Parish
VEIN • LASER • DERMATOLOGY

DR. TIMOTHY PARISH
DIRE[illegible]
MD. [illegible]S

3055 Lorna Road
Hoover, Alabama 35216
Phone: 205-822-6333
Toll free:800-536-VEIN
Fax:205-822-6788
www.facemd.com

Dr. Parish would love to provide you with more information on other procedures he offers.

Please ☑ each procedure you would like more information on. All procedures are performed in the office with little or no downtime.

	Pamphlet given	F/U on return visit
___ **VEIN TREATMENTS:** Alabama's most experienced vein center since 1995- offering state of the art Ultrasound technology and advanced treatment for varicose, spider, and facial veins, including: 1. Sclerotherapy 2. Ultrasound Guided Sclerotherapy 3. Endovenous Laser 4. Ambulatory Phlebectomy	_____	_____
___ **KRYPTON LASER**—for the treatment of facial veins	_____	_____
___ **SKIN REJUVENATION/ACNE PROGRAMS (home products and chemical peels)** 1. Neostrata products 2. Obagi Nu-Derm 3. Skin Ceuticals 5. IS Clinicals 6. Glytone 7. Chemical Peels (Glycolic, Mandelic, Pyruvic, Jessner's, Retinol)	_____	_____
___ **OBAGI BLUE PEEL:** For pigmentation and under eye wrinkles	_____	_____
___ **VELASHAPE:** cellulite treatment combining radiofrequency and suction	_____	_____
___ **JUVEDERM/RESTYLANE**—fills in deeper depressions and wrinkles plumps up lips and restores loss of collagen	_____	_____
___**VOLUMA/RESTYLANE LYFT**—replaces volume loss in the cheeks	_____	_____
___ **BOTULINUM TOXIN FOR FACIAL WRINKLES (BOTOX, DYSPORT)** (frown line, forehead & crow's feet)	_____	_____
___**IPL PHOTO-REJUVENATION**-treatment for sun damage and pigmentation	_____	_____
___ **LASER HAIR REMOVAL**—for dark colored hair	_____	_____
___ **LED PHOTOMODULATION**—the interaction of light delivered through Light Emitting Diodes (LED) to activate cells causing them to produce collagen	_____	_____
___ **VENUS VIVA**—the latest no downtime technology for wrinkles, crepiness, acne scars and the décolleté	_____	_____
___ **DERMATOLOGY SERVICES** 1. Skin Cancer Screenings (biopsy and excision) 2. General Dermatology; rashes, sun damage, eczema, dermatitis and warts	_____ _____	_____ _____

_____ Signature

_____ Date

Parish
VEIN LASER DERMATOLOGY

Timothy D. Parish, MD
M.D., M.B.B.S., D.A.B.A., D.A.B.P., F.A.C.Ph., R.V.T., R.P.V.I.

Welcome to the Parish Vein Laser Dermatology, founded in 1995 by Timothy D. Parish, M.D., M.B.B.S., D.A.B.A., D.A.B.P., F.A.C.Ph., R.V.T., R.P.V.I., D.A.B.V.L.M. Board Certified Laser Surgeon, to provide state of the art in office procedures, performed under local anesthesia for skin aging, fatty bulges, cellulite and veins.

As a commitment to patient safety and optimum clinical care, the center has been nationally accredited by AAAHC since 1999. Dr. Parish has treated over 16,000 patients and performs all vein treatment himself (they are not performed by a nurse or a P.A.). Dr. Parish was the first physician in Alabama to introduce Ultrasound Guided Sclerotherapy, Endovenous Laser and Ambulatory Phlebectomy for veins.

Varicosis (spider veins and/or varicose veins) is a hereditary condition that runs in families and does not have a definitive cure. Generically speaking, varicosis patients inherit weaker veins than average and over time these veins appear like stretching balloons on the surface of the legs. The diagnosis should be made as soon as possible in order to begin therapy aimed at stabilizing the problem, the earlier the diagnosis the less aggressive the treatment. Completion of the treatment course outlined by Dr. Parish and compliance with an ongoing maintenance program is necessary for the control of the evolution of the disease. Follow up visits will be as instructed (on average at 2-4 week intervals), and then annual maintenance once the condition has been controlled. Your legs will never be totally clear of veins. Prevention (medical grade support hose while standing), is encouraged but totally up to the patient.

Conditions that worsen veins of the legs are hormones and pregnancy, aging, gravity (standing professions such as teachers, hairdressers, etc.). Staying slim and fit promotes good health.

Risks in not treating varicosis include chronic pain, blood clots (DVT and/or phlebitis), ankle discoloration with sores and bleeding.

Many vein problems are more complex that patients realize. We are committed to giving you our best, however, with venous disease, success depends very much on the patient faithfully following detailed instructions and completing the treatment course specifically tailored to you as an individual. With all of us working together, we look forward to achieving, with you, the best results possible.

Dr. Parish is board certified by the American College of Phlebology which recognizes that the gold standard treatment of spider veins on the legs is sclerotherapy (injections) and not lasers. Lasers are used for the face.

_____ _____

Patient Signature Date

NAME: _____ DATE: _____ AGE: _____

REASON FOR CONSULTATION: _____

What percentage of improvement do you expect? ☐0-30% ☐40-60% ☐100% Are you willing to accept less than your expectations? ☐YES ☐NO

FOR VEIN CONSULTATION: Reason for consultation: ☐pain ☐cosmetic ☐prevention ☐ulcers ☐bleeding

If pain, is it: ☐heaviness ☐burning ☐fatigue ☐stinging ☐aching ☐throbbing

Have you had any injuries to your legs? ☐YES ☐NO If so, what part of leg? _____

Any previous treatments for varicose or spider veins? ☐YES ☐NO Where? _____ When? _____

Was treatment: ☐stripping ☐injections ☐laser ☐other: _____

FOR WOMEN: Are you pregnant? ☐YES ☐NO Breast feeding? ☐YES ☐NO Number of pregnancies: _____

Age of youngest child: _____ Miscarriages? ☐YES ☐NO How many? _____

YOUR OCCUPATION: _____ **DO YOU SMOKE?** ☐YES ☐NO

MEDICAL HISTORY - PAST AND PRESENT- Answer each section. If yes, answer all in the section. If no, go on to the next section.

BLOOD DISORDERS ☐Yes ☐No

YES NO

☐ ☐ blood clotting disorders hypercoagulable syndrome inherited thrombophilia, etc.
☐ ☐sickle cell or sickle cell trait
☐ ☐blood clots
☐ ☐phlebitis
☐ ☐Pulmonary embolism
☐ ☐blood thinners/heparin coumadin-lovenox-aspirin

RESPIRATORY ☐Yes ☐No

☐ ☐ vocal cord problems
☐ ☐ problems with anesthesia
☐ ☐problem being intubated
☐ ☐ malignant hyperthermia
☐ ☐asthma/wheezing
☐ ☐tuberculosis
☐ ☐hiatal hernia/GE reflux
☐ ☐sleep apnea
☐ ☐snoring/airway problems

NEUROLOGICAL ☐Yes ☐No

YES NO

☐ ☐Lou Gehrig Disease
☐ ☐Myasthenia Gravis
☐ ☐Eaton-Lambert Syndrome
☐ ☐multiple sclerosis
☐ ☐stroke-TIA
☐ ☐seizures
☐ ☐fainting spells
☐ ☐migraines

AUTOIMMUNE ☐Yes ☐No

☐ ☐arthritis
☐ ☐muscular disease
☐ ☐immune deficiency
☐ ☐collagen disease- (lupus, Scleroderma, photosensitive disorders, Rheumatoid Arthritis)
☐ ☐history of severe allergic reaction- anaphylaxis
☐ ☐allergic to human albumin
☐ ☐have taken immunosuppressants (Embrel, steroids, Cyclosporin, methotrexate)
☐ ☐Hives, urticaria, whelps

INFECTIOUS ☐Yes ☐No

YES NO

☐ ☐hepatitis
☐ ☐HIV
☐ ☐staph infection/MRSA

GASTROENTEROLOGICAL ☐Yes ☐No

☐ ☐liver problems
☐ ☐kidney/bladder problems
☐ ☐ulcerative colitis/ Crohn's disease
☐ ☐hiatal hernia/GE reflux

METABOLIC ☐Yes ☐No

☐ ☐insulin dependent diabetic
☐ ☐thyroid (hypo/hyper)
☐ ☐Adrenal insufficiency (Cushings)

CARDIOLOGICAL ☐Yes ☐No

☐ ☐high blood pressure
☐ ☐stents
☐ ☐heart attack
☐ ☐chest pain
☐ ☐irregular heart beat
☐ ☐mitral valve prolapse
☐ ☐pacemaker

YES NO

☐ ☐heart murmur
☐ ☐congenital heart defect
☐ ☐congestive heart failure
☐ ☐heart valve disease
☐ ☐hole in heart
☐ ☐arterial problems

DERMATOLOGICAL ☐Yes ☐No

☐ ☐dermatitis/eczema
☐ ☐rosacea
☐ ☐psoriasis
☐ ☐keloid scars
☐ ☐herpes simplex/fever blisters

CANCER ☐Yes ☐No

Type: _____
When: _____
☐ ☐chemotherapy
☐ ☐radiation
☐ ☐metal plates

PSYCHOLOGICAL ☐Yes ☐No

☐ ☐depression/anxiety
☐ ☐alcohol/drug abuse

Other: _____

IS THERE A FAMILY HISTORY OF ANY OF THE ABOVE ILLNESSES? ☐YES ☐NO IF SO, LIST: _____

LIST ALL SURGERIES (INCLUDING COSMETIC AND BLOOD TRANSFUSIONS) AND ANY SIGNIFICANT MEDICAL EVENTS WITH DATES: _____

LIST ALL MEDICATIONS (INCLUDING HERBS AND VITAMINS) WITH DOSAGE YOU ARE CURRENTLY TAKING: _____

DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS? ☐YES ☐NO **IF SO, LIST AND EXPLAIN REACTION:** _____

DO YOU HAVE ALLERGIES TO: ☐TAPE ☐BAND-AIDES ☐ASPIRIN ☐SEAFOOD ☐XYLOCAINE ☐IODINE ☐LATEX **OTHER:** _____

I verify the above information to be correct: PATIENT SIGNATURE: _____

Director: Timothy Parish, M.D.
3055 Lorna Rd
Hoover, AL 35216
205-822-6333
fax:205-822-6788

Patient Registration

DATE: _____/_____/_____

_____ _____ _____ _____/_____/_____
Last First MI Date of birth

_____ _____
Address City Zip code

_____ _____ (_____)_____-_____
Who can we contact in case of emergency? Relation Emergency contact phone number

_____ _____ _____ _____
Patient Employer Address City State

_____ _____ _____ _____
Primary Doctor's Name Address City State

IT MAY BE NECESSARY FOR US TO CONTANCT YOU CONCERNING YOUR MEDICAL TREATMENT OR APPOINMENT (WE WILL ATTEMPT TO CALL YOU TO REMIND YOU OF ANY FUTURE APPOINTMENTS).

YES NO

HOMEPHONE#: (_____) _____-_____May we leave a message at your home#? ☐ ☐ _____
Sign

CELLPHONE#:(_____) _____-_____May we leave a message on your mobile #? ☐ ☐ _____
Sign

WORKPHONE#:(_____) _____-_____May we leave a message at your work #? ☐ ☐ _____
Sign

EMAIL ADDRESS: _____May we E-Mail you? **YES** ☐ **NO** ☐ _____
Sign

MAIL: May we send information via Mail? (Address Above) **YES** ☐ **NO** ☐ _____
Sign

INSURED PARTY INFORMATION

Name of the Insurance: _____

Name of the Policy Holder: _____
Last name First MI

Date of Birth: _____/_____/_____
**(required to file insurance) **

How Did You hear about us?
___Patient/Friend _____
___Yellow pages
___Radio
___Doctor _____
___Internet
___T.V.
___Other

verify that the above information is the most current and correct information: _____
Patient Signature

bove Information still current:
Date: _____ Patient Initials:_____ Date:_____ Patient Initials:_____ Date:_____ Patient Initials:_____

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VENOUS CONSULTATION, TESTING AND TREATMENT PRICE SHEET

CONSULTATION- includes DPPG Pleysmography screen for venous insufficiency..... **$75.00**

TESTING- Venous Ultrasound Imaging Scan- .....**Both legs -$175.00. One leg- $87.50**
(Venous Imaging Scans will be billed to Blue Cross Blue Shield of Alabama Only- you will be responsible for any co-payments and/or deductibles)

SCLEROTHERAPY.....**$225.00** per leg per visit
-The gold standard treatment for spider veins - approximately 2-4 visits depending on how many veins you have.

ULTRASOUND GUIDED SCLEROTHERAPY.....**$475.00** per leg per visit
-treatment for varicose veins- approximately 2-5 visits

ENDOVENOUS LASER TREATMENT (covered by most insurance, preapproval necessary...**$1,800.00**

MICROPHLEBECTOMY.....**$750.00**

COMPRESSION HOSIERY.....**$54-$84 (+TAX)**
-type of compression hosiery will be determined by the type of veins and treatment.

NITROUS OXIDE **$40.00**

PLEASE NOTE: WE DO NOT FILE ANY SCLEROTHERAPY OR ULTRASOUND GUIDED SCLEROTHERAPY TO INSURANCE

PLEASE READ CAREFULLY BEFORE SIGNING

****

MOST INSURANCE CARRIERS DO NOT CONSIDER SCLEROTHERAPY TREATMENT OR TREATMENT OF SPIDER VEINS MEDICALLY NECESSARY AND DO NOT COVER ULTRASOUND GUIDED SCLEROTHERAPY OF VARICOSE VEINS.

To help keep costs down, we request payment at the time of service for sclerotherapy/ultrasound guided sclerotherapy treatment and compression hosiery. For your convenience, we will provide you with an itemized statement for treatment charges so you may submit to your insurance carrier for reimbursement. **WE DO NOT FILE FOR ANY SCLEROTHERAPY or ULTRASOUND GUIDED SCLEROTHERAPY CHARGES.** I understand that Blue Cross and Blue Shield of Alabama and most insurances consider sclerotherapy of telangiectasia (spider veins) and ultrasound guided sclerotherapy (UGS) non-covered and therefore excludes the procedure from coverage. I understand that I will be financially responsible and liable to Parish Vein Laser Dermatology and/or Timothy D. Parish, M.D. for all charges incurred in the performance of injection sclerotherapy. We will, however, submit all consultation and diagnostic testing charges (if applicable) to Blue Cross Blue Shield of Alabama. You will be responsible for any copays or deductibles. **We are not on assignment with any other insurance companies or MEDICARE therefore you will be responsible for any consultation charges, Venous Ultrasound Testing and Injection/Laser Treatments.**

EVLT SURGERY and Microphlebectomy- We will assist you in interpreting your insurance benefits and obtaining any required pre-determination prior to surgery.

By signing below, I hereby acknowledge that I have read and understand the fee schedule policy described above. If Parish Vein Laser Dermatology is submitting any claims to my insurance carrier on my behalf, I hereby authorize the release of any medical information (including copies of medical records and photographs) or any other information necessary to process the claim. I also hereby authorize payment directly to Parish Vein Laser Dermatology and/or Timothy D. Parish, M.D. of benefits payable under the terms of my policy for consultation, diagnostic testing and/or treatment if applicable.

PATIENT SIGNATURE _____ DATE _____

Blue Cross and Blue Shield of Alabama/Medicare
Sclerotherapy and Ultrasound Guided Sclerotherapy Waiver

I, _____, understand and hereby acknowledge that my insurance carrier, Blue Cross and Blue Shield of Alabama and Medicare, considers sclerotherapy of telangiectasia (spider veins) and ultrasound guided sclerotherapy non-covered and therefore excludes the procedure from coverage. I understand that I will be financially responsible and liable to Parish Vein Laser Dermatology for all charges incurred in the performance of injection sclerotherapy for veins and ultrasound guided sclerotherapy. We are **NOT** on assignment with Medicare, therefore we **DO NOT** file any charges to Medicare. You are responsible for all charges incurred.

_____ _____

Patient's Signature Date

HIPAA Notice of Privacy Practices

_____ [Name]

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

I hereby authorize Timothy D. Parish, M.D. and the staff of the Varicosis and Laser Center of Alabama to release or discuss my medical condition or medical records with the following individuals:

- ☐ Myself only
- ☐ My spouse _____ SSN_____DOB_____
- ☐ Other _____ SSN_____DOB_____

Relationship to patient_____

Signature:_____

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____Date_____