

# Midwest Vein Treatment Clinic, Inc

RONALD G. BUSH M.D., F.A.C.S.  
8101 MILLER FARM LANE CENTERVILLE, OH 45459  
937-281-0200 • Fax 937-281-0200

You have been scheduled to see Dr. Ronald Bush. PLEASE COMPLETE AND BRING THIS INFORMATION to your appointment on \_\_\_\_\_ . Please arrive at \_\_\_\_\_

NAME \_\_\_\_\_  
Last First MI

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_

AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

SOC. SECURITY NO. \_\_\_\_\_

OCCUPATION \_\_\_\_\_

WORK NUMBER \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_

FAMILY DOCTOR \_\_\_\_\_

REFERRING DOCTOR \_\_\_\_\_

PHARMACY \_\_\_\_\_

PHARMACY NUMBER \_\_\_\_\_

Spouse's occupation \_\_\_\_\_

Spouse's employer \_\_\_\_\_

Work Number \_\_\_\_\_

## HEALTH INSURANCE

Primary carrier \_\_\_\_\_

Insurance address \_\_\_\_\_

Insurance ID# \_\_\_\_\_

Group # \_\_\_\_\_

Policyholders name and date of birth and social security number  
\_\_\_\_\_  
\_\_\_\_\_

Secondary carrier \_\_\_\_\_

Insurance address \_\_\_\_\_

Insurance ID# \_\_\_\_\_

Group # \_\_\_\_\_

Policyholders name and date of birth and social security number  
\_\_\_\_\_  
\_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship \_\_\_\_\_

Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_  
\_\_\_\_\_

Your first visit is a consultation with the doctor. If you have any questions regarding the information enclosed, please call our office. Any applicable co-pays will be collected at time of each visit.

**PLEASE BRING YOUR INSURANCE CARDS AND A PAIR OF SHORTS WITH YOU**

# MEDICAL HISTORY

**THE FOLLOWING INFORMATION WILL HELP YOUR PHYSICIAN PLAN YOUR CARE.  
PLEASE PRINT AND COMPLETE THIS SECTION**

Male \_\_\_\_\_ Female \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

What problem are you seeking care for?

---

---

---

Check and or list all illnesses/problems you have been treated for in the past and present:

- |                                       |  |  |   |
|---------------------------------------|--|--|---|
| <input type="checkbox"/> none         | <input type="checkbox"/> heart attack          | <input type="checkbox"/> angina              | <input type="checkbox"/> diverticulitis     |
| <input type="checkbox"/> heart murmur | <input type="checkbox"/> mitral valve prolapse | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> crohn's disease    |
| <input type="checkbox"/> stroke       | <input type="checkbox"/> asthma                | <input type="checkbox"/> low blood pressure  | <input type="checkbox"/> ulcerative colitis |
| <input type="checkbox"/> blood clots  | <input type="checkbox"/> stomach trouble/ulcer | <input type="checkbox"/> bleeding disorder   | <input type="checkbox"/> hepatitis          |
| <input type="checkbox"/> COPD         | <input type="checkbox"/> emphysema             | <input type="checkbox"/> kidney problems     | <input type="checkbox"/> seizures           |
| <input type="checkbox"/> bladder      | <input type="checkbox"/> arthritis             | <input type="checkbox"/> diabetes            | <input type="checkbox"/> tuberculosis       |
| <input type="checkbox"/> cancer       | <input type="checkbox"/> depression            | <input type="checkbox"/> cirrhosis           | <input type="checkbox"/> other              |

---

---

Please list any surgeries you have had:

---

---

---

**LIST ALL MEDICATION YOU CURRENTLY TAKE, THE DOSE AND HOW OFTEN**

\_\_\_\_\_ NONE      **DRUG ALLERGIES** \_\_\_\_\_

**MEDICATION, DOSE AND FREQUENCY**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_
11. \_\_\_\_\_
12. \_\_\_\_\_
13. \_\_\_\_\_
14. \_\_\_\_\_
15. \_\_\_\_\_

## Venous History

Please answer the following questions.

### Past Medical History – provide estimates for date of occurrence

- |  |  |            |
|--|--|------------|
| 1. Have you ever had vein stripping?       | <input type="checkbox"/> Yes <input type="checkbox"/> No | When _____ |
| 2. Have you ever had vein injections?      | <input type="checkbox"/> Yes <input type="checkbox"/> No | When _____ |
| 3. Have you ever had a blood clot?         | <input type="checkbox"/> Yes <input type="checkbox"/> No | When _____ |
| 4. Have you ever had a pulmonary embolism? | <input type="checkbox"/> Yes <input type="checkbox"/> No | When _____ |
| 5. Have you ever had phlebitis?            | <input type="checkbox"/> Yes <input type="checkbox"/> No | When _____ |
| 6. Bleeding varicose veins?                | <input type="checkbox"/> Yes <input type="checkbox"/> No | When _____ |
| 7. Have you ever had migraines?            | <input type="checkbox"/> Yes <input type="checkbox"/> No | When _____ |

### Family History

Anyone in your family with a history of blood clots, pulmonary embolism or ulcers?

Yes  No

Are you currently pregnant or breast feeding?  Yes  No

### Current Vein History

Do you experience any of the following symptoms that interfere in activities of daily living?

- |                   |                                |                               |
|-------------------|--------------------------------|-------------------------------|
| Aching/pain       | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| Heaviness         | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| Tiredness/fatigue | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| Itching/burning   | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| Swelling/edema    | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| Restless legs     | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| Bleeding          | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| Sores/Ulcers      | <input type="checkbox"/> Right | <input type="checkbox"/> Left |

### What pain medication have you taken for relief of symptoms?

Aspirin  Ibuprofen  Aleve  Tylenol  Other \_\_\_\_\_

Does elevation relieve your leg symptoms?  Yes  No

### What else have you tried to improve your symptoms?

Exercise  Weight loss  Compression stockings How long \_\_\_\_\_

HAVE YOU HAD	YES	NO	EXPLAIN
allergic rhinitis			
asthma, chronic bronchitis			
eczema, hives, rash			
reactions to bandaids			
<b>HAVE YOUR REACTED FROM</b>			
poinsettia plant			
balloons, rubber gloves			
elastic or stretchy fabric			
elastic bandages			
<b>DENTAL VISITS</b>			
itching, tearing, sneezing,			
unexplained fatigue, drowsiness			
facial swelling, itching redness			
<b>HAVE YOU REACTED TO</b>			
avocados, bananas, tropical fruit			
chestnuts			
urinary catheters			
have you been tested for latex allergy			
do you wear an allergy bracelet?			
does your job involve latex contact?			

NAME \_\_\_\_\_ DATE \_\_\_\_\_

# Midwest Vein Treatment Clinic, Inc.

8101A Miller Farm Lane  
Centerville, OH 45459

## FINANCIAL AGREEMENT

We are committed to providing you with the best possible care. If you have medical insurance, we are qualified to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

**Vein Surgery Patients:** As a courtesy, we will send your photos and medical information to your insurance company. The letter will request that your insurance company send you a letter stating whether these procedures/supplies are covered and how much they will pay. This letter is normally sent out within 2-3 weeks of your first visit to our office. If you do not hear from your insurance company within 6-8 weeks, we recommend that you contact them for their response. We have no control over whether they respond to this request. (This letter will not be sent to Medicare or secondary insurance). If an insurance plan requires a precertification for outpatient procedures, it is the patient's responsibility to alert their insurance plan themselves.

**Payment for services not covered by insurance are due at the time of services are rendered unless payment arrangements have been approved in advance by our management. All other balances must be paid within 90 days of the date of service. Returned checks and balance older than 90 days will be subject to additional collection fees and interest charges of 1 1/2% per month.**

We require at least a two (2) week notice for all vein surgery cancellations. A \$200.00 fee will be charged if a two (2) week notice is not given.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most insurance companies. This statement does not apply to insurance companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. Midwest Vein Treatment Clinic, Inc. and doctors participate ONLY with the insurance companies listed on our current information sheet.
5. For Medicare Risk Plan HMO patients, we do not participate with your HMO, therefore you will be responsible for all charges out of pocket.
6. For Medicare patients, we do accept assignment with Medicare. Therefore, we will file your vein surgery claims, Laser and Sclerotherapy claims for symptomatic varicose to Medicare and you will be responsible for the Medicare co-insurance amount and deductible. You will be responsible for payment of any non-covered services/supplies and no claim will be sent to Medicare.
7. Any insurance payment paid to you by your insurance company must be paid to Midwest Vein Treatment Clinic, Inc. Within one (1) week of receipt.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment on your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

I request that payment of authorized Medicare/Insurance benefits are made to Midwest Vein Treatment Clinic, Inc. for any services furnished to me by that physician. I authorize release to the Health Care Financing Administration or said insurance company and its agents any medical information about me needed to determine these benefits or benefits payable for related services.

I have read and fully understand the above statements regarding payment policies and agree that I am responsible for any fees incurred on account of services provided to me.

-----  
Patient/Guarantor's Signature

-----  
Witness

-----  
Date