



Dear Patient,

You have recently scheduled a consultation with Dr. Kass at Kass Clinic for Vein Therapy. Enclosed are the Varicose & Spider Vein Information Packet, which you might have previously received, and other forms for you to complete prior to your visit.

We encourage you to read the Varicose & Spider Vein Information Packet since it contains most, if not all, of your questions and concerns and is a pertinent part of your consultation.

**You must complete the Demographics & Patient Questionnaire prior to your visit as completely as possible or arrive 30 minutes early.**

Failure to do so will forfeit the consultation and your deposit and there will be a charge to reschedule. Dr. Kass is very prompt and requires the full consultation time to evaluate you properly.

In addition, **you will need to bring a pair of loose fitting shorts to change into for the examination.** The shorts should enable examination in the groin area.

At this consultation Dr. Kass will determine the severity of your problem and will then inform you of your treatment options and whether or not you will need a more extensive workup and/or diagnostics. Most will not require the additional workup and will be able to begin treatment at their next appointment. Please do not bring children to this exam.

If you have any further questions, feel free to contact the office at 952-926-3311.

Thank you,

Kass Clinic for Vein Therapy

**Appointment Date:** \_\_\_\_\_, \_\_\_\_\_

**Appointment Time:** \_\_\_\_\_

**IMPORTANT:** Our introductory consultation is complimentary. A valid credit card to secure your appointment is required. **A missed appointment or cancellation/rescheduling without 72 hours notification will incur a \$50 charge to your credit card.** If one wishes to reschedule their appointment and did not provide 72 hours notice, there is a \$150 non-refundable charge for the consultation.

## Kass Clinic for Vein Therapy

### Patient Information

Patient Name (Last - First - Middle) Mr. Dr. Ms. Mrs.		Gender M F	Date of Birth	Social Security No.
Address (street - City - State - Zip)		Home Phone No. ( )		Work Phone No. ( )
City, State, Zip		Employer		Occupation
In Case of Emergency, Notify			Emergency Contact's Phone No. ( )	
Family Physician			Physician's Phone No. ( )	
How Did You Hear About Us? NEWSPAPER ___ INTERNET ___ BILLBOARD ___ YELLOW PAGES ___ DOCTOR ___ Patient ___ Other _____			E-Mail _____	

### Insurance Information

<b>We cannot guarantee insurance coverage by your insurance carrier.</b> The information below will assist us in determining if some of the expenses are reimbursable by your HMO or insurance carrier. <b>Please give your insurance card to our receptionist to be copied.</b>				
<b>Primary Insurance Carrier</b>		ID #	Group #	Social Security No.
Name of Insured		Relationship to Insured	Date of Birth	Gender M F
Address (street - City - State - Zip)		Home Phone No. ( )		Work Phone No. ( )
City, State, Zip		Employer		Occupation
<b>Secondary Insurance Carrier</b>		ID #	Group #	Social Security No.
Name of Insured		Relationship to Insured	Date of Birth	Gender M F
Address (street - City - State - Zip)		Home Phone No. ( )		Work Phone No. ( )
City, State, Zip		Employer		Occupation

### Authorizations & Releases

Initial	
	I certify the above information is true and correct to the best of my knowledge. I certify that I (or my dependent) have insurance coverage and assign directly to <b>Kass Clinic for Vein Therapy</b> all insurance benefits, if any, otherwise payable to me for services rendered. I understand and agree that I am ultimately responsible for payment – and that at this time services rendered <b>may not</b> be covered by my insurance. I understand that I am financially responsible for all charges whether or not paid by insurance.
	I authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.
	I have received a copy of the Payment/Cancellation Policy.
<hr style="border: 0; border-top: 1px solid black; margin: 10px 0;"/> <div style="display: flex; justify-content: space-between;"> <span>Patient / Responsible Party Signature</span> <span>Relationship</span> <span>Date</span> </div>	

Demographics

(PLEASE FILL OUT AS COMPLETELY AS POSSIBLE)

NAME \_\_\_\_\_ DATE \_\_\_\_\_  
AGE \_\_\_\_\_ GENDER \_\_\_\_\_

**How Did You Hear About Us:**

NEWSPAPER \_\_\_\_\_ INTERNET \_\_\_\_\_ BILLBOARD \_\_\_\_\_  
YELLOW PAGES \_\_\_\_\_ DOCTOR \_\_\_\_\_ PATIENT \_\_\_\_\_  
OTHER \_\_\_\_\_

**HPI:**

1. AT WHAT AGE DID YOUR VEINS OCCUR? \_\_\_\_\_

BEFORE PREGNANCY \_\_\_\_\_ DURING PREGNANCY \_\_\_\_\_  
AFTER BIRTH CONTROL OR ESTROGEN THERAPY \_\_\_\_\_ AFTER TRAUMA \_\_\_\_\_  
OTHER (PLEASE EXPLAIN) \_\_\_\_\_

2. HAVE YOU EVER BEEN EVALUATED FOR THIS PROBLEM? \_\_\_\_\_ IF SO, WHEN? \_\_\_\_\_ BY WHOM? \_\_\_\_\_

3. HAVE YOU HAD TESTS DONE FOR THIS PROBLEM? \_\_\_\_\_ IF SO, WHEN? \_\_\_\_\_ BY WHOM? \_\_\_\_\_

WHAT TESTS: \_\_\_\_\_

4. HAVE YOU EVER BEEN TREATED FOR THIS PROBLEM (YES/NO) ? \_\_\_\_\_ WITH WHAT METHOD?  
INJECTION \_\_\_\_\_ # TIMES? \_\_\_\_\_ WHEN? \_\_\_\_\_  
ELECTROCAUTERY \_\_\_\_\_ # TIMES? \_\_\_\_\_ WHEN? \_\_\_\_\_  
LASER \_\_\_\_\_ # TIMES? \_\_\_\_\_ WHEN? \_\_\_\_\_  
VEIN SURGERY \_\_\_\_\_ # TIMES? \_\_\_\_\_ WHEN? \_\_\_\_\_  
WERE YOU SATISFIED WITH RESULTS (YES/NO)? \_\_\_\_\_

DESCRIBE PROCEDURE: \_\_\_\_\_

5. ARE YOU DEVELOPING NEW VEINS (YES/NO)? \_\_\_\_\_ ARE YOUR VEINS GETTING BIGGER/LONGER (YES/NO)? \_\_\_\_\_

6. INDICATE WHICH OF THE FOLLOWING PROBLEMS YOU HAVE EXPERIENCED:

A) PAIN OR TENDERNESS IN YOUR:	L LEG	R LEG	# OF YEARS
• THIGH	_____	_____	_____
• CALF	_____	_____	_____
• LOWER LEG (BELOW KNEE)	_____	_____	_____
• FOOT	_____	_____	_____
B) SWELLING OF THE LEGS	_____	_____	_____
C) SKIN OR ULCER PROBLEMS	_____	_____	_____
D) OTHER: _____	_____	_____	_____

7. IF YOU EXPERIENCE PAIN IN YOUR LOWER LIMBS: **(VERY IMPORTANT TO BE ACCURATE)**

A) INDICATE THE TYPE OF PAIN	L LEG	R LEG
• ACHING	_____	_____
• AGONIZING	_____	_____
• BURNING SENSATION	_____	_____

- |                                   | L LEG | R LEG |
|-----------------------------------|-------|-------|
| • CONSTANT                        | _____ | _____ |
| • DULL                            | _____ | _____ |
| • GNAWING                         | _____ | _____ |
| • HEAVINESS IN LEGS               | _____ | _____ |
| • INTERFERES WITH NORMAL FUNCTION | _____ | _____ |
| • ITCHING                         | _____ | _____ |
| • NIGHT CRAMPS                    | _____ | _____ |
| • NUMBNESS                        | _____ | _____ |
| • RESTING CRAMPS                  | _____ | _____ |
| • RESTING PAIN                    | _____ | _____ |
| • RESTLESS LEGS                   | _____ | _____ |
| • TENDER                          | _____ | _____ |
| • THROBBING                       | _____ | _____ |
| • TIREDNESS/FATIGUE               | _____ | _____ |
| • ADDITIONAL COMMENTS:            | _____ |       |

- | B) DESCRIBE THE CONDITIONS BELOW:       | IMPROVES | WORSENS | DOESN'T CHANGE |
|---|----------|---------|----------------|
| • EXTENDED PERIODS IN STANDING POSITION | _____    | _____   | _____          |
| • WARM WEATHER                          | _____    | _____   | _____          |
| • COLD WEATHER                          | _____    | _____   | _____          |
| • MENSTRUAL PERIODS                     | _____    | _____   | _____          |
| • EXERCISING AND /OR WALKING            | _____    | _____   | _____          |
| • ELEVATION OF LIMBS                    | _____    | _____   | _____          |
| • ELASTIC STOCKINGS                     | _____    | _____   | _____          |
| • OTHER:                                | _____    |         |                |

- | 8. IN THE COURSE OF A NORMAL DAY, HOW MUCH TIME IS SPENT: | STANDING | SITTING |
|---|----------|---------|
| A) 10% OF THE DAY   | _____    | _____   |
| B) 20% OF THE DAY   | _____    | _____   |
| C) 30% TO 50% OF THE DAY                                  | _____    | _____   |
| D) MORE THAN 50%  | _____    | _____   |

- | 9. DOES YOUR WORK REQUIRE: | Yes   |
|----------------------------|-------|
| A) PROLONGED STANDING      | _____ |
| B) PROLONGED SITTING       | _____ |

10. DO YOU EXERCISE REGULARLY? (Yes/No) \_\_\_\_\_

11. DO YOU WEAR ELASTIC SUPPORT STOCKINGS? (Yes/No) \_\_\_\_\_

IF SO, WHAT KIND? \_\_\_\_\_ HOW OFTEN? \_\_\_\_\_ DO THEY HELP? \_\_\_\_\_

12. OVERALL, DO YOU FEEL YOUR CONDITION IS (CIRCLE ONE):     **IMPROVING**     **WORSENING**

13. INDICATE THE DATE OF YOUR LAST PHYSICAL EXAM \_\_\_\_\_

14. HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

**ALLERGIES:**

- | 1. DO YOU HAVE ANY ALLERGIES TO <b>MEDICATIONS OR OTHER</b> (PLEASE LIST)? | <b>PLEASE DESCRIBE REACTION</b> |
|--|---------------------------------|
| A) _____   | _____                           |
| _____  | _____                           |
| b) ALLERGY TO <b>ADHESIVE TAPE</b>   | _____                           |
| c) ALLERGY TO <b>LATEX</b>   | _____                           |
| d) ALLERGY TO <b>SOTRADECOL OR POLIDOCANOL</b>                             | _____                           |
| e) ALLERGY TO <b>ALCOHOL</b>   | _____                           |



	<b>YES</b>	<b>WHEN?</b>
NEUROLOGIC DISORDERS	_____	_____
PARALYSIS	_____	_____
PERIPHERAL VASCULAR DISEASE	_____	_____
PULMONARY DISORDERS	_____	_____
RAYNAUD'S	_____	_____
RHEUMATIC HEART DISEASE OR FEVER	_____	_____
SEIZURES OR CONVULSIONS (EPILEPSY)	_____	_____
SKIN DISEASE	_____	_____
STROKE	_____	_____
THYROID DISEASE	_____	_____

PLEASE DESCRIBE ANY OF THE ABOVE "YES" ANSWERS \_\_\_\_\_

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4. DO YOU HAVE ANY OTHER PRESENT ILLNESS WE SHOULD BE AWARE OF? (Yes/No) \_\_\_\_\_  
 IF SO, WHAT? \_\_\_\_\_

5. HAVE YOU EVER HAD ANY MISCARRIAGES (NOT ABORTIONS)? (Yes/No) \_\_\_\_\_ IF SO, HOW MANY? \_\_\_\_\_

**SURGIAL HISTORY:**

HAVE YOU EVER HAD ANY SURGERY? (Yes/No) \_\_\_\_\_ IF SO, WHAT & WHEN? \_\_\_\_\_

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**FAMILY HISTORY:**

DOES ANYONE IN YOUR FAMILY HAVE? (PLEASE INDICATE FAMILY MEMBER)

	<b>YES</b>	<b>FAMILY MEMBERS</b>
• VARICOSE VEIN PROBLEMS	_____	_____
• PHLEBITIS (INFLAMMATION OF A VEIN)	_____	_____
• BLOOD CLOTS	_____	_____
• LEG ULCERS	_____	_____

**SOCIAL HISTORY:**

1. DO YOU SMOKE? (Yes/No) \_\_\_\_\_ IF SO, HOW MUCH? \_\_\_\_\_

2. ARE YOU PREGNANT? (Yes/No) \_\_\_\_\_

3. ARE YOU PLANNING A PREGNANCY SOON? (Yes/No) \_\_\_\_\_ IF SO, WHEN? \_\_\_\_\_

4. ARE YOU PRESENTLY BREASTFEEDING? (Yes/No) \_\_\_\_\_

**OTHER HISTORY:**

DO YOU CURRENTLY HAVE OR ARE EXPERIENCING:	<b>YES</b>	<b>WHEN?</b>
ANEMIA	_____	_____
ASTHMA ATTACK RECENTLY	_____	_____
BLEEDING PROBLEMS, TENDENCIES	_____	_____
BRUISE EASILY	_____	_____
CALF PAIN	_____	_____
CHEST PAIN OR PRESSURE	_____	_____
CLOTTING DISORDERS	_____	_____
PAIN OR CRAMPING WHEN WALKING	_____	_____
CONVULSIONS	_____	_____
DIFFICULTY HEALING	_____	_____
ELEVATED BLOOD PRESSURE	_____	_____

	<b>YES</b>	<b>WHEN?</b>
FAINTING OR DIZZY SPELLS	_____	_____
FATIGUE	_____	_____
HEART PALPITATIONS	_____	_____
HEPATITIS B CARRIER	_____	_____
LEG SWELLING	_____	_____
NUMBNESS	_____	_____
PACEMAKER	_____	_____
PARALYSIS	_____	_____
RACING HEART	_____	_____
RASH	_____	_____
SHORTNESS OF BREATH AT REST OR ON EXERTION	_____	_____
SORES	_____	_____
WHEEZING	_____	_____

9. ARE YOU PRESENTLY UNDER THE CARE OF A PHYSICIAN BESIDES ROUTINE VISITS? (YES/NO) \_\_\_\_\_  
 IF YES, PLEASE EXPLAIN: \_\_\_\_\_  
 \_\_\_\_\_

**MISCELLANEOUS**

IS THERE ANY ADDITIONAL INFORMATION THAT YOU WOULD CONSIDER PERTINENT?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

FOR DOCTOR USE ONLY:

**PLAN:**

- ROUTINE SCLERO  APPROX. 1-2 TX's  2-3 TX's  2-4 TX's  3-4 TX's  3-5 TX's  4-6 TX's  >5 TX's
- FULL WORKUP
- ULTRASOUND
- D-PPG
- PHLEBECTOMY
- REFERRED OUT

**FINDINGS:**

- OUT-OF-NETWORK STATUS DISCUSSED
- PROCEDURE FEES DISCUSSED
- INSURANCE REIMBURSEMENT CHARGE SHEET GIVEN

The following is the Payment/Cancellation Policy for our clinic. Time, staff and great expense have been invested to provide you with the personal care one does not typically receive in today's healthcare environment. Missed appointments or appointments cancelled/rescheduled on short notice (regardless of the reason) cause a significant expense to our practice and inconvenience to other patients who could have been scheduled. We hope you understand the need for such a policy.

**Introductory Consultation:**

Our introductory consultation is complimentary. A valid credit card to secure your appointment is required. **A missed appointment or cancellation/rescheduling without 72 hours notification will incur a \$50 charge to your credit card.** If one wishes to reschedule their appointment and did not provide 72 hours notice, there is a \$75 non-refundable charge for the consultation.

**Complete Consultation + Diagnostics:**

A deposit of \$350 is taken at the time of scheduling to secure your appointment. The remainder of payment is made at the conclusion of your exam. **Failure to show for your appointment or cancellation/rescheduling without 72 hours notification will forfeit your deposit.**

**Ultrasound:**

A deposit of \$75 is taken at the time of scheduling. **Failure to show for your appointment or cancellation/rescheduling without 72 hours notification will forfeit your deposit.**

**Sclerotherapy:**

A deposit of \$75 is taken at the time of scheduling. **Failure to show for your appointment or cancellation/rescheduling without 72 hours notification will forfeit your deposit.**

**VNUS™ Closure/EVLT:**

A deposit is typically taken which may vary depending on your deductible and/or copay. Several hours is reserved for you. **Failure to show for your appointment or cancellation/rescheduling without 72 hours notification will forfeit your deposit.**

**Other Procedures:**

These costs may vary and require a deposit to reserve your appointment. **Failure to show for your appointment or cancellation/rescheduling without 72 hours notification will forfeit your deposit.**

\*MN Care Tax is added. These policies might differ for insurance patients. These rates and policies may change.

**Late Arrivals:**

We strive to be timely with our appointments, rarely there is a slight delay. Please plan your arrival accordingly to allow for weather, traffic, etc. If you show up late for your appointment or your paperwork is not completed prior to your arrival it will most likely result in your appointment being shortened or cancelled.

**Appointment Reminders:**

As a courtesy we will give you a reminder call unless notified otherwise. Regardless, this is a courtesy call and your appointment is your responsibility.

**Payment:**

We accept cash, check, VISA, Mastercard, American Express or Discover.

**Late Payment:**

Any outstanding balance will incur a 1.5% monthly late charge that will be added to your bill. Typically we do not begin billing you until all insurance payments have been received.

**Insurance:**

In many cases your insurance may cover all or a portion of the consultation, diagnostics and procedures, however we cannot guarantee this and you are responsible for payment at the time of service if you are out of one of our insurance networks. As a courtesy, we will file a claim to your carrier for any visit that may be reimbursable.

We hope your experience at the Clinic is favorable. We have made many efforts to provide you with a quality of care not seen in today's healthcare environment. If you have any concerns, do not hesitate to bring them to our attention.

Dr. Kass and Staff  
Kass Clinic for Vein Therapy

Signature:

Date:

\_\_\_\_\_

I have received a copy of this policy.

\_\_\_\_\_

\*MN Care Tax is added. These policies might differ for insurance patients. These rates and policies may change.

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# kassclinics

COSMETIC CARE  
VEIN THERAPY

## ***The Center for Electrolysis, Skin and Laser Therapy, LLC***

### **Acknowledgement of Receipt of Notice of Privacy Practices**

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my PHI that might occur in my treatment, payment of my bills or in the performance of *The Center for Electrolysis, Skin and Laser Therapy, LLC's* health care operations. The Notice of Privacy Practices also describes my rights and *The Center for Electrolysis, Skin and Laser Therapy, LLC's* duties with respect to my protected health information. The Notice of Privacy Practices is posted in (location in the office where NPP is posted).

*The Center for Electrolysis, Skin and Laser Therapy, LLC* reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment, or accessing *The Center for Electrolysis, Skin and Laser Therapy, LLC's* website.

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Name of Patient or Personal Representative

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Date

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Signature of Patient or Personal Representative

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Description of Personal Representative's Authority

## Instructions for Patients Affected by Chronic Venous Insufficiency

Leg veins transport blood from the foot upward to the heart. Healthy veins have valves which prevent blood from flowing downward. It is the rhythmic movements of the foot-flexion and extension-that drive blood up. Therefore, good venous circulation depends on two factors: (1) healthy veins with normal valves and (2) muscular exercise.

These two elements build the "muscular-venous leg pump." If the "pump" does not function properly, movement of blood up the leg becomes difficult, and consequently blood tends to stagnate. In such cases, accumulation of fluid may occur beginning at the ankle and extending up the thigh. Vein dilation, leg swelling and induration, skin redness, inflammation, itching, and brown or white discoloration develop and with time skin ulceration may occur. Such ulcers may stay open for many months or even years, then heal only to reopen. Some do not heal at all without prolonged bed rest.

You have a chronic venous disorder. Some leg veins may be obstructed whereas others are dilated, some valves are destroyed, and consequently blood flows down rather than up. This explains why your leg starts swelling in the morning, and increases during the day.

Many of the diseased veins may be eliminated by the treatments we offer. It is important to understand that we are **TREATING** your condition, not **CURING** it. For this reason, continued care is indispensable to maintain your leg in optimal condition. This care consists of: (1) regular use of elastic support stockings we prescribe, (2) an appropriate lifestyle, which includes the suggestions discussed later and (3) most importantly treatment and follow-up care per our recommendations. Ultimately, it is your responsibility to take care of your legs.

If your leg is in very poor condition, treatment may require a few months (or even more than a year). Once healing is achieved, it is usually possible to maintain your leg in an acceptable condition by adhering to a few simple rules.

To maintain your leg in good condition, you must not allow swelling to occur. Therefore, it is indispensable to wear the prescribed medically approved graduated compression stockings daily and every evening make sure that the calf is soft and the leg is not swollen.

1. Put on the stocking early in the morning, before starting your daily activities; because in some legs swelling may start a few minutes after assuming an upright position. You may have additional benefit if, after putting on the stocking, you lay down, raise your leg and move the foot repeatedly up and down for a few minutes.
2. Avoid prolonged standing or sitting without moving the legs. During long trips (car, train, and airplane), always wear your compression stockings, move your feet up and down often and when possible get up for a walk.

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3. Make it a habit to take long walks. Walking with an elastic support stocking is an important exercise for the venous circulation. The elastic support stocking alone does not pump blood upwards, but does so only during leg movement. Leg movement during usual daily activities is of limited value when compared with long, regular pace walking.
4. Make it a habit to keep your legs higher than the rest of the body a few times a day; keep your knees flexed, as full-knee extension obstructs venous circulation. Some activities; i.e., reading, may well be done lying down with the legs raised.
5. If necessary, lose weight and maintain your optimal body weight. Being overweight makes it much more difficult to keep your legs in good condition.
6. Avoid lifting and carrying weights of >20 pounds.
7. If you smoke, know that smoking damages not only your heart and lungs, but also your legs. The best thing to do is to stop smoking.
8. Keep your feet and toenails clean. Wear comfortable shoes and avoid high heels. Avoid activities which risk leg trauma.
9. If you have dry skin, use an appropriate skin moisturizing cream regularly. Do not use medicated products without consulting a physician. Many topical preparations may damage the sensitive skin of your leg.
10. Check your leg every evening for swelling. If leg compression and lifestyle are adequate, your leg should not be swollen in the evening.
11. If you do not have gastritis or gastric reflux disease, make it a habit to sleep with your legs slightly elevated (~6 in.). You need not keep your legs fully extended.
12. Keep a spare stocking on hand to avoid going without the needed elastic support. Replace the old support stocking when it wears out and loses its efficacy. With proper care, good quality elastic support hose will last up to 6 months.
13. Should symptoms like swelling, itching, redness or pain occur, or you traumatize the leg, contact us immediately. Even a trivial or small wound, if not promptly and adequately treated, may lead to serious consequences.

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