SUMMIT
SKIN & VEIN CARE
3521 NE Ralph Powell Road
Lee's Summit, MO 64064
(816) 554-7546
Fax# (816) 554-9470
www.summitskinandveincare.com

Welcome! We are pleased you have chosen Summit Skin & Vein Care to help with your vein needs.

Have your legs ever had any of the following common symptoms & signs?

Pain
Swelling of the legs and feet
Restless legs
Tired, Achy or Heavy legs
Burning and / or Itching
Cramping of the legs and feet
Discoloration or Skin Changes of the ankles and legs
Open sores or Ulcers on the lower legs

Then, your vein treatments will likely be covered by insurance.

To pursue your vein treatment further, please complete the attached documentation prior to your appointment then bring to your scheduled appointment.

- ✓ Patient Profiles – page 1 and page 2
- ✓ Medication List
- ✓ Guarantor Billing & Responsibility Agreement
- ✓ Late Policy and Cancel / Reschedule Policy
- ✓ HIPAA – please keep for your records
- ✓ Pre-Auth Demand Letter (signature only) – This letter will be kept on file and sent to your insurance company, if needed.

You will also need to bring the following items:

- ✓ Photo ID
- ✓ Insurance card(s)
- ✓ Loose fitting shorts

We offer two Check–In processes:

1) **Conventional Check-In**
   - Please arrive 30 minutes prior to your scheduled appointment time with the above documents.
2) **XPRSS Check-In**
   - Please complete and fax the above documents to (816) 554-9470 or email to newpatient@summitskincare.net at least 48 business hours prior to your scheduled appointment time.
   - Please arrive 15 minutes prior to your scheduled appointment time.
   - We will confirm documents have been received at reminder call. If we have not received them, you will need to arrive 30 minutes early and bring the above documents with you to your scheduled appointment.

Please allow 2 – 2 ½ hours for the New Patient appointment.

If you have any questions, please feel free to call us or ask us at your appointment.

Thank you for allowing us to help you!
Summit Skin and Vein Care

SUMMIT SKIN & VEIN CARE

Bruce E. Fearon, MD (Vein Specialist)
Joe Baker, DO (Vein Specialist)
Diplomates of the American Board of Venous & Lymphatic Medicine

Paige Medlin, FNP-C
Advanced Practice Provider

3521 NE Ralph Powell Road * Lee's Summit MO 64064
(816) 554 – VEIN (8346) or (816) 554 – SKIN (7546) (816) 554 – 9470 Fax

LATE ARRIVAL POLICY
NO SHOW and CANCELLATION / RESCHEDULE POLICY

Patient Name: _____ **Date of Birth:** _____

Thank you for entrusting your varicose vein treatment to Summit Skin & Vein Care (SSVC). When you schedule an appointment with SSVC, we set aside the right amount of time to be seen by our physicians and staff so we are able to provide you with the highest quality care. That's why it is important patients keep their scheduled appointment and arrive on time.

Effective December 1, 2023, we are establishing a Late Arrival Policy and No Show and Cancellation / Reschedule Policy.

Late Arrival Policy:

Patients are asked to arrive to their appointments before their scheduled appointment time. New patients are to arrive 30 minutes before their scheduled appointment time. Established patients are to arrive 30 minutes before a scheduled procedure and 15 minutes before an office visit appointment. This allows enough time for the check-in process to be completed before the actual appointment time.

A grace period of 15 minutes will be permitted for unforeseen delays a patient may encounter while travelling to their appointment. If a patient arrives more than 15 minutes late of their scheduled appointment time, the patient will be given the option of either being seen that day as a walk-in, if the schedule permits, or rescheduled for a later date. This process will ensure patients that do arrive on time are seen in a timely manner.

_____ (Initials) I understand the Late Arrival Policy.

No Show and Cancellation / Reschedule Policy:

As a courtesy to assist the patient in keeping appointments, a reminder call or reminder text will be made 24 – 48 business hours before the patient's scheduled appointment with the date, scheduled appointment time and arrival time. All reminders are documented in the patient's electronic health record (EHR) with actual recordings of the reminder call or reminder text available in SSVC software should there be any discrepancy. If the patient's phone is "out of service" or "mailbox is full" and we are unable to leave a message, or if a reminder call or a reminder text did not go through the phone service, the patient is still responsible for keeping the scheduled appointment.

The patient is responsible for cancelling or rescheduling the appointment no less than 24 hours before the scheduled appointment. Please feel free to leave a message in the weekend or after hours' SSVC phone system.

A "No Show" appointment is when a patient fails to appear for a scheduled appointment.

A "Cancelled / Rescheduled" appointment is when a patient cancels / reschedules an appointment with less than 24 hours' notice of the scheduled appointment time.

All patients who have **three (3) no show appointments or have cancelled / rescheduled appointments with less than 24 hours' notice** will be given two options:

1) Patient will no longer be able to "schedule" an appointment, but will be moved to a "call ahead" status. The patient will need to call on the day of to see if an appointment is available. Walk-ins will not be permitted.
2) Patient may place a credit card on file prior to scheduling an appointment. The credit card will be charged a $150 fee for a no show or cancelled / rescheduled appointment with a less than 24 hours' notice. If credit card is declined, the patient will automatically be moved to a "call ahead" status. This fee will not be reimbursable by the insurance company.

Should your schedule change and you need to cancel or reschedule an appointment, please contact our office as soon as possible to reschedule your appointment. This gives us time to schedule other patients who may be waiting for an appointment.

_____ (Initials) I understand the No Show and Cancellation / Reschedule Policy.

_____ (Initials) I am reliant on a service or someone to provide my transportation to appointments.

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Patient Profile

Date_____ **New Patient ( ) Update ( )**

Last Name _____ First _____ MI _____ ☐ Male ☐ Female

Social Security No._____ Date of Birth _____ Age: _____

Marital Status _____ Spouse / Sign Other (First / Last Name) _____

Home Address _____ City _____ State _____ Zip _____

E-mail _____

Which number(s) for reminder calls:

Cell _____ *Do you authorize text / SMS messaging appointment reminders?* □ Yes □ No

Home _____ *Can we leave a voicemail?* □ Yes □ No

If we reach someone other than you, may we leave a message: Name(s) _____

Employed □ Yes □ No □ Retired Former Occupation _____

Employer's Name _____ Occupation _____

Spouse Employed □ Yes □ No □ Retired Former Occupation _____

Employer's Name _____ Occupation _____

Emergency Contact Name: _____ Relationship _____ Phone _____

****

Availability Preference? Mon (AM / PM) Tues (AM / PM) Wed (AM / PM) Thurs (AM / PM) ☐ No Preference

Reason for Visit _____ **Referred to us by** _____

Primary Care and Other Physicians You See _____

PLEASE COMPLETE - I give permission for my Protected Health Information (PHI) to be disclosed to the following individual(s) (please print):

_____(PCP / Specialist) _____(Spouse / Sign Other) _____(Child)

****

INSURANCE INFORMATION

***PRIMARY* Insurance Company:** _____ **Pt is… □ Self □ Spouse □ Child □ Other… to subscriber.**
Subscriber's Name: _____ **Subscriber's DOB:** _____
Subscriber's Address: _____ **City** _____ **State** _____ **Zip** _____
Subscriber's ID #: _____ **Subscriber's Group #:** _____

***SECONDARY* Insurance Company:** _____ **Pt is… □ Self □ Spouse □ Child □ Other… to subscriber.**
Subscriber's Name: _____ **Subscriber's DOB:** _____
Subscriber's Address: _____ **City** _____ **State** _____ **Zip** _____
Subscriber's ID #: _____ **Subscriber's Group #:** _____

***TERTIARY* Insurance Company:** _____ **Pt is… □ Self □ Spouse □ Child □ Other… to subscriber.**
Subscriber's Name: _____ **Subscriber's DOB:** _____
Subscriber's Address: _____ **City** _____ **State** _____ **Zip** _____
Subscriber's ID #: _____ **Subscriber's Group #:** _____

Please read the following statements carefully. *By signing below*:

I acknowledge the importance of documenting my care with before & after photos. I understand that **photos may be needed for insurance purposes which I cannot opt out of**.

_____ (Initials) My photos may be used for marketing including social media, educational / training purposes without gratuity and my identity concealed.

_____ (Initials) **OPT OUT** - I do not want my photos used for marketing including social media, educational / training purposes.

I acknowledge that I have received Summit Skin & Vein Care's / Patient's Privacy Practices & Rights and it is also posted for my viewing at the practice.

Signature: _____ **Date:** _____

PATIENT NAME: _____ **DOB:** _____

ADMIN USE ONLY
☐ Scanned
☐ Uploaded

MEDICAL HISTORY

Do you have any food or drug allergies? ☐ Yes, *please list below:* ☐ No ☐ Unknown

_____ _____ _____ _____ _____

Do you take any medications or vitamins? ☐ Yes, please complete attached form ☐ No

If applicable,

Do you use birth control pills? ☐ *Yes* ☐ *No* Are you currently pregnant? ☐ *Yes* ☐ *No*

Are you attempting pregnancy? ☐ *Yes* ☐ *No* Are you breast feeding? ☐ *Yes* ☐ *No*

How many pregnancies? _____ How many children? _____

PERSONAL HEALTH HISTORY

General History (Please check any which apply to you)

☐ *Arthritis* ☐ *Asthma/COPD* ☐ *Bleeding Disorder / Problem* ☐ *Cancers* ☐ *Diabetes*
☐ *Heart problems* ☐ *Hepatitis B* ☐ *Hepatitis C* ☐ *High Blood Pressure* ☐ *High Cholesterol*
☐ *HIV* ☐ *Migraines* ☐ *Seizures* ☐ *Stroke* ☐ *Thyroid*
☐ *Varicose Veins*

Leg Symptoms / History (Please circle all that apply)

Throbbing *Pain* *Tingling / Numbness* *Heaviness* *Aching* *Tired*
Restless legs *Swelling* *Bleeding vein* *Burning* *Cramping* *Itching*

RL / LL Deep Vein Thrombosis (DVT)? ☐ *Yes* ☐ *No* When? _____
RL / LL Superficial Vein Thrombosis (SVT)? ☐ *Yes* ☐ *No* When? _____
RL / LL Phlebitis? ☐ *Yes* ☐ *No* When? _____
Previous vein treatment? ☐ *Yes* ☐ *No* When? _____ Type? _____

SURGICAL HISTORY (Please check any which apply to you)

☐ *Appendix* ☐ *Heart* ☐ *Gall Bladder* ☐ *Hysterectomy / Ovaries* ☐ *Back* ☐ *Neck*
☐ *Arm* ☐ *Leg* ☐ *Colon* ☐ *Skin Cancer* ☐ *Nasal* ☐ *Facial*
☐ *Breast* ☐ *Eye* ☐ *Rectal*

Other _____

IMMUNIZATIONS *Tetanus (every10 yrs)* _____ *Pneumococcus (every 7 yrs)* _____ *Influenza* _____

FAMILY HISTORY

Blood clots? ☐ *Yes* ☐ *No* Relation: _____ Varicose Veins? ☐ *Yes* ☐ *No* Relation: _____
Stroke? ☐ *Yes* ☐ *No* Relation: _____ Heart Problems? ☐ *Yes* ☐ *No* Relation: _____
Explain: _____
Mother (if deceased please list age of death) _____ Reason: _____
Father (if deceased please list age of death) _____ Reason: _____
Brothers / Sisters (if deceased please list age of death) _____

SOCIAL HISTORY

Tobacco usage? ☐ *Yes* ☐ *No* Chew / Smoke How much per week? _____
Caffeine usage (Tea / Coffee) ? ☐ *Yes* ☐ *No*
Alcohol usage? ☐ *Yes* ☐ *No* How many drinks per night? _____ Per week? _____

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ADMIN USE ONLY
☐ Scanned
☐ Uploaded

Patient Name:_____ **DOB:**_____ **Date:**_____

Please list **ALL** known prescriptions, over the counter, herbal /vitamins/minerals and dietary supplements with dosage, frequency & route of administration.

Please **PRINT** on the form and bring completed list with you to the appointment.

(If any changes occur please let the staff know, so we are able to correctly update medication list.)

Prescriptions/Over the counters/ Herbals/ Vitamins/Minerals & Dietary Supplements	Dosage	Frequency: How often it is taken.	Route of Administration (oral / injected / patch)
Example: Azithromycin	Example: 20 mg	Example: 2 times daily	Example: Oral

Initial Date Initial Date Initial Date Initial Date

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PATIENT'S / GUARANTOR BILLING & RESPONSIBILITY AGREEMENT

(Initial) _____ I understand that Summit Skin & Vein Care will make every effort possible to verify my benefits with the insurance company information provided by me. I understand it is ultimately my responsibility to understand my benefits and agree to not hold Summit Skin & Vein Care responsible for incorrect benefit information that may be provided to Summit Skin & Vein Care by my insurance company.

(Initial) _____ I understand that, under the terms of the contract with my insurance company, that the co-payment, deductible, and estimated amount of co-insurance must be paid at the time of service.

(Initial) _____ **TRICARE PATIENTS ONLY**: I understand that it is my responsibility to know if Tricare requires a referral for my care. And, if a referral and authorization are required, it is my responsibility to call Tricare prior to each appointment to verify I have a current referral and authorization on file. If a current referral and authorization are not on file at the time of service, I understand the services provided will not be covered by Tricare and I will be billed and payment in full will be due.

(Initial) _____ **CIGNA PATIENTS ONLY:** I understand that it is my responsibility to provide Summit Skin & Vein Care my insurance company's terms of coverage and they are requesting this as a courtesy to me. I also understand if I choose to proceed without the terms of coverage, I will be responsible for 100% of the allowed amount until it is determined that my insurance company does not exclude varicose vein treatment. Once it is determined that varicose vein treatment is not an exclusion, my money will be refunded minus my patient responsibility. If varicose vein treatment is excluded, I will be 100% responsible for my treatment and will proceed as a cash pay patient.

(Initial) _____ I understand that Summit Skin & Vein Care will make every effort possible to file my claim(s) in a timely and accurate manner with my insurance company to assist in the payment of my care and I authorize the release of medical information to the insurance company concerning my treatment. If necessary, I authorize Summit Skin & Vein Care to file an appeal / complaint, on my behalf, with the appropriate authorities to assist in the payment of my claim(s).

(Initial) _____ I understand that Summit Skin & Vein Care will send a statement for any additional balance due to the address on file after my insurance company has made payment on my behalf. At this time, they will request I pay any balance due within 30 days by cash, check or credit card.

(Initial) _____ I understand that if my insurance claim is denied due to incorrect personal information or incorrect insurance information or an omission of information on my part, I will be responsible for 100% of the dates of service not covered and payment in full will be due immediately

(Initial) _____ I understand if I have no insurance coverage, I agree to pay the balance in full at the time services are provided.

(Initial) _____ A service charge of $25.00 will be assessed on all returned checks or credit transactions.

(Initial) _____ I, Patient / Guarantor, acknowledge and understand that I am financially responsible for all services rendered to me by Summit Skin & Vein Care. Although Summit Skin & Vein Care may bill my insurance company for services on my behalf, I understand that it is still my responsibility to make sure that the bill is paid within a reasonable length of time.

(Initial) _____ I, Patient / Guarantor, understand that multiple patient accounts at the same address, i.e., spouse and / or dependent accounts held within Summit Skin & Vein Care Accounts Receivables are considered as one "Household" account.

(Initial) _____ I, Patient / Guarantor, also understand any credit balances on a patient account within the "Household" may be used for other "Household" accounts until all "Household" accounts are settled and paid in full.

(Initial) _____ If for any reason, there is a balance owing after my insurance company pays, I, Patient / Guarantor, agree to pay the balance within 30 days of being billed. I also understand that if litigation becomes necessary to recoup any balance due to Summit Skin & Vein Care, I will be held liable for any attorney's fees and court cost that are applicable.

By initialing above and signing below, I verify that I have reviewed and understand the information on this form.

Printed Patient Name _____ Date of Birth _____

Patient/Guarantor Signature_____ Date _____

DATE: _____

INSURANCE COMPANY:_____

PRE CERT FAX #: _____

SUBSCRIBER NAME: _____

PATIENT NAME: _____

DOB: _____

SUBSCRIBER ID #: _____

SUBSCRIBER GROUP #: _____

ATTENTION: PRE-CERTIFICATION / PRE-AUTHORIZATION DEPT

I, _____, have been told by my Provider, Summit Skin & Vein Care, that a Pre-Certification to determine medical necessity may not be required and that medical necessity will be determined after the service(s) are provided. They have also been told that a Pre-Authorization may not be required for the procedure(s) which gives my provider permission from my insurance company to perform the procedure(s) and to ensure that the service(s) being provided are eligible for payment under my contract.

But due to the cost of the procedure(s), I demand a Pre-Certification letter be sent to my provider's office at Summit Skin & Vein Care, 3521 NE Ralph Powell Road, Lee's Summit, MO 64064 or faxed to (816) 554-9470 stating the service(s) for Varicose Vein Treatment are a covered benefit when medically necessary under my employer's insurance contract (Summary of Benefits) with a current effective date.

In addition, once it is determined that the service(s) to be provided are a covered benefit under my insurance plan / Summary of Benefits and my medical records support medical necessity, I am demanding a letter of Pre-Authorization for the following procedure(s) / code(s).

CPT _____ - _____

CPT _____ - _____

with the following diagnosis codes: _____.

Sincerely,

_____

Patient Signature