PHONE 559-721-4910 FAX 559-721-4920

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CLOVIS	3120 WILLOW AVE STE 101 CLOVIS CA 93612
HANFORD	1320 BAILEY DR STE 103 HANFORD CA 93230
SELMA	1850 FLORAL AVE SELMA CA 93662

FIRST NAME: ___________________________ **LAST NAME**: ___________________________

DOB:_____________ **SEX**: ☐ MALE ☐ FEMALE **SOCIAL SECURITY**:_______________

ADDRESS: ____

CITY: _____________________________ **STATE**: ____________ **ZIP**: ________________

HOME PHONE:____________________ **CELL PHONE**: ____________________

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

RACE: ☐ BLACK/AFRICAN AMERICAN ☐ WHITE/CAUCASIAN ☐ ASIAN ☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER ☐ AMERICAN INDIAN/ALASKA NATIVE

ETHNICITY: ☐ HISPANIC ☐ NON-HISPANIC ☐ PREFER NOT TO SPECIFY

PRIMARY CARE PHYSICIAN: ____

PRIMARY INSURANCE

INSURANCE COMPANY NAME: _________________________ **ID#** :____________________

SECONDARY INSURANCE

INSURANCE COMPANY NAME: _________________________ **ID#** :____________________

INSURED RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY NAME: ______________________________ **DOB**: __________________

RELATIONSHIP TO PATIENT:_____________________ **PHONE NUMBER**: ______________

ADDRESS: ___________________________________**EMPLOYER**: _______________________

EMERGENCY CONTACT

NAME: _____________________________ **RELATIONSHIP TO PATIENT**: ______________

HOME PHONE: ________________________ **CELL PHONE**: ________________________

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NAME: ________________________________ **DATE OF BIRTH**: ___________________

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

- ☐ High Cholesterol
- ☐ Aortic Aneurysm
- ☐ Irregular Heartbeat
- ☐ Diabetes
- ☐ Cancer
- ☐ Kidney Disease
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Pacemaker
- ☐ Allergies
- ☐ Lung Disease
- ☐ Heart Disease
- ☐ Clotting Disease
- ☐ Congestive Heart Failure
- ☐ Pneumonia
- ☐ Other: __________ ________________

Other Medical Problems:____

____

Previous Surgeries:

- ☐ Appendectomy
- ☐ Eye
- ☐ Breast
- ☐ Gallbladder
- ☐ Heart/Vascular
- ☐ Hysterectomy
- ☐ Hernia
- ☐ Hemorrhoid
- ☐ Back/Neck
- ☐ Hip/Knee
- ☐ Other:__________ ________________

Family history of Vascular Disease:

- ☐ Diabetes
- ☐ Heart Disease
- ☐ Varicose Veins
- ☐ High Blood pressure
- ☐ Cancer
- ☐ Stroke
- ☐ Aortic Aneurysm
- ☐ High Cholesterol
- ☐ Other: __________ ________________

Allergies to medications: ____
Allergies to food/shellfish: ☐Yes ☐No
Allergies to tape: ☐Yes ☐No (Adhesive or Paper) **Allergies to latex**: ☐Yes ☐No

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Please list all Medications you are presently taking

______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Pharmacy: ____
Address:______________________________________**Phone:**_______________

Do you or have you ever smoked? ____
If so, how much a day? ____
Do you consume alcohol? ____
If so, how much a day? ____

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

☐ Fever	☐ Irregular Heartbeat	☐ Rash
☐ Chills	☐ Cough	☐ Numbness
☐ Weight Loss	☐ Wheezing	☐ Weakness
☐ Blurred Vision	☐ Nausea	☐ Diarrhea
☐ Eye Pain	☐ Vomiting	☐ Ringing in Ears
☐ Loss of Hearing	☐ Headache	☐ Kidney Stones
☐ Nose Bleeds	☐ Seizures	☐ Blood in Urine
☐ Sinusitis	☐ Fainting	☐ Indigestion
☐ Chest Pain	☐ Shortness of breath	☐ Other_____________
☐ Palpitations	☐ Hepatitis	__________________
☐ Heart Murmur	☐ Jaundice	
☐ Leg Swelling	☐ Anemia	
☐ Dizziness	☐ Bruising	

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FINANCIAL AND 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 Central Valley Vein and Wound Center, the providers of medical services, and the patient who is receiving medical services, or the responsible party for minor patients (those who are 18 years old). Responsible party is the individual who is financially responsible for the 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 your appointment. 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 a Non-Sufficient Funds (NSF), Account Closed (AC), it is the patients or patients guardians 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 a collection agency and a late charge of $25 will be added to your outstanding balance, and an additional $25 check service charge.

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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 your insurance company does not pay the practice within a 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 Central Valley Vein and Wound Center 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 the assignment. I understand that I am financially responsible to make prompt payment to the account of Central Valley Vein and Wound Center as bills are presented.I understand that I am financially responsible for any changes 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 Central Valley Vein and Wound Center.

I understand and agree with Central Valley Vein and Wound Center office policies and wish to continue care.

Patient Printed Name: ____

Patient / Guardian Signature: ____

Date:______________________

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NOTICE OF PRIVACY PRACTICES OF CENTRAL VALLEY VEIN AND WOUND CENTER

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. Central Valley Vein and Wound Center 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 Central Valley Vein and Wound Center, examples include transcription services, coding consultants and telephone answering services. Again, all our business associates are required to uphold 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 pharmacists who need 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.

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MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: ________________________________ Date of Birth:_____________

The information you may release subject to this signed release form is as follows:

- ☐ Complete Records
- ☐ History & Physical
- ☐ Progress Notes
- ☐ Care Plan
- ☐ Lab Reports
- ☐ Radiology Reports
- ☐ Pathology Reports
- ☐ Treatment Record
- ☐ Operative Reports
- ☐ Hospital Reports
- ☐ Medication Record
- ☐ Other (please specify below)

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Name:____

Address:____

City:______________________________ **State:**______________ **Zip Code:**____________

The purpose/reason for this release of information is as follows: ______________________

____

Patient Name: ______________________________________ **Date:** ___________________

Date of Birth: ___________________

Printed Name of Patient or Personal Representative: _______________________________

Description of Personal Representative: ____

Signature of patient or Personal Representative: ___________________________________

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Personal Representative

In the space below, if you so choose, please list the personal representatives*persons permitted to receive or learn information concerning your health care for a period of 12 months from the date you sign this form . In the event your designated personal representatives change during the term of this form, you must contact CVVWC in writing and request the change.

Names(s):____

____ _______________________

Patient Signature **Date**

**A personal representative, as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), is any family member, friend, or person designated by the patient, to whom information may be disclosed about the patient's health.*

CENTRAL VALLEY VEIN & WOUND CENTER (CVVWC) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.