Vein Specialists of Northern California
Patient Information

Date:_____
Home Phone #:_____ Birth Date:_____
Mobile (cell) Phone #:_____
Name: (First)_____ (MI)_____ (Last)_____
I prefer to be addressed as: _____
Address: (Street)_____
(City)_____ (State)_____ (Zip)_____
Email: _____
I wish to be contacted regarding treatment updates and promotions: (yes)_____ (no)_____
Gender: (Male)_____ (Female)_____

Patient
Occupation:_____
Work Phone #:_____
Employer:_____
City, State:_____
SS#:_____

Spouse (if needed for insurance purposes):
Occupation:_____
Work Phone #: _____
Employer:_____
City, State: _____
SS#: _____

Primary Physician or Health Provider:_____
Street Address: _____
City: _____State: _____ Zip: _____
Phone #: _____Specialty: _____
Permission to Contact?: (Yes)_____ (No) _____

Referral:
Primary Physician as above: (Yes)_____ (No) _____
Other Physician/Provider: _____
Street Address: _____
City: _____ State:_____ Zip:_____
Phone #:_____Specialty:_____

Friend (Name): _____
Newspaper/Magazine: _____
Radio: [ ] TV: [ ] Yellow Pages: [ ] Web: [ ]
Other: _____

Primary Insurance: _____ ID #: _____
HMO [ ] PPO [ ] Private [ ] Insured's Name: _____
Secondary Insurance:_____ ID #: _____
HMO [ ] PPO [ ] Private [ ] Insured's Name: _____

In case of emergency contact:_____ Phone #: _____

The above information is correct to the best of my knowledge:
Signature:_____

PATIENT HISTORY

Please fill out this page as completely as possible.

Patient Name: _____ Date: _____

☐ Male
☐ Female

_____ Age

_____ Occupation

Were you referred by your Physician? ☐ Yes ☐ No

If Yes, M.D. Name: _____ Specialty: _____

What made you decide to seek treatment at this time? _____

Symptoms (Please check all that apply)

	Left	Right
Aching/pain in leg	☐	☐
Heaviness	☐	☐
Tiredness/fatigue	☐	☐
Itching/burning	☐	☐
Swelling	☐	☐
Leg cramps	☐	☐
Leg restlessness	☐	☐
Throbbing	☐	☐

Additional Comments: _____

Check box if true:

- ☐ My veins have deteriorated in recent months.
- ☐ I elevate my legs to relieve discomfort.
- ☐ I wear support hose.
  - Type of support hose _____ (name)
  - ☐ These are prescription hose.
  - ☐ They help reduce symptoms.
- ☐ Standing makes my symptoms worse.
- ☐ I stand ____ hrs. daily.
- ☐ I smoke. ____ packs per day.
- ☐ I am able to walk 3 miles daily.

Women:
- ☐ My symptoms are worse before or during menstruation.
- ☐ I am pregnant or actively trying to become pregnant.
- ☐ I am breast feeding.

Medications Please list all medications, hormones, birth control pills, or supplements you're currently taking—by Prescription or Over the Counter.

_____ _____
_____ _____
_____ _____

Allergies Please list all allergies to medicines, iodine, IVP dye, foods, or other substances and the type of reaction you have (e.g. hives, rash, trouble breathing, etc...)

_____
_____
_____

Medical History Please check all boxes that are true and give descriptions where appropriate.

History of:

- ☐ Vein Surgery Date: _____
- ☐ Vein Injections
- ☐ Blood Clots (Phlebitis)

_____
_____

- ☐ Previous Vein Evaluations
- ☐ Leg Ulcer
- ☐ Heart Disease
- ☐ HIV (AIDS)
- ☐ Other Surgeries: _____
- ☐ Leg Swelling
- ☐ Leg Injury
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Hospitalizations

_____

- ☐ Pregnancies Number: _____
- ☐ Deliveries Number: _____
- ☐ Hepatitis
- ☐ Other: _____

_____

Family History of:

- ☐ Varicose Veins
- ☐ Heart Disease
- ☐ Leg Ulcers
- ☐ Other (Diabetes or Vascular Disease)

FINANCIAL POLICY

Thank you for choosing Dr. Mark N. Isaacs or Deborah Francesconi, R.N. as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is part of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship.

All patients must thoroughly complete our Patient Information form and view the informational video (**only** if seeking leg vein treatment) prior to seeing the doctor or the nurse.

We accept cash, money orders, debit cards and all major credit cards. We also have our own patient financing called Care Credit. (Please ask Front Office for more details).

U. C. R. (Usual and Customary Rate)

Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area, for the amount of treatment received per visit. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.

PAYMENT FOR SERVICE

All patients, regardless of age, are responsible for payment of their services. If you have **MEDICARE,** please advise us. We will submit medically necessary Medicare claims for you. If you have secondary coverage, Medicare usually forwards the claim directly to the secondary for payment. Whatever the balance is (i.e. co-pays, deductible, etc.) we will bill you for after Medicare has made payment. If you have no secondary coverage you will be responsible for your 20% co-pay.

REGARDING INSURANCE

We are contracted with most major PPO insurance carriers. We will bill for the medically necessary portion of you treatment, however, you will be responsible for any applicable co-pays, deductible, etc. Any superficial or cosmetic treatment will be out of pocket. For insurances we are not contracted with, it will be your responsibility to submit for reimbursement directly with your carrier for any medically necessary treatment. We will provide you **the appropriate information to forward to your insurance carrier when you file your claims for reimbursement.** Reimbursement is subject to the terms of your contract with your carrier.

MEDI-CAL/ WORKERS COMPENSATION

We do not accept Medi-cal or Workers Compensation claims.

MISSED OR LATE APPOINTMENTS

Vein Specialists of Northern California has a 1 Business Day (24 hour) cancellation / rescheduling policy.

If you miss your appointment, cancel, or change your appointment with less than 1 Business Day advance notice it is our policy to charge $50.

This policy is in place in consideration of others. Cancellations with less than 1 business day are hard to fill. Please keep in mind that our office is typically not open on Mondays so for example a Tuesday 11am appointment would need to be canceled by Friday at 11am to avoid a cancellation charge.
By giving last minute notice or no notice at all, you prevent someone else the opportunity of scheduling.
If you are **over FIFTEEN (15) minutes LATE** arriving to your upcoming scheduled appointment you will need to reschedule as it is our policy to run on time. By signing below you acknowledge and understand this Financial Policy as described above. ** Please help us serve you better by keeping your appointments. **

Thank You!

Patient Name (Please Print):_____

Patient Signature: _____ Date: _____

VEIN SPECIALISTS OF NORTHERN CALIFORNIA
MARK N. ISAACS, M.D., INC.

NOTICE OF PRIVACY PRACTICES

Effective Date: 04/14/2003

ACKNOWLEDGEMENT OF RECEIPT

Patient Name:

_____

(Please Print)

By signing this form, I acknowledge that I am aware of the HIPPA Notice of Privacy Practices that went into effect 04/14/2003 and that Vein Specialists of Northern California adheres to a strict protocol of following these privacy guidelines. This Notice of Privacy Practices provides information about how we may use and disclose your medical information (Protected Health Information). If needed we can provide you with a copy for reference. Should you have any questions please don't hesitate to ask. This Notice of Privacy Practices is subject to change. If so, we will provide you with a revised notice.

COMMUNICATION PREFERENCES

Please select which method of communication works best for you regarding your Protected Health Information.

Billing Statements

All correspondence relating to your health information will be automatically mailed to your home address, unless instructed otherwise. Is this okay? _____ Yes _____ No
If not, please list the address you want used:

_____

_____

If you release us to give your protected health information to any family member please list:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Appointment Reminder Courtesy Calls

_____ Yes, I would like a reminder call.
_____ No, I would not like to be reminded of my upcoming appointment.

Thank you for helping us serve you better.

I do hereby acknowledge awareness of the Notice of Privacy Practices of Vein Specialists of Northern California and have designated my communication preferences.

_____ _____
Signature Date

_____
Name (please print)

Revised 08/21/13 agh