VEIN & WOUND INSTITUTE

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PATIENT CONSULTATION FORM

Patient Information PLEASE PRINT					
LAST NAME		FIRST NAME			M.I.
ADDRESS		APT. #	CITY	STATE	ZIP
DATE OF BIRTH / /	AGE	HOW DID YOU HEAR ABOUT US		REFERRED BY	
HOME PHONE	ALTERNATE PHONE	EMAIL			
EMERGENCY CONTACT NAME & PHONE NUMBER					

PATIENT BILLING AGREEMENT

Medical Services Billing–If we are in-network with your insurance company, we will submit the charges directly to your primary insurance. After your insurance(s) complete(s) payment to us you are responsible for payment of any allowable remaining patient balance.

Co-pays -are always collected at check-in. The amount is usually listed on your insurance card.

Deductibles – If your plan has a deductible, you are required to pay a portion of it at check in. After insurance processes the claim, you will be billed for any remaining balance.

Self-Pay Patients- If you are "self-pay" for any routine visit you must pay $100 in advance at check-in.
At the end of your visit you can:

1. Pay the total charges (less the pre-paid $100) for services and tests done during the visit; OR
2. Sign a Payment Agreement stating you will have the balance paid in full within 3 months. You will be billed monthly. If you would like to set up a payment plan, please discuss with our office manager.

Billing Process - Once we have received the final payment statement from your insurance, we will mail you a statement requesting the remaining allowable patient amount. You will receive a second bill 30- 60 days later for remaining balances. If you are unable to make payment in full before 60 days, you may call our Billing Department and make installment payment arrangements to avoid having your account go to the collection agency. If your account is not paid 30 days after we send you the third statement, your account will be turned over to our collection agency without further notice from us. After your account has been turned over to our collection agency, you will be responsible for the outstanding balance you have with us as well as any agency fees, legal/attorney fees, and court costs. This could be placed on your credit record and may affect your ability to make any credit purchases.

Other Billing Policies:

Payment methods accepted - For your convenience, we accept Visa, MasterCard, American Express, Debit Cards linked to your credit card account, money orders, cash or personal checks with proper ID.

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Insufficient funds - If your cheque is returned due to insufficient funds, you will be charged a **$20.00** fee by us in addition to whatever your bank charges you. You will receive a statement for amounts due in this case. Also, you will not be allowed to pay us by cheque for the next 6 months following the returned cheque.

Patients in Collections - Patients with unpaid balances in collections will not be scheduled for appointments unless approved by the Billing Department. Generally, "Collections" balances must be paid in full before you can be seen here again.

_____
Signature over Printed Name

Date _____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to which I may be entitled from an insurance plan(s) to **CENTER FOR VEIN WELLNESS**. This assignment will remain in effect until revoked by me in writing.
I understand that I am financially responsible for all charges whether or not paid by said insurance.
I hereby authorize said assignee to release all information necessary to secure payment of benefits.

_____
Signature over Printed Name

Date _____

MEDICARE ASSIGNMENT ***If you have Medicare, please sign the following*

I request that payment of authorized Medicare benefits may be made on my behalf to **CENTER FOR VEIN WELLNESS** for any services furnished me by that physician or supplier.
I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine this benefits payable to related services.
I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.
If other health insurance coverage is indicated on the CMS1500 or any electronically generated claim form, my signature authorizes releasing of the information to the insurer or agency shown.
In Medicare assigned cases, the physician or supplier agrees to accept the charge determined by the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services.
Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature (Patient, Legal Representative) _____
Date _____ **Time** _____

If signed by other than patient, indicate relationship
☐Parent or guardian of minor patient
☐Guardian or conservator of an incompetent patient

Witness Signature _____
Date _____ **Time** _____

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NO SHOW AND CANCELLATION POLICY

"**No Show**" shall mean any patient who fails to arrive for a scheduled appointment.

"**Same Day Cancellation**" shall mean any patient who cancels an appointment less than 24 hours before their scheduled appointment.

Policy
It is the policy of the practice to monitor and manage appointment no-shows and late cancellations. Our goal is to provide excellent care to each patient in a timely manner**. If it is necessary to cancel an appointment, patients are required to call or leave a message at least 48 hours before their appointment time.** Notification allows the practice to better utilize appointments for other patients in need of medical care.

I. **Booking Reminder**
- A patient is notified of the appointment **No-Show & Cancellation Policy** at the time of scheduling. This policy can and will be provided in writing to patients at their request.

II. **Fees**
- Patients who fail to show for their **scheduled appointment** or did not notify the office within 48 hours before their scheduled appointment time, shall be subject to a **No Show/Cancellation fee of $50.00**. In the event of an actual emergency and prior notice could not be given, consideration will be given, and a one-time exception may be granted.
- Patients who fail to show for their **scheduled office procedure** (vein procedure or other related procedures) appointment or did not notify the office within 48 hours before their scheduled appointment time, shall be subject to a **No Show/Cancellation fee of $100.00**.
- If cancelled by the physician as a medical necessity, then the patient is not subject to this charge. Insurance authorization denials are also an exemption of the fees.
- These fees are not covered by insurance and is therefore the sole responsibility of the patient.

III **Credit Card Authorization**
- By affixing my signature below, I hereby authorized **Center for Vein Wellness** to auto charge my credit card on file for the agreed **No Show and Cancellation Policy,** and acknowledge the fees discussed above. I also understand that my credit card information will also be saved to file for future transactions.

How to Cancel Your Appointment
To cancel or reschedule appointments call us at **310.402.2849**, or email **luxe@luxeaestheticsurgery.com**
If you have any problems getting through the hotline, you can send us an email with your name, appointment date and cancellation reason or request for rescheduling.

Thank you for your continuing support.

_____
Signature over Printed Name

Date _____

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NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received instructions regarding access to the digital copy of **Center for Vein Wellness Notice of Privacy Practices** on their website. I further acknowledge that a copy of the current notice is posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signature (Patient, Legal Representative) _____
Date _____ Time _____

If signed by other than patient, indicate relationship
☐ Parent or guardian of minor patient
☐ Guardian or conservator of an incompetent patient

Witness Signature _____
Date _____ Time _____

NOTICE OF OPEN PAYMENT DATABASE

CA Assembly Bill 1278 requires physicians and their employers to provide patients with notices about the Open Payments database starting January 1 2023.

The **Open Payments database** is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://open paymentsdata.cms.gov , for more informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. **The federal Physician Payments Sunshine Act required that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices and biologics to physicians and teaching hospitals be made available to the public.**

I have read the above notice for the Open Payments database. By signing this document, I certify that I am aware of the Open Payments Database.

Signature (Patient, Legal Representative) _____
Date _____ Time _____

If signed by other than patient, indicate relationship
☐ Parent or guardian of minor patient
☐ Guardian or conservator of an incompetent patient

Witness Signature _____
Date _____ Time _____

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.): ☐ M ☐ F	**Date of Birth:**
Marital status ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Primary Care Doctor	**Reason for visit**
Referring Doctor	

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed		
Surgeries		
Year	Reason	Hospital
Other hospitalizations		
Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name of the Drug	Strength	Frequency Taken
Allergies to medications		
Name of the Drug	Reaction You Had	

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HEALTH HABITS AND PERSONAL

	ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.			
Alcohol	Do you drink alcohol?		☐Yes	☐No
	If yes, what kind?	How many drinks per week?		
Tobacco	Do you use tobacco?		☐Yes	☐No
	☐ Cigarettes – packs/day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
	☐ # of years	☐ Or year quit		
Drugs	Do you currently use recreational or street drugs?		☐Yes	☐No
	Have you ever given yourself street drugs with a needle?		☐Yes	☐No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	

WOMEN

Number of pregnancies ___ Number of live births ___			
Are you pregnant or breastfeeding?	☐ Yes	☐ No	

OTHER PROBLEMS (CHECK IF YOU HAVE, OR HAD ANY SYMPTOMS IN THE FOLLOWING AREAS TO A SIGNIFICANT DEGREE)

General	☐ Weight loss or gain	☐ Fatigue	☐ Fever or chills	☐ Weakness	
Skin	☐ Rash	☐ Itching	☐ Color changes		
Respiratory	☐ Cough ☐ Sputum	☐ Shortness of breath	☐ Wheezing		
Cardiovascular	☐ Chest pain	☐ Palpitations	☐ Swelling		
Gastrointestinal	☐ Heartburn	☐ Rectal bleeding	☐ Constipation	☐ Diarrhea	
Vascular	☐ Calf pain with walking	☐ Leg cramping	☐ Leg Aches	☐ Leg Swelling	
	☐ Varicose Veins	☐ Redness/Inflammation			
Musculoskeletal	☐ Muscle or joint pain	☐ Swelling of joints			
Neurologic	☐ Dizziness	☐ Fainting	☐ Seizures	☐ Numbness	☐ Tingling ☐ Tremor
Hematologic	☐ Ease of bruising	☐ Ease of bleeding	☐ Blood clots		
Endocrine	☐ Heat or cold intolerance	☐ Sweating	☐ Frequent urination	☐ Thirst	
Infectious Disease	☐ HIV/AIDS	☐ Hepatitis B	☐ Hepatitis C		

_____

Signature over Printed Name

Date _____

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VASCULAR SCREENING QUESTIONNAIRE

☐Yes ☐No 1. Leg pain, aching or cramping?
☐Yes ☐No 2. Do you get numbness in feet/legs?
☐Yes ☐No 3. Do you have varicose veins?
☐Yes ☐No 4. Do you get swelling of ankles or feet?
☐Yes ☐No 5. Do you have restless legs?
☐Yes ☐No 6. Do you easily get fatigue of legs when walking?
☐Yes ☐No 7. Burning or itching of the skin on the legs?
☐Yes ☐No 8. Do you have any skin discoloration?
☐Yes ☐No 9. Any history of leg ulcers?
☐Yes ☐No 10. Are you diabetic?
☐Yes ☐No 11. Burning or tingling in feet?
☐Yes ☐No 12. Any toe or toenail changes in color and/or texture?
☐Yes ☐No 13. Do you have cold feet/toes?
☐Yes ☐No 14. Any family history of circulatory/blood clot problems?
_____15. How far (or how many minutes) can you walk before you get cramping (claudication) or pain in your legs?

_____
Signature over Printed Name

CUESTIONARIO DE EVALUACION VASCULAR

☐Sí ☐No 1. Tiene dolor o calambres en las piernas?
☐Sí ☐No 2. Tiene sensacion de adormecimientoen las piernas?
☐Sí ☐No 3. Tiene venas varicosas?
☐Sí ☐No 4. Tiene hinchazon en los tobillos o los pies?
☐Sí ☐No 5. Tiene movimientos involuntarios en las piernas?
☐Sí ☐No 6. Se siente cansado/a facilmente al caminar?
☐Sí ☐No 7. Siente ardor o picazón en las piernas?
☐Sí ☐No 8. Tiene usted alguna decoloración de la piel?
☐Sí ☐No 9. Tiene historia de úlceras en las piernas?
☐Sí ☐No 10. Es usted diabético?
☐Sí ☐No 11. Siente ardor o hormigueo en los pies?
☐Sí ☐No 12. Tiene cambio de color o textura en las unas?
☐Sí ☐No 13. Siente los dedos o pies frios?
☐Sí ☐No 14. Tiene historia familiar de problemas circulatorios o coagulos de sangre?
_____15. Qué tan lejos (o cuanto tiempo) puede caminar antes de sentir de calambres (claudicación) o dolor en las piernas?

_____
Firma sobre nombre impreso

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CONSENT FORM SURGERY OR SPECIAL PROCEDURE

I authorize **Dr Haimesh Shah** and his associates or assistants to perform the following operation or procedure:
Excisional Debridement of the ulcer: _____Or, other procedure: _____
During the procedure, if your physician believes that other procedures are needed for your health or safety, those other procedures will be performed at his or her direction.

ANESTHESIA: The procedure will be performed under X Topical X Local ___Other anesthesia

RIGHT TO INFORMATION OR REFUSE:
Your procedure has some risks including the risk of unsuccessful results, complications, injury, or even death, from both known and unforeseen causes. You have the right to be told about:

- The nature of the procedure;
- The expected benefits and risks of the procedure, including potential problems that might occur during the recuperation;
- The likelihood of achieving treatment goals;
- Reasonable alternatives to the procedure, and their benefits, risks and side effects, including what might happen if you do not receive the procedure;
- Any research or financial interests your doctor/s may have related to your operation.

Except in an emergency, your procedure will not be performed until you have received this information and have given your consent to have the procedure. You may refuse to have the proposed procedure at any time before the procedure begins.

MEDICAL DEVICE REPRESENTATIVES:
Your physician may have asked for representatives from a medical device company to be present to assist with the medical devices or equipment used in your procedure. The representatives' names will be documented in the medical record. These representatives are not doctors, nurses, agents or representatives of the Center. You have the right to refuse to have them present. Please discuss any questions about their presence with your doctor/s.

OTHER OBSERVERS:
Other persons who will not take part in your procedure may be present in the room, or maybe observing your procedure by audio or visual communication, as part of the educational training. These observers may include resident physicians, students, or trainees enrolled in a health professional training program affiliated with the Center.

DISPOSAL OF TISSUES:
By signing this consent form, you give permission for the pathologist to decide how to dispose of any body part, organ or other tissue removed from you during your procedure. If you want to place special conditions on the use or disposal of your tissues, you may do so here: _____

RESULTS ARE NOT GUARANTEED:

I understand that no guarantee has been made as to the results of the procedure and that it may not cure the condition.

ACKNOWLEDGEMENT and SIGNATURE:
By signing this form you are indicating that:

- You have read and understand the information in this form;
- Your doctor has discussed the procedure with you and explained the risks and benefits and any foreseeable problems;
- Your doctor has discussed alternative methods of treatment available, the risks and benefits and what would happen if you did not have the procedure;
- You had a chance to ask your doctor any questions about the procedure;
- You authorize and consent to the performance of the procedure and anesthesia.

In connection with the medical care that I am receiving through this facility, I consent that any digital photograph be taken of wound areas on my body, under the following conditions: The photographs be taken with the sole intent of medical records purposes and that at no time will my name. or any other identifying material be connected to theses photographs that could violate my privacy as per HIPAA.

_____ _____

Patient or Witness Signature / Date **Physician Signature / Date**

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AUTHORIZATION FOR USE / DISCLOSURE OF HEALTH INFORMATION

Authorization for Use / Disclosure of Information:
I voluntarily consent to authorize my health care provider, **Center for Vein Wellness or Haimesh Shah, MD,** to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):
Name: _____
Address: _____

Purpose: I authorize the release of my health information for the following specific purpose:
_____
(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be disclosed: I authorize the release of the following health information:
(check the applicable box below)

☐All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.
☐Only the following record or types of health information:
_____

Term: I understand that this Authorization will remain in effect:
☐From the date of this Authorization until the _____ day of _____, 20_____.
☐Until the Provider fulfills this request.
☐Until the following event occurs: _____

Redisclosure:
I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Note:
This authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman Petris Act.

Refusal to sign / right to revoke:
I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at **Center for Vein Wellness or Haimesh Shah, MD**. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the **Center for Vein Wellness or Haimesh Shah, MD** at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Questions:
I may contact **Center for Vein Wellness or Haimesh Shah, MD** for answers to my questions about the privacy of my health information at 2460 N Ponderosa Dr., Suite A101, Camarillo, CA 93010, or by telephone at 310 402 2849.

Signature (Patient, Legal Representative) _____
Date _____ Time _____

If signed by other than patient, indicate relationship
☐Parent or guardian of minor patient
☐Guardian or conservator of an incompetent patient

Witness Signature _____
Date _____ Time _____