



Full Name of Patient: _____

Home Address: _____

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

E-Mail address: _____

Date of Birth: _____ Age: _____ Sex: Male Female

Marital Status: Single Married Divorced Widowed

Race: Black/African American White/Caucasian Native Hawaiian/Other pacific islander

American Indian/Alaska Native Asian

Ethnicity: Hispanic Non- Hispanic Prefer not to specify

Social Security # _____ Driver's License # _____

Primary Care Physician: _____ Referred By: _____

PRIMARY INSURANCE

Insurance Company Name: _____ ID# _____

SECONDARY INSURANCE

Insurance Company Name: _____ ID# _____

INSURED RESPONSIBLE PARTY INFORMATION

Responsible Party Name: _____ Relation to Patient: _____

Address: _____ Phone#: _____

Employer: _____ Responsible Party SS#: _____

Driver's License#: _____ Date of Birth: _____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Home Phone#: _____ Work#: _____



Name: _____ Date: _____

Date of Birth: _____ Age: _____

What Physician referred you? _____

Primary Care Physician: _____

Risk Factors: Do you have and/or have ever had any of the following:

<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Aortic Aneurysm	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Stroke	<input type="checkbox"/> Clotting Disease
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Congestive Heart Failure
<input type="checkbox"/> Cancer	<input type="checkbox"/> Allergies	<input type="checkbox"/> Pneumonia

Other medical problems: _____

Family History of Vascular Disease:

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Cancer	<input type="checkbox"/> Aortic Aneurysm
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke	<input type="checkbox"/> High Cholesterol

Previous Surgeries:

<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Hysterectomy
<input type="checkbox"/> Eye	<input type="checkbox"/> Hernia
<input type="checkbox"/> Breast	<input type="checkbox"/> Hemorrhoid
<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Back/Neck
<input type="checkbox"/> Heart/Vascular	<input type="checkbox"/> Hip/Knee

Other surgeries: _____

Allergies to medication: _____

Allergies to food/shellfish: Yes or No

Allergies to tape: Yes or No (Adhesive or Paper) Allergies to latex: Yes or No



Please list all medications you presently take

Pharmacy: _____

Address: _____

Phone#: _____

Do you or have you ever smoked? _____

How much a day? _____

Do you consume alcohol? _____

How much a day? _____

Are you currently experiencing any of the following: (Please check all that apply)?

<input type="checkbox"/> Fever	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Cough	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Ringing in Ears
<input type="checkbox"/> Chills	<input type="checkbox"/> Dentures	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Nausea	<input type="checkbox"/> Anemia	<input type="checkbox"/> Blood in Urine
<input type="checkbox"/> Glasses	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Bruising	<input type="checkbox"/> Indigestion
<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Headache	<input type="checkbox"/> Rash	<input type="checkbox"/> Other
<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Leg swelling	<input type="checkbox"/> Seizures	<input type="checkbox"/> Numbness	
<input type="checkbox"/> Loss of Hearing	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Fainting	<input type="checkbox"/> Weakness	
<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Diarrhea	



FINANCIAL & OFFICE POLICIES AGREEMENT

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial and office policies. If you have any questions about the form, please discuss them with our office manager. We provide the best possible care and service to you and regard your complete understanding of your financial responsibility as an essential element of your care and treatment.

Your signature below forms a binding agreement between Sequoia Vein & Wound, the providers of medical services, and the patient who is receiving medical services, or the responsible party for minor patients (those who are under 18 years old.) Responsible party is the individual who is financially responsible for payment of medical bills.

NO SHOW AND CANCELLATION POLICY

In order to provide the best possible service and availability to all our patients, please call us as early as possible if you know you need to cancel or reschedule your appointment. There is a no show, late cancellation fee if you do not cancel or reschedule your appointment before 24 hours of your appointment. The fee is \$25 for office visit and \$50 for office procedures.

COPAY AND BALANCE POLICY

Pay any required copay at the time of visit.

A written agreement must be made between the manager and the responsible party. This is required for any payment arrangements made. The entire balance is due upon receipt of the statement.

RETURNED CHECK POLICY

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), it is the patient's or patient guardian's responsibility for the original check amount in addition to a \$25 service charge. We will send you a letter to notify the responsible party of the returned check. If there is no response within 10 days from the letter date, the account will be turned over to our collection agency and a late charge of \$25 will be added to the outstanding balance, and an additional \$25 check service charge.



INSURANCE POLICY

As a Courtesy, we will file your insurance claim for you if you assign the benefits to the doctor, in other words, you agree to have your insurance pay the doctor directly. If you're your insurance company does not pay the practice within reasonable length of time (within 45 days) you may be responsible for the account balance. If you fail to notify us of any change in insurance, you are fully responsible for any amount not paid by your insurance company.

FINANCIAL AGREEMENT

I hereby authorize Sequoia Vein & Wound to furnish my insurance company with all the information which they request concerning my present illness or injury. I request that payment of authorized benefits be made on my behalf for services provided to me by the party which accepts assignment. I understand that I am financially responsible to make prompt payments to the account of Sequoia Vein & Wound as bills are presented. I understand that I am financially responsible for any charges not covered by this assignment. I also understand that failure to make payment for any services not covered will result in my account being sent to collections.

NOTICE OF PRIVACY POLICIES

I have been presented and given a copy of this practice's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal law. I understand the contents of the notice, and subject to the following restriction(s) concerning my personal medical information. I agree to the disclosures named in the Notice: Notice of Privacy Practices of Sequoia Vein & Wound.

I understand and agreed by Sequoia Vein & Wound office policies and wish to continue care.

Patient Printed Name _____

Patient/Guardian Signature _____ Date _____



NOTICE OF PRIVACY PRACTICES OF SEQUOIA VEIN & WOUND

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) OF 1996 ENACTED BY CONGRESS PROTECTS YOUR PATIENT HEALTH CARE INFORMATION. HIPAA IS ENFORCED BY STATE AND FEDERAL GOVERNMENT AGENCIES. THE HIPAA PRIVACY RULE ENSURES THAT PERSONAL MEDICAL INFORMATION YOU SHARE WITH DOCTORS, HOSPITALS AND OTHERS ARE PROTECTED. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS CAREFULLY.

Our Staff cares about your privacy and guard your information carefully. Sequoia Vein & Wound is required by law to maintain the privacy of your patient health information. Patient health information is information that may identify you and anything relating to your past, present and future health care services. This notice describes our legal duties and our privacy practices. It describes how we may use and disclose information about you.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

We may use or disclose information without your written authorization for the following reasons

PAYMENT FOR TREATMENT: We may use and disclose your information to bill collect payment for the treatment and services provided. For example, we might send your information to your insurance company or health plan to get paid for the health care services that we provided to you. There are some services provided to us by contracts with business associates such as billing services and payment recovery services. We require all our business associates to abide by our privacy practices.

HEALTH CARE OPERATIONS: We may use your information in connection with our business operations. For example, we may use information to evaluate the performance of the health care professionals who provided such services to you. This information will be used to continually improve the quality and effectiveness of the health care services we provide to you. We may also provide information to business associates who perform services for Sequoia Vein & Wound, examples include transcription services, coding consultants and telephone answering services. Again, all our business associates are required to uphold to our privacy practices.

AS REQUIRED BY LAW: We will disclose information about you when we are required by law to do so. Examples of these disclosures would be for law enforcement or national security purposes, response to subpoenas or other court orders, disaster relief, review, review of our activities by government agencies, to avert serious threat to health or safety or in other types of emergencies.

HEALTH RELATED BENEFITS OR SERVICES: We may use information to inform you about treatment alternatives, other health care services or benefits that we offer or to refer you to another provider. For example, we may share medical information with other physicians or health care providers who will provide service which we do not provide, or we may share this information with pharmacist who needs information in order to dispense a prescription to you or a laboratory that will be performing a test. We may also disclose medical information to members of your family or others that can help you when you are sick or injured.

If you give us written authorization to do so, we may use and disclose information for other purposes. If you give us written authorization, you have the right to change your mind and revoke the authorization. For example, with your written authorization, we may disclose your health care information to other health care providers.