RESTORE
VEIN AND WELLNESS

R. Brian Thoma, M.D. | Vicki Burleson, p.a.

Welcome to RESTORE VEIN AND WELLNESS. In the following pages, you will find release of records forms, insurance forms, and your clinical forms. Filling these out before the day of your visit will save valuable time at the office, hopefully resulting in a timelier visit with your provider.

Please see the enclosed medical records request form to enable your other doctors' office to send your records to Cahaba Pain and Spine Care. **Your outside records, especially of your care at other pain clinics, may need to be reviewed before we can prescribe certain pain medications for you. Not every patient is prescribed pain medication at their first visit.**

We encourage you to visit our website www.restorevein.com to review key information about our practice including specific treatments we offer. We look forward to taking care of you!

Appointments and Cancellations

Our office hours are 7:30am – 4:30pm, Monday through Thursday. Please arrive on time to your appointments. We reserve the right to reschedule your appointment if you are more than 15 minutes late.

Due to the high demand for our providers' services, we ask that you provide 24 hours' notice for the cancellation of any office visit and 48 hours' notice if cancelling a procedure. Failure to show for a visit without proper cancellation notice will result in cancellation fees of $25 and $100 for office visits and procedures respectively.

We look forward to taking care of you!

Your appointment is schedule with

Dr. Thoma/Vicki Burleson, PA on_____ @ _____

RESTORE
VEIN AND WELLNESS

YOUR FIRST VISIT

Restore Vein and Wellness
2010 Patton Chapel Road, Suite 102
Hoover, AL 35216

Phone: 205-208-0324
Fax: 205-208-0031

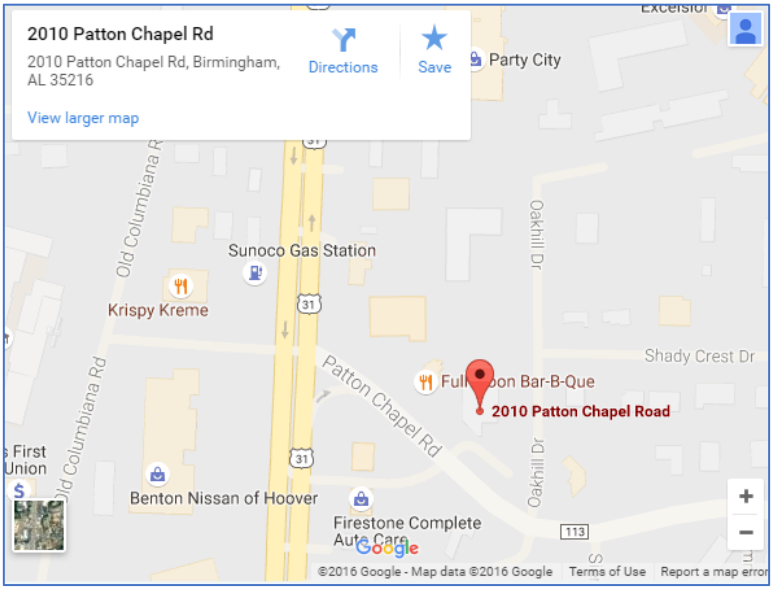
Directions

We are conveniently located just off Hwy 31 between I-65 and I-459.

From Hwy 31

Traveling South on 31: Go South on Highway 31 until you see a Nissan dealership and Krispy Kreme on the right and a Full Moon BBQ on the left. At traffic light, turn Left onto **Patton Chapel Road North.** Hoover Medical Plaza is on the left immediately after Full Moon BBQ. Turn left onto **Oakhill Drive**, and proceed to the back parking lot. There is an entrance at the back of the building directly to the second floor for easy entry. We are in Suite 102.

Traveling North on 31: Go North on Highway 31 until you see a Nissan dealership and Krispy Kreme on the left and a Full Moon BBQ and Regions Bank on the right. At the traffic light, turn Right onto **Patton Chapel Road North.** Hoover Medical Plaza is on the left immediately after Full Moon BBQ. Turn left onto **Oakhill Drive**, and proceed to the back parking lot. There is an entrance at the back of the building directly to the second floor for easy entry. We are in Suite 102.



From I-459

Take the Hoover Highway 31/Montgomery Highway Exit (Exit 13 from I-459S and Exit 13B from I-459N). Go **North on Highway 31** until you see a Nissan dealership and Krispy Kreme on the left and a Full Moon BBQ on the right. Turn Right onto **Patton Chapel Road North**. Hoover Medical Plaza is the building immediately after Full Moon BBQ on the left side. Turn left onto **Oakhill Drive**, and proceed to the back parking lot. There is an entrance at the back of the building directly to the second floor for easy entry. We are in Suite 102.

From I-65

Take the Hoover Highway 31/Montgomery Highway Exit (Exit 252). Go **South on Highway 31**. Travel approximately one mile until you see a Nissan dealership and Krispy Kreme on the right. At the traffic light, turn Left onto **Patton Chapel Road North**. Hoover Medical Plaza is the building immediately after Full Moon BBQ on the left side. Turn left onto **Oakhill Drive**, and proceed to the back parking lot. There is an entrance at the back of the building directly to the second floor for easy entry. We are in Suite 102.

What to Bring

- Insurance Card(s) and Prescription Card (if applicable)
- Valid Government-Issued Photo ID (driver's license, passport, etc.)
- Copay (if applicable)
- Completed New Patient Clinical Forms
- All current medications, in their bottles

RESTORE
VEIN AND WELLNESS

Patient Contact Information Sheet

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

Social Security Number:_____

Any physician, staff, employee or representative of Cahaba Pain and Spine Care, LLC has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment:

Name	Relationship	Phone Number(s)
Name	Relationship	Phone Number(s)
Name	Relationship	Phone Number(s)
Name	Relationship	Phone Number(s)
Name	Relationship	Phone Number(s)

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Cahaba Pain and Spine Care, LLC or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals it may be subject to redisclosure by the individual(s).

Patient Signature: _____Date: _____

Copy available to patient upon request

RESTORE
VEIN AND WELLNESS

PATIENT INFORMATION

PATIENT NAME:
_____

LAST FIRST MIDDLE

ADDRESS:
_____

ZIP CODE: _____ **CITY:** _____ **STATE:** _____

HOME PHONE #: (_____) _____-_____ **WORK PHONE #:** (_____) _____-_____ **CELL PHONE #:** (_____) _____-_____

EMAIL ADDRESS: _____ **RACE:** _____ **HEIGHT:** _____ **WEIGHT (lbs):** _____

DATE OF BIRTH: _____/_____/_____ **SOCIAL SECURITY NUMBER:** _____-_____-_____

MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED OTHER

LANGUAGE: English Arabic Chinese Polish Portuguese Russian Somali Spanish Vietnamese ☐ I decline to answer

RACE: American Indian Asian Asian Indian Black or African American European Filipino Japanese Korean
Native Hawaiian or other Pacific Islander White ☐ I decline to answer

ETHNICITY: Central American Cuban Dominican Hispanic or Latino/Spanish Mexican Not Hispanic or Latino Puerto Rican
South American Spaniard ☐ I decline to answer

EMERGENCY CONTACT NAME:_____ **WORK PHONE #:** (_____) _____-_____

HOME PHONE #:(_____) _____-_____**CELL PHONE #:** (_____) _____-_____**Relationship to patient**_____

PRIMARY CARE PHYSICIAN:_____ **REFERRED BY:**_____

PREFERRED PHARMACY NAME:_____ **PHONE #:**_____

PATIENT'S EMPLOYER INFORMATION:

COMPANY: _____ OCCUPATION_____

CITY: _____ PHONE #: _____

RESTORE
VEIN AND WELLNESS

Patient Name:_____Date of Birth:_____

RESPONSIBLE (OR INSURED) PARTY INFORMATION

RESPONSIBLE PARTY RELATIONSHIP TO THE PATIENT: (circle one)

SELF SPOUSE CHILD OTHER

SEX: (circle one)

FEMALE MALE

RESPONSIBLE PARTY NAME:

_____

LAST FIRST MIDDLE

ADDRESS:

_____

ZIP CODE: _____ **CITY:** _____ **STATE:** _____

DATE OF BIRTH: _____/_____/_____ **SEX:** (circle one) FEMALE MALE

HOME PHONE #: (_____) _____-_____ **WORK PHONE #:** (_____) _____-_____

SOCIAL SECURITY NUMBER: _____ - _____ - _____

RESPONSIBLE PARTY'S EMPLOYER INFORMATION: COMPANY: _____

CITY: _____PHONE #: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:

_____

ADDRESS: _____ PHONE: _____

CONTRACT (ID#) NUMBER: _____ **SUBSCRIBER'S NAME:** _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ GROUP NUMBER: _____

COPAYMENT AMOUNT: $ _____ INSURED'S DATE OF BIRTH: _____/_____/_____

RESTORE
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Patient Name:_____Date of Birth:_____

SECONDARY INSURANCE COMPANY:_____ _____

ADDRESS: _____ PHONE: _____

CONTRACT (ID#) NUMBER: _____ **SUBSCRIBER'S NAME:** _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ GROUP NUMBER: _____

COPAYMENT AMOUNT: $ _____ INSURED'S DATE OF BIRTH: _____/_____/_____

WE APPRECIATE THE OPPORTUNITY TO SERVE YOU!

RESTORE
VEIN AND WELLNESS

Photograph/Video/Media Release Form

Restore Vein and Wellness
2010 Patton Chapel Road, Suite 102
Hoover, AL 35216
205-354-2805

Subject: _____

Location: _____

This Photograph/Video/Media release is made by _____, an individual (the "**Participant"**), in favor of Restore Vein and Wellness, (the **"Photographer"**). The Participant agrees as follows:

1. **PERMISSION TO TAKE AND USE PHOTOGRAPHS AND/OR VIDEO.**
   a. **Permission to Use**. The Participant grants the Photographer the full irrevocable right to take pictures, portraits, digital images, photographs or video of the Participant or in which the Participant may be included (the **"Photographs"**) and use, publish reproduce, edit, exhibit, license, distribute, or otherwise exploit the Photographs, in whole or in part.
   b. **No Obligation**. The Photographer's right to use the Photographs does not constitute an obligation make use of this right.
2. **ASSIGNMENT; WAIVER.**
   The Participant assigns to the Photographer all interest in the Photographs, including copyright. The Photographs and any associated negatives or digital imprints are the sole property of the Photographer and the Participant waives any right to:
   a. Inspect or approve the Photographs;
   b. Inspect or approve any text, graphics, images, videos, or other content created in connection with or combined with the Photographs; or
   c. Receive any royalties or other compensation related to the Photographic use.
3. **RELEASE.**
   The Participant hereby releases the Photographer from any liability arising from the Photographic Use, including that based on copyright infringement, invasion of privacy, right of publicity, libel, defamation, or false light, or resulting from any alteration, blurring, optical illusion, use in composite form, distortion, or other modification that may occur, intentionally or otherwise, in connection with taking the Photographs, processing the Photographs, or the Photographic Use.
4. **PARTICIPANT'S REPRESENTATIONS.**
   The Participant hereby represents that:
   a. Her/she is a legal adult and has the full legal capacity to execute this release;
   b. The rights granted under this release do not conflict with or violate any other commitment the Participant has; and
   c. He/she has read the release before signing it and fully understands its contents, meaning and impact.

The Participant is hereby signing this release on the date stated below:

Signature: _____

Printed Name: _____

Address: _____

Email: _____

Date: _____

Parent or Guardian Signature: _____
(if under 18 years of age)

New Patient Clinical Forms

Welcome to Restore Vein and Wellness. The following questionnaire is an important tool we use to evaluate you. Please read and fill out each item in this packet. Your physician will use this information to select the best treatments for you.

PATIENT NAME: _____

DATE OF BIRTH: _____

YOUR PHYSICIANS/PROVIDERS:

REFERRING PHYSICIAN:_____

PRIMARY CARE PHYSICIAN: _____

HPI: (Circle all that apply)

LOCATION: Right Lower Extremity / Left Lower Extremity

Other:_____

QUALITY: Aching / Burning / Stabbing / Throbbing / Sharp / Dull / Heaviness / Drainage / Numbness / Tingling / Occasional / Frequent / Constant / Worsening/Improving During The Day / Worse During The Night / Legs Swell Equally / Legs Do Not Swell

Other:_____

ASSOCIATED SYMPTOMS: Swelling / Redness / Rash / Itching / Throbbing / Warmth / Discoloration / Skin / Thickening / Spontaneous Bleed From Spider Veins / Healed Ulcer (how many___) / Active Ulcer (how many_____)

Other:_____

SEVERITY: No Pain / Mild / Moderate / Severe / Intermittent / Constant

Other:_____

ONSET: Abrupt Onset / Gradual Onset / Date Of Onset _____Months, _____Years

Patient Name:_____

CONTEXT: Injury / Edema / Deep Vein Thrombosis / Previous Pregnancy /
Family History Of Deep Vein Thrombosis / Family History Of Vein Disease

ALLEVIATING FACTORS: Nothing Gives Relief / Nothing Makes Worse / Elevation / Compression
Medication_____ / Rest / Exercise
Other:_____

AGGRAVATING FACTORS: Cannot Identify / Exercise / Weight Bearing / Previous Childbirth /
Standing / Sitting
Other:_____

PREVIOUS SURGERY: Endovenous Thermal Ablation (Date_____) / Vein Stripping (Date_____)
Sclerotherapy (Date_____)

Have you had any of the following *diagnostic tests* in the last 2 years? If so, when and where?

□MRI/MRV_____

□CTScan_____

□Venous Ultrasound_____

□ArterialUltrasound_____

□Other_____

Patient Name:_____

ALLERGIES: □ I have no known drug or medication allergies

Please list any drugs or medications that you are allergic to and include the reaction to each.

_____

_____

Are you allergic to any of the following? (Circle all that apply.)

Betadine/Iodine IV Contrast Dye Eggs Latex Adhesives or tape Skin Glue

FAMILY HISTORY: (Please limit to your parents, siblings, or children)

Do any family members suffer from the following conditions? If so, who?

□ Venous disease _____

□ History of Blood Clots _____

□ Bleeding disorders _____

□ Heart disease (e.g. heart attack, vascular disease) _____

□ Malignancy _____

SOCIAL HISTORY:

Do you drink alcohol? Y / N , If so, how much/how often? _____

Do you smoke? Y / N , If so, how much/how often? _____

□ If quit, When? _____

What is your current work status? □ Employed □ Unemployed □ Retired

□ Disabled □ Homemaker □ Student □ Self-employed

If you are currently working, where do you work? _____

Do you wear compression hose? Y / N , if so, how long? _____

Do you exercise? Y / N , if so, how much/how often? _____

Are you currently: □ Married □ Single □ Divorced □ Separated

With whom do you live? □ Spouse □ Children □ Alone □ Friends/other family □ Assisted living facility

Patient Name:_____

MEDICATIONS:

Please list all medications you are currently taking. Include dose and number of times taken per day.

_____

_____

_____

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY: (Please indicate if you have been diagnosed or treated for any of the following.)

SPINE: □ Degenerative Disc Disease □ Spinal Stenosis □ Herniated Disc

Other:_____

NEUROLOGIC: □ Seizure □ Stroke □ Brain Mass/Tumor □ Migraines

□ Neuropathy □ MS □ Hearing Or Vision Loss □ Muscle Problems

Other:_____

PSYCHIATRIC: □ Depression □ Bipolar Disorder □ Suicidal Thoughts/Attempts □ Schizophrenia

CARDIAC: □ Chest Pain □ Heart Attack □ Abnormal Heart Rhythm □ Valve Disease

□ Heart Failure □ Pacemaker or AICD Implantation

Other:_____

PULMONARY: □ Asthma □ COPD □ Lung Cancer □ Chronic Bronchitis

□ Pneumonia □ Sarcoidosis □ Tuberculosis □ Obstructive Sleep Apnea

Patient Name:_____

ABDOMINAL: □ Liver Disease □ Cirrhosis □ Hepatitis □ Ulcers/GI Bleed

□ Pancreatitis □ Diverticulitis □ Appendicitis □ Crohn's Disease

□ Ulcerative Colitis □ Colon Cancer □ Gallbladder Disease

Other:_____

URINARY: □ Kidney Disease/Failure □ Renal Cancer □ Kidney Failure □ Bladder Cancer

□ Interstitial Cystitis □ Kidney Stones

Other:_____

ENDOCRINE: □ Hypothyroidism □ Hyperthyroidism □ Diabetes

□ Thyroid cancer □ Adrenal tumors

Other:_____

MUSCULOSKELETAL: □ Varicose Veins □ Spider Veins □ Osteoarthritis

□ Rheumatoid Arthritis □ Gout □ Fibromyalgia

Other:_____

HEMATOLOGIC: □ Anemia □ Low Platelets □ Sickle Cell Anemia □ Blood Clot Or DVT

□ Hypercoagulable State (Blood clots abnormally well) □ Hemophilia □ Lupus

□ Leukemia/Lymphoma

Other:_____

SKIN: □ Eczema □ Cellulitis □ Foot/Ankle Ulcers □ Infected Surgical Wound

□ MRSA Infection □ Skin Cancer (Melanoma, Squamous Cell Carcinoma, Basal Cell Carcinoma)

Other:_____

ENT: □ Chronic Sinusitis □ Oral or Throat Cancer

Patient Name:_____

SURGICAL HISTORY:

Please list all **Surgeries** you have had, and approximate year it was done.

_____

_____

_____

_____

_____

_____

REVIEW OF SYSTEMS: (Check all that apply)

CONSTITUTIONAL: □ Excess Weight Loss/Gain □ Fever □ Fatigue □ Loss of Appetite

Other:_____

HEENT: □ Recent Head Trauma □ Vision Changes □ Dry Eyes □ Hearing Loss

□ Ear Lesions □ Nose Lesions □ Mouth Lesions □ Sore Throat □ Difficulty Swallowing

Other:_____

CARDIOVASCULAR: □ Fainting (Syncope) □ Chest Pain □ Palpitations □ Leg Pain

Other:_____

PULMONARY: □ Cough □ Shortness Of Breath □ Coughing Up Blood □ Pain with Deep Breaths

Other:_____

GASTROINTESTINAL: □ Abdominal Pain □ Nausea/Vomiting □ Constipation □ Blood in Stool

□ Diarrhea

Other:_____

GENITOURINARY: □ Pain with Urination □ Blood In Urine □ Genital Pain

□ Incontinence □ Scrotal Varicose Veins □ Vulvar Varicose Veins

Other:_____

MUSCULOSKELETAL: □ Varicose Veins □ Swelling □ Leg Pain □ Joint Pain

□ Joint Swelling □ Recent Trauma

Other:_____

Patient Name:_____

SKIN: □ Hyperpigmentation □ Rash □ Skin Lesions □ Skin Sensitivity □ Wounds

Other:_____

NEUROLOGIC: □ Weakness □ Numbness □ Tingling □ Headache □ Loss of Consciousness

□ Balance Problems □ Falls

Other:_____

HEM/ONC: □ Blood Clots □ Swollen Glands □ Easy Bruising □ Easy Bleeding

Other:_____

ENDOCRINE: □ Heat intolerance □ Cold Intolerance □ Increased thirst

Other:_____

PSYCHIATRIC: □ Depression □ Anxiety □ Poor sleep

Other:_____

Patient Name:_____

OTHER DOCTORS' RECORDS → SEND TO RESTORE VEIN AND WELLNESS

Authorization to Disclose Health Information

Patient Name: _____Social Security Number: _____

1. I authorize _____to disclose
(*Physician and/or Practice name you are coming FROM*)
the above named individual's health information as described below.

2. This information may be disclosed to and used by the following individual or organization:
Name: Restore Vein and Wellness, LLC
Address: 2010 Patton Chapel Road, Suite 102 Birmingham, AL 35216
Office phone: (205)-208-0324 Office fax: (205)-208-0031
For the purpose: Medical evaluation and/or treatment

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- ❑ Office Visit Notes_____
- ❑ Patient Account Statement/Billing Records
- ❑ Medication list
- ❑ Procedure Notes_____
- ❑ List of allergies
- ❑ Most recent history and physical
- ❑ Most recent discharge summary
- ❑ Laboratory results
- ❑ X-ray and imaging reports From (date) _____ to (date) _____
- ❑ Consultation reports From (date) _____ to (date) _____
From (doctors' names) _____
- ❑ Entire record

Other:

_____

_____

Patient Name:_____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to our Privacy/Security Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: .

   _____.

   If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524 of the Federal Register Rules and Regulations. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure or my health information, I can contact the Privacy/Security Officer.

Signature of Patient or Legal Representative	Date
If signed by Legal Representative, Relationship to Patient	Signature of Witness

Patient Name:_____

Consent to Treat and Authorization to Release Information to Payers

I HEREBY AUTHORIZE TREATMENT BY **Restore Vein and Wellness, LLC**, PHYSICIANS AND PERSONNEL. I AUTHORIZE THE RELEASE AND DISCLOSURE OF ANY OR ALL OF MY MEDICAL AND TREATMENT RECORDS OR REPORTS TO ANY OTHER HEALTH CARE PROVIDER WHO MAY BE OF ASSISTANCE, IN THE OPINION OF **Restore Vein and Wellness, LLC**, AND/OR FOR ASSISTING IN ANY REIMBURSEMENT OR MEDICAL BENEFITS TO WHICH PATIENT MAY BE ENTITLED. I ALLOW FAX TRANSMITTAL OF MY MEDICAL RECORDS, IF NECESSARY. I FURTHER AUTHORIZE AND REQUEST THAT INSURANCE PAYMENTS BE MADE DIRECTLY TO **Restore Vein and Wellness, LLC**, SHOULD THEY ELECT TO RECEIVE SUCH PAYMENT. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

Financial agreement

I ACKNOWLEDGE FULL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED BY **Restore Vein and Wellness, LLC** THAT MY INSURANCE/MEDICARE PRODUCT DEEMS AS PATIENT RESPONSIBILITY OR ARE NON-COVERED BY MY INSURANCE/MEDICARE PRODUCT. I UNDERSTAND THAT PAYMENT OF CHARGES INCURRED IS DUE AT THE TIME OF SERVICE UNLESS OTHER DEFINITE FINANCIAL ARRANGEMENTS HAVE BEEN MADE PRIOR TO TREATMENT. I AGREE TO PAY ALL REASONABLE ATTORNEY FEES AND COLLECTION COSTS IN THE EVENT OF DEFAULT OF PAYMENT OF MY CHARGES.

Medication History

I UNDERSTAND THAT MY PARTICULAR INSURANCE/MEDICARE PRODUCT MAY ALLOW THE ELECTRONIC MEDICAL RECORD SYSTEM USED BY **Restore Vein and Wellness, LLC** TO DOWNLOAD MY MEDICATION HISTORY. I UNDERSTAND THAT THIS MEDICATION HISTORY MAY BE INCOMPLETE AND THAT I AM STILL RESPONSIBLE FOR ACCURATELY REPORTING MY MEDICATIONS AND DOSAGE ON THE NEW PATIENT CLINICAL FORMS AND AT THE NEW PATIENT VISIT. I AUTHORIZE THE ELECTRONIC TRANSMISSION OF MY MEDICATION HISTORY TO **Restore Vein and Wellness, LLC** PRIOR TO OR AT THE TIME OF MY VISIT.

Cancellation policy

I ACKNOWLEDGE THAT I MUST PROVIDE **A 24 HOUR NOTICE OF CANCELLATION OF AN OFFICE VISIT APPOINTMENT** AND/OR A **48 HOUR NOTICE OF CANCELLATION FOR ANY PROCEDURE APPOINTMENT**. FAILURE TO SHOW FOR AN OFFICE VISIT APPOINTMENT, WITHOUT PROPER CANCELLATION NOTICE, WILL RESULT IN THE ACCRUAL OF A NO-SHOW FEE OF $25 AND FAILURE TO SHOW FOR A PROCEDURE APPOINTMENT, WITHOUT PROPER CANCELLATION NOTICE, WILL RESULT IN THE ACCRUAL OF A NO-SHOW FEE OF $100.

Communication Consent

I HAVE PROVIDED **Restore Vein and Wellness, LLC** WITH MY CONTACT PHONE NUMBER(S). I AUTHORIZE **Restore Vein and Wellness, LLC** TO CONTACT ME VIA ANY CONTACT PHONE NUMBER(S) PROVIDED, INCLUDING TEXT MESSAGING, PHONE CALLS, VOICEMAIL MESSAGES AND/OR THE **Restore Vein and Wellness, LLC** PATIENT PORTAL, IF I HAVE ELECTED TO PARTICIPATE.

I HAVE READ AND UNDERSTAND THE ABOVE MENTIONED POLICIES SET FORTH BY **Restore Vein and Wellness, LLC**

Signed_____Date_____

I HAVE READ AND UNDERSTAND THE HIPAA/PRIVACY POLICY FOR **Restore Vein and Wellness, LLC**

Signed_____Date_____