



VEIN CENTER OF VENTURA

168 N. Brent St., #508 Ventura, CA 93003

Tele: (805) 643-2855 Fax: (805) 643-3511

PATIENT INFORMATION

Name _____ Date of Birth _____

SS # _____ Marital Status: _____ Sex: _____

Home Address _____ City _____

State _____ Zip _____ Email _____

Mailing Address (if different) _____

Home Telephone # (____) _____ Mobile/Cell phone # (____) _____

Employer Phone # (____) _____ which phone do you prefer we call? _____

Preferred Language: English _____ Spanish _____ Other _____

Ethnicity (not required) _____ Race (not required) _____

Employment Status: Employed _____ Retired _____ Other _____ Occupation _____

Employer Name and Address: _____

How did you hear about us? _____

PHYSICIAN INFORMATION

Referring Physician: _____

Primary Care Physician: _____

Other Treating Physicians: _____

SPOUSE INFORMATION

(or if patient is a Minor, enter responsible party information)

Name _____ Date of Birth _____

Home Address _____ City _____

State _____ Zip _____ Telephone # (____) _____

Employer Name and Address _____

Work Phone # (____) _____ Cell Phone # (____) _____

EMERGENCY INFORMATION

Please provide the nearest Adult relative, not your spouse who is **not** living with you

Name _____ Relationship _____
Address _____ City _____
State _____ Zip _____ Telephone # (_____) _____

INSURANCE INFORMATION

Please bring your Insurance card(s) to your appointment and our receptionist will take a copy of it

Medicare: Yes _____ No _____ If yes, Medicare ID# _____
Is Medicare your primary Insurance? Yes _____ No _____
Medi-Cal: Yes _____ No _____ If yes, Medi-Cal ID# _____

Primary Insurance Company or your Medicare Supplement:

Name of Company _____ Telephone (_____) _____
Identification/Policy # _____ Group # _____
Claims Address _____ City _____
State _____ Zip _____
Subscriber (Policyholder's) Name _____
Subscriber's Social Security Number _____ Subscriber's DOB: _____

Secondary Insurance Company or your Medicare Supplement:

Name of Company _____ Telephone (_____) _____
Identification/Policy # _____ Group # _____
Claims Address _____ City _____
State _____ Zip _____
Subscriber (Policyholder's) Name _____
Subscriber's Social Security Number _____ Subscriber's DOB: _____

SIGNATURE

The above information is true and correct to the best of my knowledge.

Signature of Patient or Responsible Party

Date



VEIN CENTER OF VENTURA

Financial Policy

168 N. Brent St., Ste 508, Ventura, CA 93003

805-643-2855

We are committed to providing you with the best possible care. If you have medical insurance that provides coverage for the services we render, we want you to get the maximum allowable benefits.

Regarding filing of insurance:

- Sclerotherapy – Sclerotherapy is considered cosmetic by most insurances. We will be happy to provide you copies of claim forms to assist you in filing insurance claims for sclerotherapy. Our office does not file these forms
- Surgery and Diagnostic Procedures – We will assist with your insurance for surgeries and diagnostic procedures. We will call to confirm benefits and when required we will obtain necessary pre-authorizations. For insurances with which we contract, if the carrier considers the service we provide as a covered service, we will accept the amount allowed by the carrier for the service in question. You will be responsible for any deductible or co-insurance payable at the time of service. For insurances we do not contract with, you will be responsible for the difference between our charge and what your insurance company pays.
- Medicare – If you have Medicare, we will file claims for services that Medicare covers. You will be responsible for any deductibles and co-insurance at the time of service. For services that Medicare does not cover, we will ask you to sign an Advance Beneficiary Notification as required by Medicare, which indicates that you will be directly responsible for the charges.

Regarding payment due at time of service: Payment is due at the time services are rendered. We accept cash, check, Visa, and MasterCard.

Regarding returned checks: Returned checks are subject to a \$25.00 service fee.

Regarding missed or cancelled appointments: Timeliness of treatments is important in getting the most effective results. We accommodate patient schedules to the best of our ability. In consideration of other patients, our office requires a 48 hour notice of appointment cancellation. Failure to provide this notice will result in a \$50 missed appointment charge.

Agreement: I have read and understand the above financial responsibility statement:

Patient signature: _____

Date: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of this California Cardiovascular and Thoracic Surgeon's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Patient Name: _____

Signed: _____ **Date:** _____

Print Name (If other than patient): _____

If not signed by the patient, please indicate relationship:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient