



Reveal a whole new you.™

# kassclinics

- VEIN THERAPY - HEALTHY AGING - HEMORRHOIDS - COSMETIC CARE

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 courtesy 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. You will then meet with one of our patient coordinators to explain your financial responsibility and explain how the insurance process works.

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 on at your appointment

Sincerely,

Kass Clinics  
Enclosure

Don't forget the following?

- € Completed Medical History Forms
- € Shorts
- € Insurance Card
- € Credit Card for the Deposit Refund

*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.*



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## 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: \_\_\_\_\_ Position: \_\_\_\_\_

Would you like to receive informative or promotional materials via mail or email?  Yes  No

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: \_\_\_\_\_

## 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: \_\_\_\_\_



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Kass Clinics Consent

## **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. For our vein procedures, if you have an in network insurance company you will be charged this fee separately, as you are not required to leave a deposit for your in network insurance procedure appointments.

## **Insurance 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.

Waiting for insurance payment is a courtesy provided by this clinic. Kass Clinics reserves the right to withdraw this courtesy at any time. Our billing center will bill your insurance company and we will wait a limited period of time to receive payment from you and or your insurance carrier. Kass Clinics must receive complete insurance coverage information and verification prior to the procedure. This is your responsibility. In order for Kass Clinics to receive appropriate payment, you are to contact your insurance company for the correct and complete requirements such as coverage parameters, pre-certification and pre-authorization policies, referrals, deductibles, co-payments, group number and a correct billing address. Insurance co-pays, co-insurance, deductible amounts and MN care tax are the patient's responsibility and are usually due once insurance payment has been received.

Kass Clinics does not promise that an insurance company will pay. In the event that the insurance company disputes or rejects the claim, the patient will be responsible for payment. All charges incurred in the actions necessary to collect these claims, including legal, court, collection, administrative, etc. will be the patient's responsibility and added to their bill. If the patient received payment from their insurance carrier the patient is responsible for bringing the payment to Kass Clinics immediately upon receipt and endorse it over to the clinic or mail a personal check of equal value. Failure to do this will result in late charges and or collection action. A late charge of 1.5% 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 be turned over to a collection agency. We accept cash, check, Visa, MasterCard, American Express, and Discover.

For all out-of-network insurance companies and self pay patients, you will be responsible for the cost of your procedures upfront. You will be required 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 any difference that is owed to you.

## **Payment Policy**

Failure to remit payment, for which you are deemed responsible, in a timely manner, can have many negative implications for the patient/client. These include, but are not limited to a collections agency or to our corporate attorney for possible litigation. If such actions are necessary, the patient will be responsible for all costs with collection of fees whether through an agency or through legal means, including but not limited to attorney's fees, court costs, and costs for collection agencies.

### **Deposit's:**

All Consultations: \$50.00  
Sclerotherapy Treatment: \$75.00  
EVLV Surgery: \$1,000.00

Botox and Skin Care Procedures: \$75.00  
Full Work Up: \$350.00

Filler Procedures: \$750.00  
Phlebectomy Surgery: \$500.00



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Kass Clinics Consent

### 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 is 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 and 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, 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  
Sclerotherapy Treatment: \$75.00  
EVLV Surgery: \$1,000.00

Botox and Skin Care Procedures: \$75.00  
Full Work Up: \$350.00

Filler Procedures: \$750.00  
Phlebectomy Surgery: \$500.00

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 \_\_\_\_\_ # TIMES? \_\_\_\_\_ WHEN? \_\_\_\_\_  
ELECTROCAUTERY \_\_\_\_\_ # TIMES? \_\_\_\_\_ WHEN? \_\_\_\_\_  
LASER \_\_\_\_\_ # TIMES? \_\_\_\_\_ WHEN? \_\_\_\_\_  
VEIN SURGERY \_\_\_\_\_ # TIMES? \_\_\_\_\_ WHEN? \_\_\_\_\_  
WERE YOU SATISFIED WITH RESULTS (YES/NO)? \_\_\_\_\_

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

L LEG

R LEG

• ADDITIONAL COMMENTS: \_\_\_\_\_

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.)

\_\_\_\_\_

- |                               |            |
|-------------------------------|------------|
|                               | <b>Yes</b> |
| 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?

- |                                       | <b>L LEG</b> | <b>R LEG</b> | <b>WHEN?</b> |
|---------------------------------------|--------------|--------------|--------------|
| 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?

- |   | <b>Yes</b> | <b>WHEN?</b>    |
|---|------------|-----------------|
| 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                               | _____      | _____           |

	<b>YES</b>	<b>WHEN?</b>
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? \_\_\_\_\_

**SURGICAL 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)

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

	<b>YES</b>	<b>WHEN?</b>
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**



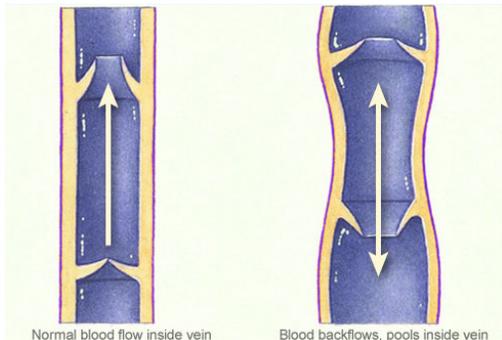
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## Varicose Vein Information

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.



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## Varicose Vein Information

- 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.

EVLT™ and RF Closure™ 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.



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## Directions To Kass Clinics

### From the Northwest

- Take 494E/694E
- Go South on Highway 169
- Go East on Highway 7
- Take a right onto Louisiana Avenue
- Take your next immediate left (West Lake Street)
- We are the second building on your left

### From the West

- Take 394E
- Go South on Highway 169
- Go East on Highway 7
- Take a right onto Louisiana Avenue
- Take your next immediate left (West Lake Street)
- We are the second building on your left

### From the East

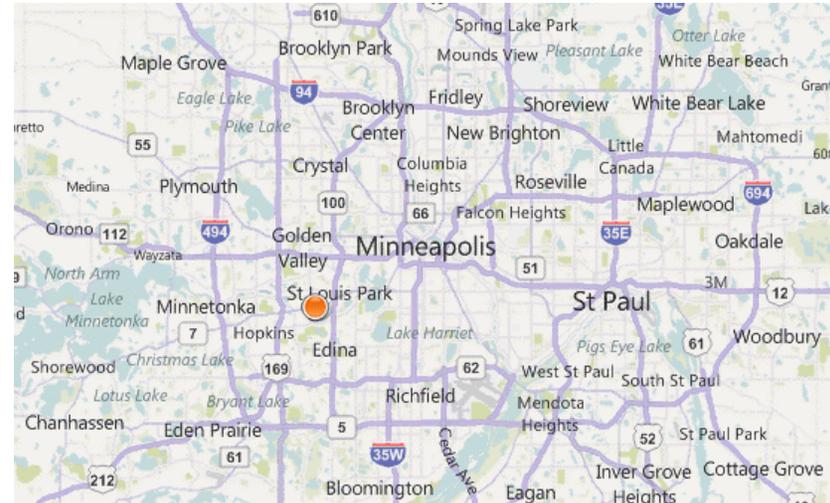
- Take 94W to 394W
- Go South on Highway 100
- Go West on Highway 7
- Take a left onto Louisiana Avenue
- Take you next immediate left (West Lake Street)
- We are the second building on your left

### From the Southwest

- Take 212E/494E
- Go North on Highway 169
- Go East on Highway 7
- Take a right onto Louisiana Avenue
- Take your next immediate left (West Lake Street)
- We are the second building on your left

### From the Northeast

- Take 694W
- Go South on Highway 100
- Go West on Highway 7
- Take a left onto Louisiana Avenue
- Take your next immediate left (West Lake Street)



- We are the second building on your left

### From the Southeast

- Take 494W
- Go North on Highway 100
- Go West on Highway 7
- Take a left onto Louisiana Avenue
- Take your next immediate left (West Lake Street)
- We are the second building on your left

Kass Clinics: 7104 West Lake Street, Suite 100, Saint Louis Park, MN 55426