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

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to which I may be entitled from an insurance plan(s) to VEIN CENTER OF VENTURA/CALIFORNIA CARDIOVASCULAR AND THORACIC SURGEONS. 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.

_____ _____

Patient's Signature/ Insured's Signature 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 VEIN CENTER OF VENTURA/CALIFORNIA CARDIOVASCULAR AND THORACIC SURGEONS 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 these 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.

_____ _____

Patient's Signature/ Insured's Signature Date

If the signature is other than the patient's, please write the patient's name followed by the signature of the person signing, and complete the following:

Name and Address of Signing Party_____

_____

Relationship to the patient _____

Reason the patient could not sign _____

CONSENT TO RELEASE INFORMATION

I hereby authorize VEIN CENTER OF VENTURA/CALIFORNIA CARDIOVASCULAR AND THORACIC SURGEONS to furnish information to any referring physician, agency, or insurance company I have listed in the Patient Information form.

_____ _____

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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Phone (805) 643-2855 fax (805) 643-3511

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