient

_____

Printed Name of Patient

_____

Date

_____

Guardian or responsible party signature

I hereby authorize the release of my protected health information to the following individuals:

_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship
_____ Name	_____ Relationship

Thank you for scheduling a venous exam. If the physician finds it necessary, additional testing may be necessary before treatment can be undertaken. You will be financially responsible for the testing and consultation. The physician will discuss your diagnosis and treatment options based on your individual situation. These options may include:

- **SCLEROTHERAPY (INJECTION THERAPY)**-This office procedure is done in the VeinSolutions office as an outpatient.
- **LASER/LIGHT THERAPY**-These office procedures are done in the VeinSolutions office as an outpatient.
- **VENOUS DUPLEX EXAM**- This diagnostic test is done it the Vascular Lab at VeinSolutions. Austin. **This test needs to be completed at the VeinSolutions Vascular lab due to the specific information needed by our surgeons.** Please check with VeinSolutions before making arrangements to have this test completed elsewhere.
- **VENOUS SURGERY**-This is done as an outpatient at various hospitals in the Austin area.
- **ENDOVENOUS LASER ABLATION / VNUS CLOSURE-** This is done in the VeinSolutions office.

At the end of your initial screening exam your surgeon will also indicate whether your diagnosis and treatment plan is considered medically necessary or cosmetic.

If sclerotherapy or laser/light therapy is recommended, you will be given an estimated fee and approximate number of treatments anticipated to achieve your desired results. **Laser/Light therapy and sclerotherapy for spider veins, reticular veins and varicose veins is typically considered cosmetic and is not covered by insurance companies.**

You will be responsible for payment for sclerotherapy, compression hose (dispensed by VeinSolutions), laser/light treatment and "co-pays" on the day services are rendered. We accept cash, check, MasterCard, Discover Visa, or Care Credit. VeinSolutions will only file a claim that the surgeon considers "medically necessary". **IF THE SURGEON DETERMINES YOUR CLAIM TO BE COSMETIC, VEINSOLUTIONS WILL NOT FILE YOUR CLAIM WITH YOUR INSURANCE COMPANY.**

If your surgeon recommends a venous duplex exam this will be completed at the VeinSolutions Vascular Lab. If your insurance plan requires a referral from your primary care physician, this will need to be obtained before you can proceed with any further medically necessary treatment or testing. Please inform the staff if you have this type of insurance plan. The test and return office visit to discuss the results may be scheduled the same day if possible, or on another day when the surgeon is available. **You will be charged an office consultation when your test results are reviewed with you.** Most insurance plans cover venous duplex exam and office consultations **if** they are shown to be **"medically necessary"** as determined by the insurance company (subject to deductible and co-insurance).

If surgery is recommended VeinSolutions will obtain pre-certification and pre-determination of medical necessity with your insurance company before surgery is scheduled. The surgeon will clearly explain to you if any of the surgical procedure is considered "cosmetic". The "cosmetic" portion of your surgery will need to be paid 2 weeks before your scheduled surgery. It is your responsibility to furnish VeinSolutions with your current insurance card(s) and notify our office if you have any changes involving your insurance plan. It is your responsibility to verify your benefits with your insurance company, which we strongly recommend.

Please sign to verify you have received and read this information.

Printed Name of Patient: _____

Signature:_____ **Date:**_____

Parent or Guardian Signature:_____

VeinSolutions ***Communication Release***

VeinSolutions would like to keep your family physician, general practitioner, internist or referring physician informed of your health care.

VeinSolutions will fax your physician of choice a letter today regarding your exam.

Please list your physician:_____

Type of physician practice:
- ❑ Family Practice/General Medical Practice
- ❑ Internal Medicine
- ❑ Other:_____

Phone Number:_____FAX Number_____

By signing below I authorize release of medical information from my office visit(s) at VeinSolutions to the above physician.

Patient Signature:_____ Date:_____

Patient Name (Printed):_____

By signing below indicates that I would not like a physician notified of my visit(s) to VeinSolutions.

Patient Signature:_____ Date:_____

Patient Name (Printed):_____

I understand that VeinSolutions does not accept Workman's Compensation Benefits.

I understand also, that VeinSolutions will not evaluate any work-related injuries.

_____

Printed Name of Patient

_____ _____

Signature of Patient **Date**

I understand on ALL services billed to my insurance provider, there maybe an additional balance due. This is determined by my insurance providers benefit plan. This includes co-pays and deductibles.

I understand that I may have a certain percentage responsibility for the surgeon's fees, hospital fees, and anesthesia fees if my procedure is done in the hospital.

I understand that if my insurance denies the claim(s) for medical necessity, etc, that I will be financially responsible for the payment of services according to the protocol of this office.

I understand that I will have full responsibility for cosmetic fees AND any balance due after insurance claim has been paid.

I understand that any deposits made for surgery will be first applied to any balance due after insurance has been billed. If there is any balance after bill is paid, I will receive a refund. I understand that if I cancel my procedure in less than 48 hrs unless for a medical emergency or I do not show up for my procedure, any deposit will not be refunded.

_____

Printed Name of Patient

_____ _____

Signature of Patient **Date**