Seton Medical Center
1850 Sullivan Ave, Suite 300
Daly City, CA 94015
Phone 650-991-1122
Fax 415-744-1199

**MELINDA L. AQUINO, MD**
Board Certified Vascular Surgeon
http://www.sfveincenter.com

St Marys Medical Center
2250 Hayes Street Ste 612
San Francisco, CA 94117
Phone 415-752-1122
Fax 415-744-1199

# PATIENT DEMOGRAPHICS

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____

Home Phone: _____

Cell Phone: _____

E-Mail Addr: _____

Emergency Contact (Next of Kin) _____

Phone: _____

Relationship: _____

Primary Physician: _____

Preferred Pharmacy and Address: _____

How did you hear about us? Please choose one option.

- ◯ I came from a doctor or hospital  Referring Physician: _____
- ◯ Web Search / Google / www.sfveincenter.com
- ◯ Yelp

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# PATIENT MEDICAL HISTORY

Name _____ Date _____ Age _____

What brings you to our office today?

| |
|---|
| |

What medical problems do you have? For example: high blood pressure, varicose veins, diabetes, etc.

| | |
|---|---|
| | |
| | |
| | |

What hospitalizations and surgeries have you had in the past?

| Approx Date | Surgery | Hospital | Surgeon |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

What medications do you take?

| Medication | Dose/Frequency | Medication | Dose / Frequency |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

# PATIENT MEDICAL HISTORY (PAGE 2)

Name _____

Are there any medical conditions that run in your family?

| Condition | Relation |
|---|---|
| | |
| | |
| | |

What allergies do you have?

| Allergy | Reaction |
|---|---|
| | |
| | |

Have you ever smoked? ◯ Yes ◯ No

If you have smoked, how many packs a day? ☐

How many years did you smoke? ☐

Have you stopped? ◯ Yes ◯ No

If you have stopped smoking. When did you stop? ☐

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How many alcoholic drinks do you have a day? ☐

Have you ever had a problem with alcohol? ◯ Yes ◯ No

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What do you do for work? ☐

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## PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

**Cancellation policy**
While we understand there may be times when you miss an appointment due to emergencies or obligations, we enforce the following cancellation policy:

- **Office visits must be canceled at least 48 hours (2 business days) in advance. Late cancellations or no-shows will incur a $75 fee.**

- **Procedures must be canceled at least 72 hours (3 business days) in advance. Late cancellations or no-shows will incur a $250 fee. Procedures require special preparation of equipment and a procedure room which is reserved.**

**Insurance**

- Your insurance policy is a contract between you and your insurance provider. You are responsible for understanding and paying your insurance copays, deductibles, and coinsurance. Our staff is happy to explain what these are if you need help.
- As a curtesy, we bill your insurance company for you and charge you copays, deductibles, and/or coinsurance as instructed by your insurance company.
- As a curtesy, we try to verify coverage and eligibility. However, it is your responsibility to determine if the doctor is in-network prior to being seen.
- You are responsible for providing us with the most correct and updated information about your insurance.
- You are responsible for any amounts not covered by insurance.

We're committed to providing excellent care. Please ask if you have any questions about our financial policy.

I have read, understand, and agree to this policy. I am responsible for all costs, including reasonable collection or attorney fees, in the event of nonpayment.

Pursuant to California Civil Code § 1785.27, no information regarding this medical debt may be furnished to a consumer credit reporting agency. Any knowing violation renders the debt void and unenforceable, in addition to any other penalties provided by law.

_____ _____ _____

Patient or Legal Representative Signature Printed Name Date

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## PATIENT HEALTH INFORMATION AUTHORIZATION AND CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. We are required by law to provide this consent form.

**Notice of Privacy Practices**
I acknowledge that I have been provided with this office's Notice of Privacy Practices. I understand that it provides a complete description of the uses and disclosures of my health information. I understand that a copy of the Notice of Privacy Practices is also available at the front desk as well as http://www.sfveincenter.com.

**Authorization for the Disclosure of PHI for Treatment, Payment, or Healthcare Operations**
I understand that as part of my healthcare this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment.
- a means of communication among the health professionals who may contribute to my healthcare.
- a source of information for applying my diagnosis and surgical information to my bill.
- a means by which a third-party payer can verify that services billed were actually provided.
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified above.

**Consent to the Use and Disclosure of PHI for Treatment, Payment, or Healthcare Operations**
I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent.
- This facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested.
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.
- It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

Patient or Legal Representative Signature _____ Printed Name _____ Date _____

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We are required by law to provide these notices:

## OPEN PAYMENTS DATABASE NOTICE

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

## NOTICE AND ACKNOWLEDGMENT OF RECEIPT AND UNDERSTANDING

Medical doctors are licensed and regulated by the Medical Board of California. To check up on a license or to file a complaint,

Go to: https://www.mbc.ca.gov
Email: licensecheck@mbc.ca.gov
Call: (800) 633-2322

| _____ | _____ | _____ |
|---|---|---|
| Patient or Legal Representative Signature | Printed Name | Date |