



Patient Name: \_\_\_\_\_ Gender:  Male  Female

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Marital Status:  Single  Married  Separated  Divorced  Widow

Race:

- American Indian or Alaska Native  Asian  Black or African American  
 Hispanic or Latino  Native Hawaiian or Other Pacific Islander  White  
 Decline to Specify

Preferred Language:  English  Spanish  Polish  Italian Other: \_\_\_\_\_

Emergency Contact: Name / Phone Number: \_\_\_\_\_

Access to patient portal:  Yes  No (selecting yes will enable you to access your medical summary notes)

Email address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Business Address: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_ Referral Required:  Yes  No

ID#: \_\_\_\_\_ Group Number: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

ID#: \_\_\_\_\_ Group Number: \_\_\_\_\_

Pharmacy Information: \_\_\_\_\_

Name of Insured if other than you: \_\_\_\_\_

Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Business Address: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Health History Form**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Name of Primary Care Physician:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Why are you here today?**

\_\_\_\_\_  
\_\_\_\_\_

**How did you hear about NJ Vein Care?**

\_\_\_\_\_

**Are you on any medications either prescribed or over the counter? List Below**  Yes  No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Do you have any allergies to medication?**  Yes  No

If yes, please list drug and reaction

\_\_\_\_\_

**Do you smoke tobacco?**  Yes  No  Quit **Packs per day for how many years?** \_\_\_\_\_

**Do you consume alcohol?**  Yes  No  Quit **Drinks per week?** \_\_\_\_\_

**Other drugs?** \_\_\_\_\_

**Have you had any past surgical procedures?**  Yes  No

If yes, please list type and date

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**Have you had any past hospitalizations?**  
If yes, please list reason and date

Yes       No

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**Do you have any of the following conditions? (Please check all that apply and describe below)**

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Leg Pain	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Stroke	<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Swelling of Legs	<input type="checkbox"/> Leg Ulcers
<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Spider Veins	<input type="checkbox"/> Other

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**Family History. (Check all that apply)**

	Father	Mother	Sibling	Other
<input type="checkbox"/> Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Leg Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Is there any other medical information that you would like to share?**

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### Venous Health History

1. Have you ever had  vein stripping  Ablation surgery  Yes  No  
 a. If yes, when and which leg? \_\_\_\_\_
2. Have you ever had vein injections?  Yes  No  
 a. If yes, which leg and where on the leg? \_\_\_\_\_
3. Have you ever had a blood clot?  Yes  No  
 a. If yes, which leg and when? \_\_\_\_\_
4. Have you ever had phlebitis?  Yes  No  
 a. If yes, which leg and when? \_\_\_\_\_
5. Do you experience any of the following in your legs?
 

a. Aching/pain?	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> No
b. Heaviness?	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> No
c. Tiredness/fatigue?	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> No
d. Itching/burning?	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> No
e. Swollen ankles?	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> No
f. Leg cramps?	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> No
g. Restless legs?	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> No
h. Throbbing?	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> No
i. Other?	_____			
6. Have your veins gotten worse in recent months?  Yes  No
7. Do you take any medication for pain (i.e., Advil, Motrin)  Yes  No
8. Do you elevate your legs to relieve discomfort?  Yes  No
9. Do you exercise?  Yes  No
10. Do you wear compression stockings?  Yes  No  
 a. If yes, what type and gradient? How long have you worn them? \_\_\_\_\_
11. Do you have any problem walking?  Yes  No  
 a. If yes, how does it affect you? \_\_\_\_\_
12. What type of work do you do? \_\_\_\_\_  
 a. How long do you stand (hours per day) at work? \_\_\_\_\_ At home? \_\_\_\_\_
13. Have you ever had any test(s) done on your veins?  Yes  No  
 a. If yes, when and what type of test and where on the leg? \_\_\_\_\_
14. Were you diagnosed with saphenous vein reflux?  Yes  No



### Our Practice Financial Policy

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions, please discuss them with our office administrator.

**Full payment is due at the time of service for cosmetic procedures.** For your convenience we will accept cash, check, or credit card for payment.

**We also participate with Care Credit that can be used to finance both cosmetic and non-cosmetic procedures including deductibles and co-insurance.**

We are **not in network** with Medicaid or Managed Medicaid plans.

We are **not in network** with BCBS Advance EPO

We are **not in network** with Americhoice or Amerigroup

We are "in network" with Medicare, Horizon Blue Cross/Blue Shield of NJ, Aetna, United Health Care, Oxford, Magnacare, Amerihealth, Care Point, OSCAR, Qualcare and Cigna. **Patients are responsible for knowing if referrals are needed and obtaining referrals prior to an appointment at NJ VeinCare.**

If you have other medical insurance with "out of network benefits", we will work with you to obtain coverage for procedures performed due to medical necessity. We do accept "out of network benefits".

If in the event your health plan ultimately determines a service to be "not covered" or does not meet their criteria for medical necessity, you would be responsible for the complete charge.

Prior to any scheduled procedure we will provide patients with the CPT codes. **It is your responsibility to check with your insurance company to determine what your out of pocket costs will be.** Payment is due upon receipt of the Explanation of Benefits from your insurance company. It lists what you owe NJ Vein Care. **If payment to NJ VeinCare is not received within 60 days, interest at a rate of 1.5% per month will accrue. After 90 days, unless other arrangements have been made, your account will be sent to a collections agency.** This would result in an additional charge from the collections agency and/or legal fees over what you owe to NJ VeinCare.

A fee of \$30.00 will be charged on any checks returned by the bank for insufficient funds.

**Patients will be charged a fee of \$50.00 if they fail to cancel an appointment 1 day in advance. If a patient fails to give 1-day advance notice of cancellation for a cosmetic procedure, any discount that was given for the procedure may be forfeit.**

**I have read and understand the financial policy of NJ Vein Care and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.**

Print Name of Patient \_\_\_\_\_

Signature of Patient or Guardian \_\_\_\_\_ Date \_\_\_\_\_



## ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign, transfer, and set over directly to NJ VeinCare, LLC sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic or elsewhere. I authorize Gary B. Nackman, MD /NJ VeinCare, LLC to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Gary B. Nackman, MD /NJ VeinCare, LLC. I authorize Gary B. Nackman, MD /NJ VeinCare, LLC to release all medical information requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

Print Name of Patient \_\_\_\_\_

Signature of Patient or Guardian \_\_\_\_\_ Date \_\_\_\_\_



## PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1966 (HIPAA). I understand that by signing this consent I authorize you to use and disclosure my protected health information to carry out:

- Treatment (including direct and indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operation of your practice.

I have also been informed of and give the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Name of Patient \_\_\_\_\_

Signature of Patient or Guardian \_\_\_\_\_ Date \_\_\_\_\_



**You have the right:**

- To considerate and respectful care consistent with sound nursing and medical practices
- To be informed of the name of the physician responsible for coordinating your care
- To obtain from the physician complete, current information concerning your diagnosis, treatment, and prognosis in terms I can reasonably be expected to understand
- To receive from the physician information necessary to give informed consent prior to the start of any procedure or treatment
- To refuse treatment to the extent permitted by law and to be informed of the medical consequences of such action; You can still obtain alternative care.
- To privacy to the extent consistent with providing adequate medical care to you
- To privacy and confidentiality of all records pertaining to the your treatment, except as otherwise provided by law or third party payment contract, and to access to those records
- To review your medical records and if necessary have them explained to you
- To know what alternative care may be available to you
- To know what your treatment may cost

**You have the responsibility:**

- To provide all information about your past care, illness and medication to your physician
- To for being considerate to the needs of others in the office
- To provide all insurance information when requested, and following the requirements for your individual insurance plan for seeking treatment with the Doctor

Print Name of Patient \_\_\_\_\_

Signature of Patient or Guardian \_\_\_\_\_ Date \_\_\_\_\_





**Authorization For Release of Information**  
**PLEASE COMPLETE THIS FORM IN ITS ENTIRETY**

1. I hereby request and authorize NJ Vein Care to release information from the health record(s) of:

Patient's Name \_\_\_\_\_ Patient's Date of Birth \_\_\_\_\_

Patient's Social Security Number \_\_\_\_\_

**I understand that this authorization includes permission to release information related to the history, diagnosis and/or treatment of any psychiatric problems, mental illness, drug abuse, alcoholism, sexually transmitted or communicable disease, AIDS, or test for infection with human immunodeficiency virus (HIV).**

2. The requested information is to be sent to (name of doctor, hospital, person or organization where records should be sent):

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

3. The information to be released is and the records to be sent include (please provide dates of treatment and specific records):

\_\_\_\_\_  
\_\_\_\_\_

4. Purpose/reason for release of records (circle): Insurance / Legal Matters / Marketing / Fundraising

Other (explain): \_\_\_\_\_

5. I understand the nature of the authorization and that this authorization can be revoked at any time by the person giving authorization, with a written and dated notice, except to the extent that disclosure made in good faith has already been made prior to receipt of the revocation.

6. I understand that my treatment is not conditioned on obtaining this authorization.

7. I understand that this authorization is specific for release only to the above party and expires (90) days following the date of signature.

8. I understand that information used or disclosed may no longer be protected by the federal privacy laws.

9. I understand that I can be charged for obtaining copies of my records according to the fee schedule established in the New Jersey Administrative Code.

10. If the requested information involves mental health information, I acknowledge that I am aware that New Jersey has a statutory privilege accorded to confidential communications between a patient and a licensed psychologist and that release of such information may waive this privilege.

11. I understand if this authorization is for marketing purposes that NJ Vein Care may receive direct or indirect compensation.

Print Name of Patient \_\_\_\_\_

Signature of Patient or Guardian \_\_\_\_\_ Date \_\_\_\_\_