OCEANA

VEIN SPECIALISTS

Patient Registration Form

Patient Information

Patient Last Name:_____ First Name:_____ MI:_____

Date of Birth:_____ Sex:_____ SS # (Optional):_____ Drivers License #:_____

Address:_____ City:_____ Zip:_____

Home Phone #:_____ Cell #:_____ Work #:_____

Email Address:_____ Employer:_____

Emergency Contact:_____ Emergency Contact #:_____

Family Physician Name/Phone #:_____

Referring Physician Name/Phone #:_____

Insurance Information

Primary Insurance Company:_____

Identification Number:_____ Group Number:_____

Policy Holder's Name:_____ DOB:_____ Relationship to Patient:_____

Policy Holder's Employer:_____ Employer Phone #:_____

Secondary Insurance Company:_____

Identification Number:_____ Group Number:_____

Policy Holder's Name:_____ DOB:_____ Relationship to Patient:_____

Policy Holder's Employer:_____ Employer Phone #:_____

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physician, and I am financially responsible for non-covered services. I also authorize the physician to release any information required to process my insurance claims. I hereby consent to examination and treatment by Oceana Vein Specialists.

Patient Signature:_____ **Date**:_____

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New Patient History Form

Patient Name:_____ DOB:_____

Vein Health History

Veins Problematic for ____ years.

Symptoms	Both Legs	R	L
Varicose Veins	_____	___	___
Spider Veins	_____	___	___
Aching	_____	___	___
Pain	_____	___	___
Cramping	_____	___	___
Fatigue	_____	___	___
Swelling	_____	___	___
Restlessness	_____	___	___
Ulcers	_____	___	___
Awake at night	_____	___	___
Burning	_____	___	___
Leg heaviness	_____	___	___
Bleeding	_____	___	___
Itching	_____	___	___
Skin discoloration	_____	___	___

Other:_____

When do symptoms occur? _____

How Symptoms Interfere with Life:

_____Work _____Air Travel
_____Shopping _____Car Travel
_____Exercise _____Child Care
_____Daily Chores _____Routine Activities

Please give specific examples of above
(important to obtain insurance approval)

_____

Activities That Worsen Your Symptoms:

_____Walking _____Exercise
_____Standing _____Sitting
_____Traveling _____Premenstrual
_____Pregnancy _____Heat/Warm Bath

Activities That Improve Your Symptoms:

_____Resting _____Standing
_____Sitting _____Leg Elevation
_____Walking _____Exercise
_____Heat/Warm Bath

Compression Stocking Use:

___Yes, first used____years ago
___Use currently
Strength ___15-20 ___20-30 ___30-40
Who Prescribed?_____
Period of past use_____ months/years

Prior Vein Treatments

____Sclerotherapy	___Both	___R	___L
____Laser	___Both	___R	___L
____Stripping	___Both	___R	___L
____Phlebectomy	___Both	___R	___L
____Closure	___Both	___R	___L
____DVT	___Both	___R	___L
____Phlebitis	___Both	___R	___L
____Other	___Both	___R	___L

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New Patient History Form Cont'

General Medical History

Pregnancy History
____No Pregnancies ____How Many?
____First Noticed Veins? ____Worsened?

Medications ____None
_____
_____
_____
_____

Medication Allergies
___None ___Yes
If Yes, what med and what was reaction?
_____

Prior reaction to Lidocaine, Novacaine, Iodine, or Latex?
___None ___Yes
If Yes, to what and what was reaction?
_____

Past or Current Medical Conditions
___No other problems
_____
_____
_____
_____

Past Surgeries/Date ___None
_____
_____

Family with Varicose Veins
___Mother ___Father
___Others _____

Social History
Occupation_____
Prolonged ___Sitting ___Standing ___ Both
Marital Status ___S ___M ___D ___W
Smoking ___Never ___Quit ___years ago
___Yes_____Packs/day
Alcohol ___Never ___Social ___Moderate

Review of Symptoms
Head & Neck _____No Complaints
List_____
Respiratory _____No Complaints
List_____
Cardiac _____No Complaints
List_____
Gastrointestinal _____No Complaints
List_____
Extremities _____No Complaints
List_____
Neuropsych _____No Complaints
List_____
Endocrine _____No Complaints
List_____
Hematological _____No Complaints
List_____

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Oceana Vein Specialists may use or disclose my protected health information for treatment, payment or health care operations for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Oceana Vein Specialists has a detailed document called the 'Notice of Privacy Practices'. This document contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have a right for access to and to ready the 'Notice of Privacy Practices' before signing this agreement. If I ask, Oceana Vein Specialists will provide me with the most current version.

My signature below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature below means that I agree to allow Oceana Vein Specialists to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Oceana Vein Specialists has taken action relying on this consent.

You may obtain a copy of our Notice of Privacy Practices at any time by contacting Oceana Vein Specialists at 760-769-8346.

Patient Signature:_____ Date:_____

Printed Name:_____

Patient Authorization to Bill Insurance

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

I hereby authorize Oceana Vein Specialists to apply for benefits on my behalf for services rendered. I request that payment from my insurance company to be made directly to Oceana Vein Specialists.

I understand that Oceana Vein Specialists will bill insurance where applicable for all clinical services. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

I understand that compression stockings may not be a covered under my policy, therefore I will be responsible for compression stocking charges. I understand that that the initial and follow up ultrasound is not included within the global procedure fee and will be billed to my insurance.

Signature of Patient:_____**Date:**_____

Patient Liability Acknowledgement

The Approval Process: Once your information has been submitted to you insurance and a decision has been made by your insurance company you will be notified. We will go ahead and schedule your procedure while we wait for your approval to come through. Please note that the procedure will not be performed until your approval has been verified by your insurance company.

The Appeals Process: If your insurance denies your procedure we will contact your insurance company in an attempt to have this decision overturned.

Denials: If your procedure is ultimately denied you will be considered a self-pay patient, and you will be held responsible for the total balance. We prefer to go through the approval/denial process prior to performing your procedure, so you will be aware of the financial obligations in relation to your procedure.

I have read the above and I am aware that I am responsible for any financial responsibility put forth by my insurance.

Patient Signature:_____**Date:**_____

General Payment Information

Our foremost goal is to provide you with excellent medical care. We also want to excel in providing you with clear information about the financial concerns and responsibilities you have as a patient and we have as a medical practice. To that end, we hope you will carefully read the following summary about insurance and cash reimbursement. If you have any questions please ask our office manager for further explanation.

Managed Care Contracts. We have chosen to contract with a number of insurance companies or networks to provide medical care to their insured members at a negotiated discount. If you are insured by one of these companies or through one of the networks, we are considered In-Network providers for you. We abide by the terms of our contract with them which includes the collection of Co-Pays, Co-Insurance, and Deductable amounts. By contract, we collect these amounts at time of service and may not waive them.

We make every effort to obtain reliable information from the insurance companies/networks and obtain the benefits with the company. Based on that information, we collect your portion of the fee. If the information proves to be incorrect when the claim is filed, you may owe additional money or we may refund money to you. You receive an Explanation of Benefits (EOB) at the same time as we receive payment. The EOB states the contracted amount, the amount of Patient Responsibility, and the discount for which the practice cannot bill a patient. If the EOB is incorrect, we will file an appeal. Otherwise, the amount due from you stands as per the contract. If, in spite of our best effort, we have collected an incorrect amount from you, we will either refund any overpayment to you promptly or collect any underpayment from you promptly.

We welcome patients to our practice who are not covered by insurance plans/payors with whom we are contracted. Some patients are covered by insurance plans/payors with whom we are NOT contracted and are considered Out-of-Network with our practice. Some patients are not insured at all. We believe our fee schedule reflects a usual and customary fee for the medical services provided.

Financial Policy for Sclerotherapy and VeinGogh Procedure (cosmetic treatment). Treatments for spider veins is considered a cosmetic procedure and is not covered as a medical benefit. This is true even if the spider veins cause symptoms such as aching and burning. Payment will be expected at the time of service. Treatment of spider veins involves time and injection agents, both of which are expenses covered in the treatment charge. Each treatment session is a separate charge. The response to the treatment is variable with some patients having an excellent result and some less than hoped for results.

Written Estimate. You may request a written estimate of your out-of-pocket expenses. We are glad to comply with this request as we want our patients to be informed about the financial implications of their medical care.

Patient Signature:_____ **Date:**_____