Third Circle Medical

PATIENT REGISTRATION FORM

Today's Date:	**Primary Care Provider:**

PATIENT INFORMATION

Patient's Last name:	**First:**	**Middle:**	**Marital status:**

Is this your legal name?	If not, what is your legal name?	Former name:	**Birth date:**	**Age**:	**Sex:**
◉ Yes ◯ No					◯ M ◯ F

Address:	**City:**	**State:**	**Zip:**

Social Security no.:	**Home phone no.:**	**Cell phone no.:**
Your Email:	**Your Employer:**	**Employer phone no.:**

Chose clinic because/referred to clinic by (Please choose one option):	◉ [Doctor's name] ◯ Friend

IN CASE OF EMERGENCY WHO WOULD YOU LIKE US TO CONTACT :

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance.

Patient or Guardian Signature **Date**

Third Circle Medical

MEDICAL HISTORY INFORMATION SHEET

NAME: ____ **AGE:** __________ **TODAY'S DATE:** _____________________

DATE OF BIRTH: (m/d/y) _____/_____/__________ **HEIGHT:** _____ **ft** _____ **inches WEIGHT:** _______________ **lbs**

REASON FOR TODAY'S EXAM: ____

HISTORY:

Past Surgical History: Surgery	Date	Past Medical History: Condition	Date

HISTORY OF SERIOUS INJURIES OR ILLNESSES: ☐ YES ☐ NO If yes, please describe: ________________________

____

COVID Vaccine: ☐ YES ☐ NO If yes, which one: ________________________ **Booster:** ☐ YES ☐ NO

Family History: (check all that apply and relationship to patient)

☐ Heart Attack__________ ☐ Cancer ___________ ☐ Colon Problems __________☐ Diabetes ___________

☐ Blood Pressure ________________ ☐ Other: ____

☐ None

SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Children How Many? ______

Tobacco Use: ☐ Never ☐ In the Past ☐ Currently: Type? ___________ How much? _________ How long? _________

Alcohol Use: ☐ Daily ☐ Occasional ☐ Never Other substance use or abuse? ☐ Yes ☐ No Type: ________________

Do you have allergies? ☐ Yes ☐ No ☐ Food ☐ Drug ☐ Latex ☐ Other: ___________

ALLERGEN	REACTION

Medications: List of Medications (including over-the-counter medications)

(If you have list, we can make a copy)

Medications	Dosage	Frequency

Your Pharmacy Name and Address: ____

Third Circle Medical
Cenchrea Lanier, MSN, ANP-BC,
1609 Rosewood Drive
Columbia TN 38401
Phone: 855-222-7938

Dear Patient,

You are being provided this letter of acknowledgment because you have requested that your doctor visit today be coded as "self-pay" and that you receive a "self-pay cash discount". A self-pay cash discount is offered to patients who elect to pay for the service in full on the date of service and who ***will not be submitting the claim to an insurance carrier***. You have requested that this service be coded as self-pay cash discount because **(initial one):**

____ You have **no** health insurance
____ You have health insurance but you will **not** be billed and instead want to pay out of pocket.
____ Cosmetic Procedure (Botox, Sclerotherapy, PRP Facial, PRP Injections)
____ Other Service (includes IV Wellness Infusions)
____ Other (please explain):
____

We want you to know what to expect so that you can make an informed decision. In order to accomplish this, by signing below you agree to the following:

- All fees for the self-pay cash discount service must be paid on the date of service.
- The self-pay cash discount amount covers only the professional services provided by your provider. You are financially responsible for all ancillary services, for example: laboratory, x-ray, or other services at Third Circle Medical not performed by your provider. You will receive a separate bill from the ancillary services.
- If you have insurance or other types of coverage, services today that are included in the "self-pay" cash discount will not likely be reimbursed by your carrier, or applied to your deductible. You may want to discuss this with your insurance carrier before agreeing to the self-pay cash discount.

By my signature below, I acknowledge that I have read and understand the above and have been given the opportunity to ask questions.

I confirm that I am the patient, or the patient's duly authorized representative.

Patient Signature ____ Date: ________

If signed by someone other than the patient, please specify relationship to the patient:
____

Signature: ____________________________ ID#______________________ Date: ________ Time: _________

NOT PART OF THE LEGAL MEDICAL RECORD

Third Circle Medical
Cenchrea Lanier, ANP-BC
1609 Rosewood Drive
Columbia, TN 38401
Phone 855-222-7938

Laser/Sclerotherapy Consent Form

I understand that medicine is not an exact science, and that though the vast majority of patients are satisfied with their results, there is no guarantee that I myself will be satisfied with the improvement of my veins after treatment. I acknowledge that the following topics have been fully explained to me, and that I understand the explanations I was given. I have had the opportunity to ask questions. I will be undergoing a vein removal procedure that involves the use of either laser application and or sclerotherapy. This consent form is provided as a means of education between the provider and the patient as to the methods and risks involved in vein removal. I understand that laser application and or sclerotherapy treatments may be repeated several times.

Methods/Options:

1. Prior to any procedure the physician will consult the patient.
2. The consultation time will allow for assessment of the problem, determination of a diagnosis and development of a treatment plan and what my options are if I chose to do nothing about my vein problem.
3. Diagnostic evaluations utilizing Doppler and or ultrasound may be required.
4. Treatments may include both Laser and or Sclerotherapy, using physician- determined appropriate energy levels and dosages.
5. The sclerosing agent, Polidocanol, may be used in my procedure. Polidocanol is not yet approved by the FDA, but is widely used by many vein specialists in the United States and is considered by many specialists to be the safest sclerosing agent with the least amount of side effects
6. Photographs of the treatment area may be taken for the chart and for future comparison.

Risks:

1. Pain, burning, blister formation, and stinging sensation at the treatment site.
2. Infection associated with the treatment site.
3. Pigment (color) changes at the treatment site, including hyper pigmentation (Increase in skin color or darkening).
4. Scar formation at the treatment site.
5. Poor cosmetic outcome.
6. Reoccurrence of vessels at the treated site.
7. Allergic reaction possibly severe or life-threatening.
8. Superficial or deep clot formation (deep vein thrombosis).
9. Bleeding and or bruising at the treatment site.
10. Ulcer formation at site of treatment.
11. Temporary phlebitis at the treatment site.
12. Matting (bruised appearance that is often temporary, but sometimes permanent)

Benefits:

1. Lightening of the veins in the treatment site.
2. Complete removal of the veins in the treatment area.

I recognize that even though any particular problem may be extremely rare, it is always possible that any patient may have one of these problems. I accept that possibility for my own treatment. I understand that I am responsible for my own medical bills. I realize that most insurance companies do not cover treatment of spider veins and that I must pay for my treatment today. I authorize this practice to submit my bill to my insurance company and to receive reimbursement. If my insurance company reimburses this practice for the services in which I am paying for today I will receive a refund of payment from this practice.

Patient: ____ Date: ____________________