California Vein Specialists
180 Newport Center Drive, Suite 120
Newport Beach, CA 92660
(949) 515-9377

Name: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

❑ Okay to leave message with details ❑ Okay to leave message with details

❑ Do not leave detailed message ❑ Do not leave detailed message

E-Mail Address: _____

❑ Okay to email details ❑ Okay to email monthly specials ❑ Okay to be-friend you on Facebook

Employer: _____ Occupation: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Home Phone: (____)_____ Other Phone: (____)_____

Insurance Info: ❑ None ❑ HMO ❑ Medicare only ❑ Medicare with supplement

❑ PPO: Insurance Company_____

I certify that all the above information is true and correct:

Signature: Date:

How did you hear about us?

□ Internet □ E-mailer □ Newsletter
□ Image Magazine □ Insurance Website □ Our Website
□ Riviera Magazine □ Friend (name below) □ Yellow Pages
□ Radio Station: _____ □ Other_____

□ Doctor Referral: _____Phone: (____)_____

What services would you like to learn about? Please check all that apply

❑ Vein Reduction Legs	❑ Injectable Treatments	❑ Skin Care Advice
❑ Vein Reduction Hands	❑ Juvederm/Radiesse/Botox	❑ Skin care products
❑ Facial Veins	❑ Drooping brow	❑ Facials
❑ Facial Redness	❑ Drooping eyelids	❑ Microdermabrasion
❑ Facial fine lines/wrinkles	❑ Refirming Lasers	❑ Cellulite Reduction
❑ Thin lips	❑ Facial fullness/drooping	❑ Facial Contouring
❑ Blotchy skin	❑ IPL/FotoFacials	❑ Body Contouring
❑ Brown spots/age spots	❑ Pronounced Folds around Mouth	❑ Unwanted Hair
❑ Chemical peels	❑ Waxing	❑ Length/Fullness of Eyelashes

❑ *I'm not interested in any additional services provided at this time*

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NAME:_____ **DATE:**_____

VEIN CONCERNS: ❑ Varicose Veins ❑ Spider Veins ❑ Facial Veins ❑ Hand Veins ❑ Chest Veins ❑ Other

Do you experience any of the following symptoms? (Please circle all that apply)

Complaints	Type of Pain			
Swelling	Intense	Both Legs	Mainly Left	Mainly Right
Itching	Severe			
Burning	Dull	Other:_____		
Heaviness	Aching			
Restlessness	Cramping	_____		
Tenderness	Sharp			
Fatigue	Throbbing	_____		
Discoloration	Numbness			
Spider Veins	Tingling			
Numbness	Moderate	Aggravating Factors_____		
Phlebitis				
Ulceration		Relieving Factors_____		
Cellulitis				
Dematitis		How long have your veins been a problem?_____		

How does your vein condition affect your daily activity?_____

Do any of your family members have varicose veins? □ No □ Yes, Who?_____

VENOUS HISTORY

❑ Phlebitis	❑ Sclerotherapy	❑ IV Drug use
❑ DVT (Blood Clot)	❑ Sonogram	❑ AIDS/HIV/Hepatitis
❑ Pulmonary Embolism	❑ Prior Vein Surgery or Venous Ablation	❑ Previous Trauma to vein
❑ Bleeding from veins	❑ Hemorrhoids	❑ Clotting Disorder

Details for above checkmarks:_____

_____

HABITS: Alcohol_____ Exercise_____ Tobacco_____ ❑ Never Smoked

MEDICATIONS: ❑ **None** (If there are more than 3 please attach additional sheet)

Drug:_____ Dosage_____

Drug:_____ Dosage_____

Drug:_____ Dosage_____

ALLERGIES: ❑ **None** _____

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NAME:_____ DATE:_____

MEDICAL HISTORY	YES	NO
1.Acute medical condition currently under medical treatment		
2. Skin rashes or skin condition, lack of normal skin sensation		
3. Respiratory: ie Asthma, COPD, Lung Condition		
4. Cardiovascular: Atrial fibrillation, Mitral Valve Prolapse, Pacemaker etc		
5. Any heart disease or condition ie: High Blood Pressure, heart attack		
6. Gastro Conditions: ie GI bleeding, Colon Cancer		
7. Genito-Urinary conditions		
8. Pregnant, possible pregnancy or breast feeding		
9. Muscular / Skeletal conditions		
10. Any embedded material in your body (ie: plates, screws, hip replacements)		
11. Currently experiencing any pulled or strained muscles or ligaments		
12. Multiple Sclerosis		
13. Seizures		
14. Diabetes or hypoglycemia, thyroid conditions		
15. Any tumors or inflammation		
16. Any chronic infectious disease		
17. Surgeries		

IF YOU MARKED YES ON ANY OF THE ABOVE, PLEASE DESCRIBE MEDICAL HISTORY DETAILS:

#_____

#_____

#_____

#_____

#_____

FEMALES: # of Pregnancies _____ # of Births_____

Financial Policy

Thank you for choosing California Vein Specialists as your vein-health care provider. Our goal is to build a successful physician-patient relationship with you. Your understanding of our patient financial policy and your responsibility for payment for services is important to our professional relationship. If you have any questions about our fees, our policies, or your responsibilities please ask our practice manager. It is your responsibility to notify our office of any changes in your address, name, telephone, insurance information, etc. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require that you read and agree to prior to any treatment.

Insurance Claims - Dr. Leary's services are provided directly to you and not to an insurance company. Insurance is a contract between you and your insurance company. As a courtesy to you we will bill your insurance if we are contracted with them, with the requirement that you assign benefits, allowing the insurance company to pay our physician directly. To properly bill your insurance, we require that you provide all up-to-date insurance information.

- You are expected to present a current insurance card and ID at each visit. Copayments and past due balances are due at time of check-in. You may pay by cash, check, money order or credit cards.
- If we are not contracted with your insurance company you are responsible for payment in full on date of service. We will provide you with a receipt to submit for reimbursement. We are not providers under most HMO plans, Medi-Cal plans, some Affordable Care Act plans, and other plans. It is your responsibility to know if our office is participating with your plan.
- You are responsible for your own insurance benefits. Payment for services rendered to you and/or your dependents will not be postponed due to pending insurance claims. We will bill contracted insurance companies up to 60 days from the date of service at which time the balance will become the patient's responsibility if no payment has been received from the insurance company.
- Coinsurance, deductibles and payments for non-covered services, and any other portion of these services not paid by the insurance company, are not normally adjusted as part of our contractual agreement with the insurance company and will be your responsibility. Payments of known deductibles etc. are due at the time services are rendered. It is the insurance company that makes the final determination of your eligibility and benefits.
- Not all services provided by this office are covered by every plan. You are responsible for understanding your benefit plan and for knowing its requirements. It is your responsibility to pay for services if your insurance does not pay. After insurance claims are paid, remaining balances are payable in full within the regularly scheduled 30-day billing cycle.
- Payments of past due balances must be made prior to a scheduled appointment.

Self-pay Accounts

- Patients without insurance are expected to pay for services at the time of the visit.

Returned Checks

- A returned check charge of $25 will be payable by cash or credit card. A returned check may be cause for providing services on a cash-only basis.

Packages for Services

- All pre-purchased treatments and/or treatments purchased in a package must be used within 1 year of purchase or payment is forfeited.

Outstanding Balances

- If previous arrangements have not been made with our finance office, any account balance outstanding over 90 days will be forwarded to a collection agency.

We reserve the right to refuse treatment to anyone based upon the determination of the authorized agent, employees or representatives of California Vein Specialists, that said person is not an appropriate candidate for such treatment.

I agree to the financial policies of California Vein Specialists as outlined above. I agree to accept responsibility for my bill regardless of my insurance coverage. I authorize payment of medical benefits to J. Michael Leary, MD dba California Vein Specialists and the release of any medical or other information necessary to process insurance claims.

I confirm to the best of my knowledge that the information I have provided is true and correct.

Patient's Signature: _____ Date: _____

No-Show Policy

We value you as a patient and recognize the difficulties you face in trying to coordinate all the demands made upon your time.

As a result of high demand on our schedules, we ask that you give us a 24-hour notice if you cannot keep your appointment. This allows us to give that time to other patients with urgent needs.

Patients who miss appointments without calling at least 24 hours in advance will be charged a $50 fee that is not covered by insurance.

We understand when special circumstances occur. If you call us and explain those to us at your earliest opportunity, we will be happy to reschedule your appointment. And the "no show" will not be counted against you. A third No Show may result in the dismissal from this practice.

Thank you for your cooperation.

Dr. Leary and Team

Patient's Signature: _____ Date: _____