SOUTH AUSTIN
VEIN CENTER

Patient Information:

Name (First) _____ (MI) ___ (Last) _____
Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Cell Phone _____
Email Address _____
DOB ____/____/____ Social Security # _____ Sex: ☐Male ☐Female
Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Domestic Partner
Occupation _____ Employer _____

In Case of Emergency, Contact:
Name _____ Phone _____
Relationship to patient _____

Insurance Information (Please provide card to Front Office Coordinator)

☐Patient ☐Spouse – Name of Guarantor _____
Primary _____ Group _____ ID # _____
Insured's Name _____ DOB ___ / ___ / ____ SS# _____

Secondary _____ Group _____ ID # _____
Insured's Name _____ DOB ___ / ___ / ____

How did you hear about us?
Physician referral: _____ Magazine ad _____
Friend/ Family: _____ Radio ad: _____
Newspaper ad: _____ Television News Show: _____
Website: _____ Facebook: _____
Other: _____

Primary Care Physician:

Name _____
Address _____ City _____ State _____ Zip _____
Phone _____

Pharmacy:

Location: _____ Phone number: _____

I authorize South Austin Vein Center/Michael M. Di Iorio, MD, PLLC to execute any documents necessary, and release to my health insurance carrier, or other organization as required, any pertinent medical information about myself as may be required to process claims for reimbursement of fees charged to me for medical treatment at South Austin Vein Center.

Signature _____ Date _____

Michael M. Di Iorio, MD, PLLC

SOUTH AUSTIN
VEIN CENTER

HIPAA PATIENT CONSENT FORM

I understand that I have certain Rights to privacy regarding my protected health information. These rights are given to me under the Health Information Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize Michael M. Di Iorio, MD, PLLC to use and disclose my protected health information (PHI) to carry out the following:

- Treatment (including direct and indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of South Austin Vein Center

I have also been informed of, and given the right to review a secure copy of the Michael M. Di Iorio, MD, PLLC Privacy Statement, which contain a more complete description of the uses and disclosures of my PHI and my rights under HIPAA. I understand that Michael M. Di Iorio, MD, PLLC reserves the right to change the terms of this notice at anytime and that I may contact Michael M. Di Iorio, MD, PLLC at any time to obtain the most current copy of this notice.
I understand that I may revoke this consent at anytime through proper notification. However, any use or disclosure that occurred prior to the revocation date is not affected.

_____ _____
Patient Signature Date

PHONE CONSENT

I wish to be contacted in the following manner: **(check all that apply),** be sure to fill in phone numbers.

- ☐ Home Telephone #:_____
  - ☐ Can leave a message with detailed information
  - ☐ Leave a message with a call back number only
- ☐ Work Telephone #:_____
  - ☐ Can leave a message with detailed information
  - ☐ Leave a message with a call back number only
- ☐ Cellular #:_____
  - ☐ Can leave a message with detailed information
  - ☐ Leave a message with a call back number only
- ☐ Written Communication
  - ☐ Okay to mail to my Home Address
  - ☐ Okay to Fax to this number(s):_____
- ☐ Family Member #:_____

Other Requests:_____

_____ _____
Patient Signature Date

PATIENT ACKNOWLEDGEMENT

PRINTED PATIENT NAME: _____ MR#: _____

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. Our Patient Rights and Responsibilities describes your rights under the law. You have the right to review our Notices before signing this acknowledgement. By signing this form, you acknowledge that you were provided a copy of the Michael M. Di Iorio, MD, PLLC/dba: South Austin Vein Center Notice of Privacy Practices and Patient Rights and Responsibilities. These notices describe the use and disclosure of protected health information about you for treatment, payment, health care operations, and other uses and disclosures as stated. They also describe certain patient entitled rights and certain patient responsibilities to fulfill healthcare needs.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- Michael M. Di Iorio, MD, PLLC/dba: South Austin Vein Center has a Notice of Privacy Practices and Patient Rights and Responsibilities and the patient has the opportunity to receive a paper copy of these Notices.
- Michael M. Di Iorio, MD, PLLC/dba: South Austin Vein Center reserves the right to change the Notice of Privacy Practices and Patient Rights and Responsibilities at any time. A current copy of these notices may be obtained by contacting our office.
- Michael M. Di Iorio, MD, PLLC/dba: South Austin Vein Center will also use and share your health information as required/permitted by law.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION UPON REQUEST

I, _____, give my permission to disclose protected health information from my health records, including financial information, to the following person(s).

Name(s): _____

☐ I do not authorize the release of my medical and/or billing information to anyone other than myself.

Patient Signature: _____ Date: _____

AUTHORIZATION TO ASSIGN BENEFITS AND STATEMENT OF FINANCIAL RESPONSIBILITY

I authorize and request that the payment of Medicare and/or insurance benefits be made directly to Michael M. Di Iorio, MD, PLLC/dba: South Austin Vein Center for any and all services provided to me by Michael M. Di Iorio, MD, PLLC/dba: South Austin Vein Center. If my health insurance will not allow direct payment to Michael M. Di Iorio, MD, PLLC/dba: South Austin Vein Center or if Michael M. Di Iorio, MD, PLLC/dba: South Austin Vein Center chooses not to accept assignment of medical benefits, I agree to immediately forward to Michael M. Di Iorio, MD, PLLC/dba: South Austin Vein Center any and all health insurance payments I receive. I acknowledge that I am responsible for all charges for services provided by Michael M. Di Iorio, MD, PLLC/dba: South Austin Vein Center, including any non-covered services or amounts not paid by insurance. This also applies if coverage is provided by Medicare, a Health Maintenance Organization, a Worker's Compensation policy, or any other third-party payers.

Patient Signature: _____ Date: _____

GENERAL CONSENT TO TREAT

By signing below, I authorize the health care providers at Michael M. Di Iorio, MD, PLLC/dba: South Austin Vein Center, to conduct examinations, diagnostic tests and procedures to assess my health care

conditions, and to provide care, services or therapies necessary to effectively diagnosis and treat me. I understand that it is the responsibility of my treating health care provider(s) to explain to me the nature of proposed care, treatment, services, prescribed medications, suggested interventions, or procedures. Before I undergo particular procedures or tests, my provider(s) will explain the potential benefits, risks, or side effects, including potential problems that might occur during recuperation, the likelihood of achieving goals, reasonable alternatives, and the relevant risks, benefits, and side effects related to the alternatives, including the possible results of not choosing to undergo the recommended treatment. I consent to the presence of students, trainees, observers, medical sales representatives, and/or non-facility personnel as deemed necessary and/or appropriate at the discretion of my physician and/or the management of Michael M. Di Iorio, MD, PLLC/dba: South Austin Vein Center.

Patient Signature: _____ Date: _____

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Michael M. Di Iorio, MD, PLLC/dba: South Austin Vein Center. When you schedule an appointment with South Austin Vein Center, we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective June 1, 2023 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least a 24 hour notice will be considered a No Show and charged a $50.00 fee.
- For ALL cosmetic patients, a $50 deposit will be required to schedule an appointment, this fee will go towards treatment cost. However, if patient fails to show or cancel/reschedule without a 24 hour notice, then this fee will be forfeited as a no show fee.
- The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee. You may contact South Austin Vein Center 24 hours a day, 7 days a week at the numbers below. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message. Messages left are acceptable.

South Austin Vein Center (512) 614-1025.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

Printed Name:_____

Signature: _____ Date: _____

Michael M. Di Iorio, MD, PLLC

SOUTH AUSTIN
VEIN CENTER

5301-A Davis Lane, Suite 210
Austin, TX 78749
(512)614-1025

FINANCIAL RESPONSIBILITY

1. I understand that I,_____, am responsible for confirming my medical benefits or that of my dependent with my carrier/insurance group and that I am expected to have this information at the time of my first visit.
2. I understand that Michael M. Di Iorio, MD, PLLC cannot guarantee that the information received from my insurance company is accurate. I am fully responsible for all charges posted to my account.
3. I understand that Michael M. Di Iorio, MD, PLLC will bill my insurance company according to all Federal rules and regulations regarding such activities and provides my insurance company with copies of all appropriate and required information and that Michael M. Di Iorio, MD, PLLC is not responsible for lost claims.
4. I understand thatMichael M. Di Iorio, MD, PLLC will make any reasonable effort to assist me in resolving any disputed claims or payment for such claims, but that the contractual relationship for payment of such claims lies solely between myself and my insurance carrier and that I am ultimately responsible for all services provided.
5. I understand that if my plan is out-of-network or services are determined "non-covered" due to plan provisions and/or pre-existing conditions or riders on my policy, I am fully responsible for all services incurred.
6. I understand that if I elect to pay privately at my first visit, due to lack of insurance, lack of coverage, failure to provide my insurance card at the time of service, or failure to verify coverage, Michael M. Di Iorio, MD, PLLC will NOT retroactively submit claim or change account responsibility.

ASSIGNMENT OF BENEFITS

1. I assign to Michael M. Di Iorio, MD, PLLC the right to receive payments for all healthcare services rendered by the Company to me or my dependent.
2. I will cooperate, aid, and assist in procuring Michael M. Di Iorio, MD, PLLC payments for healthcare services rendered to me or my dependent from any third party that is or may be liable for such services.
3. I understand and agree that I am responsible and must pay all deductibles, co-payments and amounts disputed by my insurance carrier for healthcare services rendered by Michael M. Di Iorio, MD, PLLC to me or my dependent.
4. I understand and agree that Michael M. Di Iorio, MD, PLLC may utilize any legal means to collect payment for any healthcare services rendered to me or my dependent. In the event that legal action is taken, in order to enforce the terms and conditions of this Agreement, the prevailing party shall be entitled to recovery of all attorney and/or collection fees and costs.

Signature: _____ Date:_____
Patient, POA, Parent and/or Guardian

SOUTH AUSTIN VEIN CENTER

Name: _____ Date of Birth: _____ MR#: _____

Provider: _____

---------- Please Complete Below ----------

Current Medications: _____

_____

Allergy to Medications: _____

_____

Past Medical History: _____

_____

Do you experience any of the following in your leg(s):

Aching/pain	☐ Y ☐ N	Leg: ☐ R ☐ L
Heaviness	☐ Y ☐ N	Leg: ☐ R ☐ L
Tiredness/fatigue	☐ Y ☐ N	Leg: ☐ R ☐ L
Itching/burning	☐ Y ☐ N	Leg: ☐ R ☐ L
Swelling	☐ Y ☐ N	Leg: ☐ R ☐ L
Cramps	☐ Y ☐ N	Leg: ☐ R ☐ L
Restless legs	☐ Y ☐ N	Leg: ☐ R ☐ L
Throbbing	☐ Y ☐ N	Leg: ☐ R ☐ L
Skin or ulcer problems	☐ Y ☐ N	Leg: ☐ R ☐ L
Other:	☐ Y ☐ N	Leg: ☐ R ☐ L

When did you first notice enlarged or discolored veins, or begin experiencing leg discomfort?

_____

Do you have a family history of vein problems? ☐ No ☐ Yes

Have you had previous vein treatment/surgery? _____

Have you ever had any of the following?
Family history of blood clots? ☐ No ☐ Yes, What family member? _____
Clotting disorder? ☐No ☐Yes please explain: _____
Deep vein blood clot (DVT)? ☐No ☐Yes, When _____
Pulmonary embolus (blood clot to lungs)? ☐No ☐Yes, When _____
Migraine with aura: ☐No ☐Yes
Patent Foramen Ovale (PFO): ☐No ☐Yes

In the past 90 days have you tested positive for COVID-19? ☐Yes ☐No

Are you breast feeding? ☐Yes ☐No

Are you pregnant? ☐Yes ☐No

Patient Counseling Consent for Sclerotherapy with Asclera

ABOUT THIS FORM

This form is designed to provide you with the information you need to make an informed decision about whether to have Sclerotherapy performed today. If you have any questions or do not understand any potential risks, please do not hesitate to ask us.

WHAT IS SCLEROTHERAPY?

Asclera® (polidocanol) Injection is a prescription FDA-Approved medicine that is used in a procedure called sclerotherapy to remove unwanted varicose and spider veins on your legs. It is administered by your healthcare provider.

Sclerotherapy (pronounced sklair-o-THAIR-uh-pee) is a medical procedure that has been used since the 1930's to treat varicose and spider veins. As the standard of care, it is Gold Standard therapy and is considered one of the most effective treatments for removing unwanted leg veins.

Today's procedure involves injecting Asclera directly into your vein(s), to seal, shut down and fade over several weeks. The treated vein is then naturally resorbed by the body.

DOES SCLEROTHERAPY WORK FOR EVERYONE?

Individual results may vary depending on varicose vein severity, disease progression, skin tone, and number of treatments.

Most people treated will have good results, however, there is no guarantee that Sclerotherapy will be effective in every case.

In clinical studies, 88% of patients were satisfied or very satisfied with their Asclera treatment at 12 weeks.

HOW MANY TREATMETNS WILL I NEED?

The number of treatments differs from patient to patient, depending on the extent of spider veins present. One to six or more treatments may be needed; the average is three to four.

You and your provider will discuss a treatment plan that addresses your needs.

WHAT ARE THE MOST COMMON SIDE EFFECTS?

- Bruising: Lasts from one to several weeks. Use of support hose may be recommended and avoidance of alcohol and anticoagulant medication for 72 hours prior to each treatment session may minimize effect.
- Transient Hyperpigmentation: Approximately 30% of patients who undergo Sclerotherapy notice a discoloration of light brown streaks after treatment. In almost every patient, the veins become darker immediately after the procedure (but then go away.) In rare instances, this darkening of the vein may persist for four to twelve months.
- Pain: A few patients may experience mild pain at the site off the injection. The veins may be tender to the touch after treatment. This pain is usually temporary, in most cases lasting from 1-7 days at most.

- Blood accumulation in treated vessel: This may present as a tender bump at a treatment site. The use of prescribed compression hosiery will minimize this possibility (especially when treating Reticular Veins.)

WHAT TO DO AFTER TREATMENT?

- Wear compression hose 15-20mmHg for 2 days continuously, and then for an additional 3 days during the daytime only, for best results continue to wear compression 2 weeks during the daytime
- Walk for 15-20 minutes daily
- For 2 days, avoid heavy exercise and for 5 days avoid sunbathing, long plane flights, hot tubs/sauna and pond/lake/river water

Contraindications: Patients with significant coagulation, circulatory problems, insulin dependent diabetes or pregnant woman should not undergo today's procedure.

I acknowledge that I have read and understand this consent form. A copy has been provided by my healthcare provider.

I also acknowledge that I am not pregnant or am breast feeding and do not have any of the disease processes listed above.

_____

Patient Name (please print): _____ DATE: _____

Patient Signature: _____ DATE: _____

Provider Signature : _____ DATE: _____