



Dear Patient,

Welcome to Kass Clinics! We understand that you are making a very important decision because your body is with you for the rest of your life. So, we will provide you with detailed, individualized information to help you make an informed, intelligent decision.

Plan to spend a total of 30 minutes in our office on the day of your appointment where Dr. Sidney Kass, MD, a Board Certified Phlebologist and Anesthesiologist, will review your medical history and conduct a cursory exam with duplex ultrasound to determine the causes of your varicose and spider vein problems. At that time your treatment options will be explained and you will be informed whether your problem is cosmetic or medical and whether insurance might cover the treatments.

Enclosed you will find information regarding varicose and spider veins, as well as medical history forms to complete prior to your scheduled appointment. If you are unable to complete these forms prior to your appointment, please arrive 30 minutes early to complete them in our office. **These forms must be completed by the start of your appointment.** Failure to do so will forfeit the consultation and your deposit; you will then have to leave a second deposit to reschedule the appointment. **If you need to reschedule or cancel your appointment, we ask for a 72-hour notice. In addition, you should bring a loose fitting pair of shorts for the exam, where Dr. Kass can examine the groin area.** If there is any other information that I can provide you with please call the office at (952) 926- 3311. We look forward to seeing you at your appointment.

Sincerely,

Kass Clinics
Enclosure

Our introductory consultation is complementary. A \$50.00 deposit is required to secure the appointment. A missed appointment or cancellation/rescheduling without a 72 hour notification will forfeit the deposit.



kassclinics

COSMETIC CARE
VEIN THERAPY

Patient Information

First: _____ Middle: _____ Last: _____

Gender: Female Male Date of Birth: _____ SSN: _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Please indicate which phone number is your primary line.

Home: _____ Work: _____ Mobile: _____

Emergency Contact

Name: _____ Phone: _____

Relationship: _____

Primary Care Physician

Name: _____ Phone: _____

Clinic Name: _____ Location: _____

Employment

Employer: _____ Phone: _____

Position: _____

How did you hear about us?

Newspaper Internet Billboard Yellow Pages Other

Doctor: _____ Friend: _____

Insurance Information

Primary Insurance Carrier: _____ ID: _____

Subscriber Name: _____ Group #: _____

Relationship: Self Parent: _____ Spouse: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Employer: _____ Position: _____

Authorizations & Releases

- I certify the above information is true and correct to the best of my knowledge. I certify that I (or a dependent) have insurance coverage and assign directly to Kass Clinics for vein therapy 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 may not 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, HIPPA, and the Compression Stocking policy.

Signature: _____ Date: _____



Cancellation Policy

When an appointment is scheduled for our patients they are required to secure the appointment with a deposit. Please plan your arrival accordingly to allow for weather, traffic, etc. If you arrive late for your appointment or your paperwork, if applicable, is not completed prior to your arrival it may result in your appointment being shortened or cancelled. A missed appointment or cancellation/rescheduling without a 72-hour notification will incur a charge equal to the deposit taken for the appointment or the cost of the treatment scheduled if you have a service package. If you have an in network insurance company, for our vein procedures, you will be charged this fee separately, as you are not required to leave a deposit for your in network insurance procedure appointments.

Insurance/Payment Policy

If you are being treated for vein disorders we will submit your medical claims to your medical insurance, if it applies to your condition. In many cases your insurance company may cover all or a portion of the evaluation, diagnostics, and procedures, however we cannot guarantee this and you are responsible for payment of services rendered. Kass Clinics is in-network with Blue Cross Blue Shield, Preferred One, Medica, United Healthcare, and their secondary networks. If you are unsure if your insurance policy is in network with Kass Clinics please ask our staff.

For all out-of-network insurance companies and self pay patients you will be responsible for the cost of your procedures upfront. You will have to leave a deposit to schedule the procedure and the remaining balance is due on the day of the procedure. We will submit your claims to your out of network insurance company, if you have one, and upon payment from your insurance company you will then be refunded the difference.

A late charge of 2% will be added monthly to any patient-owed outstanding balance, not paid in full, by the due date. If this exceeds 90 days your account will then be turned over to a collection agency. We accept cash, check, Visa, Mastercard, American Express, and Discover.

Compression Stocking Policy

Your compression stockings will be specifically measured and fitted for you by our experienced fitter. The style and compression of stocking recommended is for your ultimate comfort, as well as therapeutic benefit. Once the stockings have been fitted and taken out of our office, they may not be returned. Our experienced fitter will inspect the stockings prior to you leaving the office, as well as recommend the best home care options to extend the functionality and integrity of your stockings. We recommend taking extra care with home application and washing, and are not responsible for damage. If a certain style stocking was recommended, but you chose another style and later realized your selection was uncomfortable, they may not be returned or exchanged.

Some insurance companies allow a certain number of stockings at designated intervals throughout the year. It is our policy that only one pair may be obtained at a visit. If more than one pair are desired, we are happy to provide you with a prescription to obtain the remaining pairs at a medical supply store. Special order stockings are not billed to your insurance and must be prepaid prior to ordering. It is not unusual for us to re-measure patients at certain intervals in their treatment process prior to providing another pair of new stockings.

HIPPA Policy

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 *Kass Clinics, LLC's* health care operations. The Notice of Privacy Practices also describes my rights and *Kass Clinics, 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) and online. *Kass Clinics, 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 *Kass Clinics, LLC's* website.

By signing this consent you are agreeing to all of the above terms, Cancellation, Insurance/Payment, Compression Stockings, and the HIPPA Policy.

Patient Name: _____ Date: _____

Patient Signature: _____

Minor Consent

If the patient is under the age of 18 they are considered a minor and will therefore need their legal guardian to sign for them. As the legal guardian and by signing this consent you are agreeing to the above terms on the minors' behalf.

Guardian Name: _____ Relationship: _____

Guardian Signature: _____

Deposit's:

All Consultations: \$50.00	Botox and Skin Care Procedures: \$75.00	Filler Procedures: \$750.00
Sclerotherapy Treatment: \$75.00	Full Work Up: \$350.00	Phlebectomy Surgery: \$500.00
EVLV Surgery: \$1,000.00		

NAME : _____

AGE: _____

DATE _____

HPI:

1. AT WHAT AGE DID YOUR VEINS OCCUR? _____

BEFORE PREGNANCY _____
AFTER BIRTH CONTROL OR ESTROGEN THERAPY _____
OTHER (PLEASE EXPLAIN) _____

DURING PREGNANCY _____
AFTER TRAUMA _____

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 _____
ELECTROCAUTERY _____
LASER _____
VEIN SURGERY _____
WERE YOU SATISFIED WITH RESULTS (YES/NO)? _____

TIMES? _____ WHEN? _____
TIMES? _____ WHEN? _____
TIMES? _____ WHEN? _____
TIMES? _____ WHEN? _____

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 _____
- 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: _____

L LEG

R LEG

- 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 **MEDICATIONS OR OTHER** (PLEASE LIST)?
- | | PLEASE DESCRIBE REACTION |
|--|--------------------------|
| A) _____ | _____ |
| b) ALLERGY TO ADHESIVE TAPE | _____ |
| b) ALLERGY TO LATEX | _____ |
| c) ALLERGY TO SOTRADECOL OR POLIDOCANOL | _____ |
| d) ALLERGY TO ALCOHOL | _____ |
| | PLEASE DESCRIBE REACTION |
| e) ALLERGY TO LIDOCAINE | _____ |
| f) ALLERGY TO BETADINE (IODINE PREP) | _____ |
| g) ALLERGY TO HEPARIN | _____ |

MEDICATIONS:

2. ARE YOU TAKING ANY MEDICATIONS? (CHECK ALL) **YES**
- | | |
|---|-------|
| a) ASPIRIN, MOTRIN, IBUPROFEN, NUPRIN, ETC. | _____ |
| a) BLOOD THINNERS (COUMADIN, ETC.) | _____ |

- | | |
|-------------------------------|------------|
| | Yes |
| b) IRON OR IRON SUPPLEMENTS | _____ |
| c) HORMONES OR CONTRACEPTIVES | _____ |
| d) CHEMOTHERAPY | _____ |
| e) THYROID MEDICATION | _____ |
| f) CORTISONE | _____ |
| g) INSULIN | _____ |
| h) APPETITE SUPPRESSANTS | _____ |
| i) ANTABUSE (DISULFURAM) | _____ |
| j) ANY OTHER: _____ | _____ |

PAST MEDICAL HISTORY (ONLY WHAT APPLIES TO YOU AND NOT YOUR FAMILY):

1. HAVE YOU EVER BEEN TREATED FOR ONE OF THE FOLLOWING?

- | | L LEG | R LEG | WHEN? |
|---------------------------------------|-------|-------|-------|
| A) PHLEBITIS (INFLAMMATION OF A VEIN) | _____ | _____ | _____ |
| B) LEG ULCER | _____ | _____ | _____ |
| C) LEG FRACTURE | _____ | _____ | _____ |
| D) DEEP VEIN THROMBOSIS (BLOOD CLOT) | _____ | _____ | _____ |
| E) PULMONARY EMBOLISM (YES/NO) | _____ | _____ | _____ |

2. DO YOU HAVE ANY BLEEDING TENDENCIES OR CLOTTING DISORDER YOU ARE AWARE OF? (Yes/No)

IF SO, WHAT TYPE? _____

3. DO **YOU (PERSONALLY)** HAVE A HISTORY OF?

- | | Yes | WHEN? |
|---|-------|-----------------|
| SEVERE ALLERGIC REACTION | _____ | _____ |
| ANEMIA | _____ | _____ |
| ANEURYSM | _____ | _____ |
| ASTHMA | _____ | _____ |
| AUTOIMMUNE DISEASE (I.E., LUPUS) | _____ | _____ |
| BLOOD TRANSFUSIONS | _____ | _____ |
| BONE OR JOINT DISEASE | _____ | _____ |
| CANCER OR TUMORS | _____ | _____ |
| CARDIAC DISEASE | _____ | _____ |
| DARK SPOTS AFTER PREGNANCY, | _____ | _____ |
| DIABETES | _____ | _____ |
| ENDOCRINE PROBLEMS | _____ | _____ |
| FREQUENT OR SEVERE HEADACHES, MIGRAINES | _____ | _____ |
| HAY FEVER, HIVES, ECZEMA | _____ | _____ |
| HEART MURMUR, DEFECTS, HOLES | _____ | DESCRIBE: _____ |
| HEPATITIS OR JAUNDICE | _____ | _____ |
| HIGH BLOOD PRESSURE | _____ | _____ |
| HIV POSITIVE (AIDS TEST) | _____ | _____ |
| KIDNEY PROBLEMS | _____ | _____ |
| LIVER DISORDER | _____ | _____ |
| MENINGITIS | _____ | _____ |
| MUSCULOSKELETAL DISORDERS | _____ | _____ |
| NEURITIS, NEURALGIA | _____ | _____ |
| NEUROLOGIC DISORDERS | _____ | _____ |
| PARALYSIS | _____ | _____ |

	YES	WHEN?
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 _____

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? _____

FAMILY HISTORY:

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

	YES	FAMILY MEMBERS
• 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:	YES	WHEN?
ANEMIA	_____	_____
ASTHMA ATTACK RECENTLY	_____	_____
BLEEDING PROBLEMS, TENDENCIES	_____	_____
BRUISE EASILY	_____	_____
CALF PAIN	_____	_____
CHEST PAIN OR PRESSURE	_____	_____
CLOTTING DISORDERS	_____	_____
PAIN OR CRAMPING WHEN WALKING	_____	_____
CONVULSIONS	_____	_____

	YES	WHEN?
DIFFICULTY HEALING	_____	_____
ELEVATED BLOOD PRESSURE	_____	_____
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:

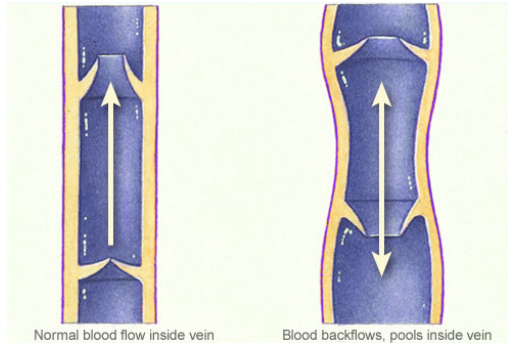
- ROUTINE SCLERO APPROX. 1-2 Tx's 2-3 Tx's 2-4 Tx's 3-4 Tx's 3-5 Tx's 4-6 Tx's >5 Tx's
- FULL WORKUP
- ULTRASOUND
- D-PPG
- PHLEBECTOMY
- REFERRED OUT

FINDINGS:

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

Varicose Vein Information

Varicose veins are twisted, enlarged veins that bulge and are seen on the surface of the skin. They are commonly in the legs and ankles. Healthy veins carry blood to the heart through a series of one-way valves. These valves allow blood to flow in the right direction from superficial veins to deeper veins and to the heart. The vessels are surrounded by muscles which contract and help pump blood to the heart. Normally the veins have a one-way valve to prevent backflow. However, defective valves allow blood to flow backward and pool inside the vein. As blood pools within the vein, pressure builds and the vessel wall weakens. As a result,



the vein tends to bulge and twist. Depending on the size of the blood vessel and extent of swelling, the result is a spider vein or varicose vein.

Factors that contribute to the formation of varicose veins are genetics, age, hormones, being overweight or pregnant, or having a job where you

must stand for long periods of time which increases pressure on leg veins.

Mild symptoms of varicose veins may include:

- A dull ache, burning, or heaviness in the legs. These symptoms may be more noticeable late in the day or after you stand or sit for long periods of time.
- Mild swelling, usually involving the feet and ankles only.
- Itching skin over the varicose vein.

More serious symptoms include:

- A buildup of fluid and swelling in the leg and ankle.
- Significant swelling and calf pain after sitting or standing for a long time.
- Skin color changes (stasis pigmentation) around the ankles and lower legs.
- Dry stretched, swollen, itching, or scaling skin.
- Superficial thrombophlebitis (when a blood clot and inflammation develop in a small vein near the surface of the skin).
- Open sores (ulcerations).
- Bleeding and or bruising after a minor injury.
- Symptoms of varicose veins may become more severe a few days before and during a woman's menstrual period.

For people who do not have extensive leg vein symptoms and problems, the following options can relieve symptoms and slow down the progress of varicose veins. By following these recommended guidelines you can help control the problem and keep it from getting worse:

- **Wear compression stockings.** Compression stockings improve circulation and are the mainstay of treatment for varicose veins.
- **Elevate your legs.** Prop up your legs at or above the level of your heart when possible.
- **Avoid long periods of sitting or standing.** Standing or sitting for long periods puts added stress on the veins in your legs.
- **Exercise and control your weight.** Walk, bicycle, or swim to improve blood circulations in your legs.

Sclerotherapy is a medical procedure used to eliminate varicose and spider veins. Sclerotherapy involves an injection of a solution directly into the vein. The solution irritates the lining of the vein, causing it to stick together. Over time, the vein turns into fibrous tissue and dissolves. Normal activities are resumed.

Ambulatory Phlebectomy allows for the removal of large surface veins through very small pinholes that do not need stitches. At Kass Clinics, it is performed using local anesthesia. Patients return home the same day as the procedure wearing a compression bandage.

EVLTM and RF ClosureTM are procedures in which a small catheter is inserted into the abnormal vein, commonly the Greater Saphenous Vein. Heat is delivered inside the vein, which causes the vein to collapse. The procedure is done as under local anesthesia and you can return to normal activities immediately.