PLEASE ANSWER TO THE BEST OF YOUR KNOWLEDGE TO HELP YOUR DOCTOR MAKE DECISION REGARDING YOUR CARE

NAME (First, Middle initial, Last) Mr/ Ms/ Mrs/ Dr:____ AGE _____ HT ________ WT _______

REFERRING PHYSICIAN ___________________________________ CITY_______________________PHONE #: (_______)__________________

REFERRAL SOURCE _______________________________________ REASON FOR VISIT____

YOUR VENOUS HISTORY

Do you now have or have you had: (circle affected leg(s))

Unsightly veins	Right	Left
Aches and pains in legs	Right	Left
Heaviness or tired legs	Right	Left
Ankle swelling	Right	Left
Itching in legs	Right	Left
Leg cramps	Right	Left
Bleeding from the veins	Right	Left
Pigmentation (discoloration)	Right	Left
Dermatitis (eczema)	Right	Left
Ulceration in legs	Right	Left
Which leg hurts more?	Right	Left

How many years have you had varicose or spider veins? ______________What is your occupation? ________________________________

What activities cause your leg pain and what brings relief? ____

List your daily activities that require prolonged periods of standing or sitting? ____

Have you worn compressive stockings (circle): Yes / No: (what kind): Prescriptive or Over-the-counter
How often & since when:__________________________

Do you have:

family history of varicose veins?	Yes	No
family history of blood clots?	Yes	No
family history of bleeding disorder?	Yes	No

Do you drink alcohol, wine, or beer? Yes No how much per week?_________________

How often do you exercise (please circle): daily regularly 2-3 times per week seldomly

Are you a (please circle): nonsmoker smoker ex-smoker how many packs / day? _________

LIST ALL DRUG ALLERGIES & REACTIONS: ____ ❒ No drug allergy

Are you allergic to (circle): Latex / Betadine skin prep / Local anesthetic (xylocaine) / Medical adhesive tapes

❒ Please check here if you are NOT allergic to latex, betadine, local anesthetic, or medical adhesive tapes

List any medication you have **ever taken for leg ache** including prescriptive and over-the-counter (this is for insurance requirement):

(Please Circle) Tylenol, Motrin, Aleve, ibuprofen, others:____

YOUR CURRENT MEDICATION: (List all medication you are taking: prescriptive & over the counter, blood pressure, vitamins, ibuprofen, aspirin)

____

Please circle **any history and which leg**:

Blood Clots (that required blood thinner)	Yes	No	Right	Left
Superficial phlebitis (clots in surface veins)	Yes	No	Right	Left
Pulmonary emboli (blood clots in lung)	Yes	No	Right	Left
Diabetes	Yes	No		
Congestive Heart Failure (CHF)	Yes	No		
Vascular surgery	Yes	No		
Heart or bypass surgery	Yes	No		
Recent leg trauma	Yes	No		

Please circle any **previous vein treatment**: Sclerotherapy (injection)
Spider vein laser treatment:
Vein surgery: which leg: Right Left

COMPLETE MEDICAL HISTORY (List all health issues: including high blood pressure, heart disease, stroke, diabetes, fibromyalgia etc):

____

COMPLETE SURGERY HISTORY/ OPERATIONS:

____

WOMEN ONLY: NUMBER OF PREGNANCY _______________LIVE BIRTHS______________MISCARRIAGE_______________

ARE YOU STILL ABLE TO HAVE CHILDREN? Y N. IF NO, CIRCLE REASON: tubes tied, hysterectomy, menopausal, partner had vasectomy

REVIEW OF SYSTEMS: PLEASE CIRCLE ANY FOLLOWING YOU HAVE OR HAVE HAD (you may also add anything not listed)

Constitution:	Skin:	Mental:
Change in weight	Itching	Anxiety
High blood pressure	Rash	Confusion
High cholesterol	Change in size or color of moles	Depression
Decreased appetite	Dry skin	Delusion
Fatigue	Chronic skin problem	
Fevers		
Cancer of _________		
Eyes:	**Ears/ Nose/ Throat:**	**Hematologic:**
Decreased vision	Sore throat	Easy bruising
Double vision	Sinus drainage	Anemia
Temporary blindness	Hoarseness	Clotting disorder
Blurred vision	Ear discharge	Bleeding disorder
Detached retina	Nose bleeds	
Temporal arteritis	Hearing deficit	
	Ringing in ears	
Neuro:	**Gastro:**	**Arterial/ Vascular:**
Paralysis	Painful swallow	Rest pain (leg pain when lying in bed)
Weakness	Indigestion	Claudication (leg pain during exercise)
Seizure	Vomiting	Sensitivity to cold (fingers/ toes get blue)
Fainting	Vomit blood	Gangrene
Headaches	Gallbladder disease	Chronic leg wound
Migraine	Liver disease/ hepatitis	PVD (peripheral vascular disease)
Stroke	Hemorrhoids	Raynauld's
Numbness/ tingling in arms or legs or feet	Diarrhea	
Dysphasia (speech difficulty)	Jaundice (yellowing of skin)	
Decreased memory	Constipation	
	Abdominal pain	
	Bloody stool	
	Change in stool color	
	Change in bowel habits	
Cardiac:	**Respiratory:**	**Endocrine:**
Leg edema/ swelling	Cough	Thyroid disorder
Atrial fibrillation	Production of sputum	Insulin diabetes
Dyspnea (breathing difficulty)	Coughing of blood	Non-insulin diabetes
Dizziness	COPD/ emphysema	Polyphagia (excessive appetite)
Congenital heart disease	Sleep Apnea	Polydipsia (excessive thirst)
Rheumatic heart disease	Wheezing	
Murmur	Bronchitis	
Syncope (passing out)	Pneumonia	
Palpitation		
Heart attack		
Chest discomfort / chest pain		
Urologic:	**Musculoskeletal:**	**Immunologic:**
Unable to urinate	Bone/ joint deformity	Lupus
Painful urination	Joint swelling	Rheumatoid arthritis
Prostate issue	Back pain	HIV
Kidney/ bladder disease	Muscle ache	
Decreased urine stream	Limited motion	**OB/GYN:**
Renal insufficiency/ failure	Knee replacement	Irregular period
Bloody urine	Hip replacement	Breast problem
Frequent urination	Spinal problem	Menopause

❑ **Please check here if you have not had any of the above symptoms or illnesses**

PATIENT SIGNATURE ___________________________**DATE**________________ ___________________________**Reviewed by MIMI LEE, M.D** revised 4/2011

PATIENT REGISTRATION FORM

PATIENT INFORMATION:

FULL NAME: ______________________________ SEX M F BIRTHDATE _______/_______/_______

SOCIAL SECURITY #: ______________________ MARITAL STATUS: SINGLE ( ) MARRIED ( ) DIVORCED ( ) WIDOWED ( )

ADDRESS ____
(Street) (City) (State) (Zip)

HOME PHONE (________)______________________ _____ OCCUPATION ______________________

EMPLOYER ______________________________ WORK PHONE (________)______________________

EMPLOYER ADDRESS: ____

SPOUSE OR PARENT INFORMATION:

NAME: ______________________________________BIRTHDATE: ______________________

ADDRESS ____

HOME PHONE (________)____________OCCUPATION ______________ WORK PHONE (________)______________

EMPLOYER NAME & ADDRESS:____

PRIMARY CARE PHYSICIAN INFORMATION:

PHYSICIAN NAME: ______________________CITY______________ PHONE #: (_______)______________

PRIMARY HEALTH INSURANCE INFORMATION:

NAME OF COMPANY: ______________________ ADDRESS:______________________________

NAME OF PERSON CARRYING THE INSURANCE & RELATIONSHIP: ______________________________

GROUP: ______________________________ POLICY NUMBER: ______________________________

SECONDARY HEALTH INSURANCE INFORMATION:

NAME OF COMPANY: ______________________ ADDRESS: ______________________________

NAME OF PERSON CARRYING THE INSURANCE & RELATIONSHIP: ______________________________

GROUP: ______________________________ POLICY NUMBER: ______________________________

TO ASSURE OUR PATIENT PRIVACY
PLEASE LIST YOUR PREFERRED CONTACT METHODS AND IF WE CAN RELEASE YOUR INFORMATION TO YOUR SPOUSE OR RELATIVES (if they call)

Please check the best and second best (2nd) method for Dr. Lee or her staff to contact you daytime:

Home Telephone (_________)______________________(❐ best , ❐2nd best method to contact)
❐ O.K. to leave message with detailed information (such as appointment time and reasons)
❐ Leave message with call-back number only

Email______________________________________ (❐ best , ❐2nd best method to contact)
❐ O.K. to leave message with detailed information (such as appointment time and reasons)
❐ Leave message with call-back number only

Mobile/Cellular Telephone (_________)________________(❐ best , ❐2nd best method to contact)
❐ O.K. to leave message with detailed information (such as appointment time and reasons)
❐ Leave message with call-back number only

Work Telephone (_________)______________________(❐ best , ❐2nd best method to contact)
❐ O.K. to leave message with detailed information (such as appointment time and reasons)
❐ Leave message with call-back number only

Our office will NOT share any of your information without your permission. For example, if you ask your spouse to call us to discuss your insurance payment status, we will not be able to discuss with him/her unless you sign following permission.

I give Dr. Lee and her staff permission to discuss my medical / financial information with the following person(s):

Name(s)______________________________________ Relationship: ❐ spouse ❐ parents ❐ offsprings ❐ other:_____________

Acknowledgement of notification of privacy practice: I acknowledge that I had read and have the opportunity to see the notice of privacy practice

PATIENT SIGNATURE ______________________________________**Date**______________________

MIMI LEE, M.D., P.A.
APPOINTMENT and FINANCIAL POLICIES

The following is our financial policies, which we require you to read and sign prior to any treatment. As a courtesy to you, we will bill your insurance company if we are given the necessary forms and information at the time of your initial service. We do not file cosmetic service or support hose with insurance. All patients must complete our Patient Registration Form and financial policy form in full prior to being seen by any provider at Mimi Lee, M.D., P.A.

APPOINTMENT POLICY

We call or email to confirm your appointment 48 hours in advance based on the contact information provided to us. We request your courtesy and cooperation to honor your scheduled appointments. We understand that a situation may arise that could force you to postpone your office appointments. If you cannot keep your scheduled appointment, please give us at least 24 hour notification for us to replace the affected appointment. However, **if a patient fails to provide the 24 hour advance notice of cancellation or rescheduling of the consultation/ office/ ultrasound appointment, they will be charged a $ 25 Missed Appointment Fee. This fee will not be applied to future service or visits. Cosmetic procedures including Sclerotherapy or Botox or Dermal Fillers may be scheduled with a deposit which will be applied to the service. Sclerotherapy and Botox procedure also require a 24 hour advance notice of cancellation. Dermal Filler procedure requires a 48 hour advance notice of cancellation due to extended amount time reserved. The cosmetic procedure deposit will be forfeited if we do not receive the required advance notice of cancellation.** Per regulations, this fee covers provider's loss of business opportunity and is the patient's sole responsibility and will not be billed to insurance or applied to future services. After canceling / rescheduling/ missing three appointments within a year, a patient may possibly be dismissed from our practice due to lack of commitment to own care which impairs our ability to provide quality care. We are happy to work with you to find a timely, convenient appointment. **For surgery appointment, please see our separate surgery cancellation policy at time of surgery scheduling.**

INSURANCE COVERAGE

We file claims as a courtesy to our patients (except for cosmetic service & support hose). We charge what is reasonable and customary for our area. If we are a contracted provider with your insurance and are filing the service with your insurance, your fee is determined by the "discounted allowed amount" set by your insurance (not the full amount we billed). You are responsible for deductibles, co-payments, and co-insurance. If any dispute arises between you and your insurance, you are ultimately responsible for the resolution of such dispute. We will gladly provide you with documentation regarding your claim as needed. Mimi Lee, M.D., P.A. expects you to be interactive and responsible for communicating with your insurance carrier on any open claims. **Your co-pay and applicable deductible and coinsurance are due at the time of services.** This does not apply to cosmetic service and support hose which are not covered by or billed to insurance. Cosmetic services and support hoses payments are collected in full at time of services.

If you find your self without insurance coverage at any point in time, please notify us immediately. We will make you a self-pay patient and our discounted fees will take effect at that time so that continuity of care can continue. Established self pay patients must pay 100% of each visits fees at the date of service. Any lab tests that require additional testing, resulting in extra fees, will be billed to you and payment is expected upon receipt of the bill.

PAYMENT / FINANCE PLAN

Payments to Mimi Lee, M.D., P.A. can be made by any of the following methods: Cash, Personal check, Cashier's check, Debit card, Visa, MasterCard, Discover, or American Express. You will be charged a bank fee for any returned checks for any reason. To further assist you, affordable payment plans are available through CareCredit®. If you are interested, please ask anyone on our staff or you may visit www.carecredit.com.

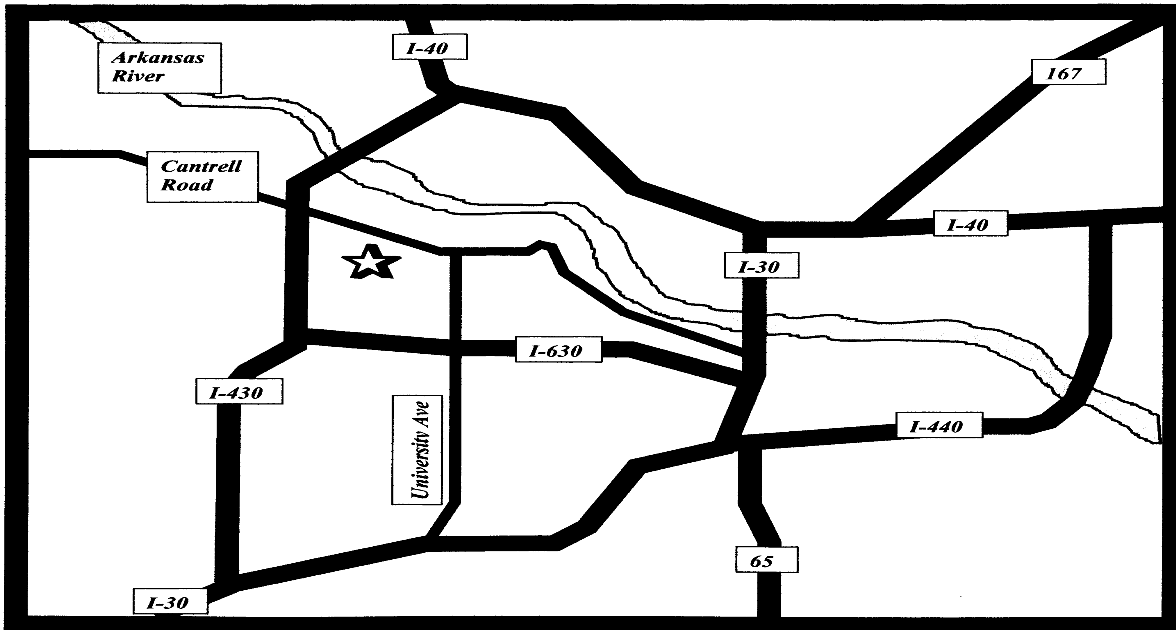
Monthly statements are issued to all outstanding accounts of Mimi Lee, MD, PA. Further action to satisfy delinquent accounts may be taken as necessary. You will be responsible for any additional collection and/or legal fees incurred to the delinquent account(s). If you have any questions or need assistance with financial matters, please call (501) 224-0880.

I have read and understand the above stated policies:

Patient Name (Print) :________________________Signature: ________________________Date_________(Revised 4/2011)

Mimi Lee, MD, PA at **Pavilion Centre**
8315 Cantrell Road, Plaza 80, Little Rock, AR 72227, **(501) 224-0880**

VISIT www.DrMimiLee.com FOR MORE INFORMATION



From I-30 from Benton and Hot Springs

From Hot Springs Hwy 70 to I-30 East. Proceed 18 miles on I-30. Exit 129 for ramp onto I-430 North. Proceed 9 miles to Exit 9 Cantrell Road. Turn right on Cantrell Road and proceed 1.5 mile to 8315 Cantrell Road - **Pavilion Centre** is on Right hand side.

From I-40 from Fort Smith, Russellville, and Conway

At exit 147, take ramp onto I-430 South. Cross Arkansas River. Exit 9 to Cantrell Road (towards Downtown). Proceed 1.5 mile East to 8315 Cantrell Road - **Pavilion Centre** is on Right hand side.

From Hwy 167/67 from Jacksonville, I-40 from Memphis

Continue on I-40 West to Fort Smith. At I-40/ I-30 split, keep right to stay on I-40 towards Fort Smith. Proceed about 4 to 5 miles. You will pass Burns Park, Crystal Hill. Exit 147 to Ramp onto I-430 South. Cross Arkansas River. Exit 9 to Cantrell Road (towards Downtown). Proceed 1.5 mile East to 8315 Cantrell Road - **Pavilion Centre** is on Right hand side.

If you mistakenly took the I-30 split to Little Rock, Exit on to I-630 West and follow I-630 direction below.

From I-630

Exit 6 A at Mississippi Ave. Turn Right on Mississippi. Proceed 1.3 miles. Turn Left at light onto Cantrell Road (Starbucks, Walgreens). Proceed 0.7 miles to 8315 Cantrell Road - **Pavilion Centre** is on Left hand side.

From Hwy 65, I-530

Head West to Little Rock. At exit 35, take ramp onto I-530 North. Proceed for 36 miles. Merge onto I-30 (US-167). At exit 139B, take ramp onto I-630 West. Proceed 6 miles. Exit 6 A onto Mississippi Ave. Turn Right on Mississippi. Proceed 1.3 mile. Turn Left at light Cantrell Road (Starbucks, Walgreens). Proceed 0.7 miles to 8315 Cantrell Road - **Pavilion Centre** is on Left hand side.

IDENTITY THEFT PREVENTION POLICY

(Also known as "RED FLAG POLICY")

Effective 8/1/09, our office will be implementing additional measures against identity theft as required by the Federal Trade Commission. This protects patients from fraudulent transactions involving insurance claims and/or credit / debit charges. Only exception to this policy would be if cash payment is collected in full for same day service.

All patients will need to present the following when checking in (every 6 months):

1. Photo ID (such as Driver's License)
2. Insurance card with name matching the photo ID
   (if we are filing insurance for your services)
3. Proof of current address, such as utility bill if
   Photo ID does not have current address.

We apologize for any inconvenience this may cause but ultimately it allows us to better serve and protect you as required by law.

Sincerely,

Dr. Mimi Lee