LA JOLLA VEIN CARE
CENTER FOR ADVANCED VEIN TREATMENT

Welcome!

Thank you for choosing La Jolla Vein Care! We strive to improve the quality of life for all patients by customizing vein care for each individual. At La Jolla Vein Care we work towards creating a warm, friendly environment ensuring a comfortable experience for all of out patients and their guests.

How to Contact Us

For appointments and general information please call:
(858) 550-0330
Or Email: info@lajollaveincare.com
Billing Questions: (858) 777-3020

Office Hours

Office Hours: Monday – Friday 8:30am-5:00pm
Appointments are available Monday – Thursday 8:30am-5:00pm

Insurance

We accept most PPO insurance types and Medicare. If you have questions regarding any out of pocket expenses prior to your appointment, please contact your insurance provider to verify your coverage and deductible information. If you have a Covered California policy, please check with you insurance provider to verify that you have out-of-network benefits, as we are not contracted with Covered California Policies.

What to expect during your first visit

- We are located in the "XiMed" Building located at the campus of Scripps Memorial Hospital La Jolla on the 4th floor in suite 410
- Please bring your insurance card and a picture identification card with your to your appointment.
- To ensure we start your appointment at your scheduled time, please complete the attached forms and bring them with you to your appointment.
- Please allow yourself plenty of time to find parking in the garage, as sometimes it is difficult to find parking. Valet parking is available for a flat rate fee.

Get Connected!

For more information, tips and updates, follow us!

Directions

From I-5

Take Genesee Avenue exit and turn east.
Go to the first traffic light; turn right onto Scripps Hospital Driveway into the Scripps Memorial Hospital Campus

From I-805

Take Miramar Road/ La Jolla Village Drive exit and proceed west on La Jolla Village Drive
Turn right onto Genesee Avenue
Go one mile; turn left onto Scripps Hospital Driveway into the Scripps Memorial Hospital Campus

Once you have entered the campus, look straight ahead and you will see the 9850 XiMed Building where we are located. Merge into the left lane, go through two stop signs and turn left. Once you have turned left, you will turn right at the next stop sign. Proceed through one more stop sign and turn right. You will then need to get a parking ticket and may park in the first parking structure B on your right hand side. Be sure to bring your parking ticket with you that way you can pay for parking when you leave. Parking costs $4.00 for the first 3 hours and $10.00 for the entire day. You will be able to pay for parking on the first level of the parking structure upon leaving.

Patient Registration Forms

Patient Information:

Patient's Name: Last:_____ First:_____ Middle Initial:_____

Date of Birth:_____ Age:_____ Sex:_____ Social Security #:_____

Home Address: Street:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____Email:_____

Which is the best way to reach you? ☐ Cell ☐ Home ☐ Email Marital Status: ☐ S ☐ M ☐ D ☐ W

Occupation:_____ Employer:_____ Work Phone:_____

Work Address: Street:_____ City:_____ State:_____ Zip:_____

Primary Care Physician:_____ Phone Number:_____City:_____

Referring Physician:_____ Phone Number: _____ City:_____

Emergency Contact: _____ Relationship:_____ Phone Number:_____

Insurance Information:

Primary Insurance

Company:_____ Policy/ ID #:_____ Group #:_____

Policy Holder's Name: _____ D.O.B: _____ Relationship:_____

Secondary Insurance-

Company: _____ Policy/ ID#: _____ Group #: _____

Policy Holder's Name: _____ D.O.B: _____ Relationship:_____

How did you hear about La Jolla Vein Care? _____

Payment Policy Statement:

Payment at time of service is requested unless you are insured by a PPO, Medicare, or an approved insurance carrier that we bill directly insures you, or other arrangements have been made. All deductibles, co-payments and services not covered by your plan are your responsibility. La Jolla Vein Care requests that financial arrangements be made at the time of your first visit. La Jolla Vein Care accepts cash, personal check, Visa, MasterCard, American Express, and Flex Spending Accounts (FSA). There will be a $35.00 charge on all returned checks. Should collections be necessary, the patient shall pay Doctor, on demand, all costs, including reasonable attorney's fees, incurring in collecting payment due from patient services performed under this agreement.

Authorization:

I hereby consent to any necessary medical treatment/ physical examination required by myself or the minor names above for whom I am legally responsible.

Assignment:

I permit payment directly to La Jolla Vein Care for any benefits due to La Jolla Vein Care for the services rendered. I understand that I am financially responsible for all charges, whether or not covered by my insurance.

Medical Records:

Authorization is hereby granted for release of any information required to process this claim. A copy of this authorization is as valid as the original. Regardless of any claim pending, you will receive periodic statements if your account has an outstanding balance. We cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.

Signature:_____ **Date:**_____

Health History Information

Patient Name:

D.O.B. Age: Today's Date:

Referring Physician Name (*if applicable)*:

Would you like us to send today's medical reports to your referring physician? Yes / No

Primary Care Physician Name (*if applicable*):

Would you like us to send today's medical reports to your primary care physician? Yes / No

What is the purpose of your visit today?

Symptoms Questionnaire

Please complete the following as accurate as possible due to insurance requirements for treatment authorizations

1. **When did you first notice your vein condition?**

2. **During the past 4 weeks, how often have you had any of the following leg problems?**

(check one box on each line)	Everyday	≥3 times per week	≤2 times per week	≤1 time per week	Never
Heavy legs	☐	☐	☐	☐	☐
Aching Legs	☐	☐	☐	☐	☐
Swelling	☐	☐	☐	☐	☐
Night Cramps	☐	☐	☐	☐	☐
Heat or Burning Sensation	☐	☐	☐	☐	☐
Restless Legs	☐	☐	☐	☐	☐
Throbbing	☐	☐	☐	☐	☐
Itching	☐	☐	☐	☐	☐
Tingling Sensation	☐	☐	☐	☐	☐
Leg Fatigue	☐	☐	☐	☐	☐

3. **At what time of the day is your leg problem <u>most intense</u>?**

☐ On walking
☐ At mid-day
☐ At the end of the day
☐ During the night
☐ At any time of day
☐ Never

4. **<u>Compared to one year ago</u>, how would you rate your leg problem in general <u>now</u>?**

☐ Much better than a year ago
☐ Somewhat better now than a year ago
☐ About the same now as a year ago
☐ Somewhat worse than a year ago
☐ Much worse than a year ago
☐ I did not have leg problem last year

5. **Have you ever had any of the following complications?**

☐ Leg Ulcer
☐ Bleeding from vein
☐ Phlebitis
☐ Skin Changes (such as discoloration around the ankles)

6. **Does your leg problem now limit you in any of the following activities? If so, please explain how.**

1. Daily activities at work **Yes / No**
2. Daily activities at home **Yes / No**
3. Social or leisure activities that require <u>standing</u> for long periods **Yes / No**
4. Social or leisure activities that require <u>sitting</u> for long periods? **Yes / No**

7. **What is your occupation?**

8. **During the past 4 weeks, have you had any of the following problems with your work or other daily activities as a result to your leg problem?**

1. Cut down the amount of time you spent on work or other activities **Yes / No**
2. Accomplished less than you would like **Yes / No**

3. Were limited to the kind of work or other activities **Yes / No**

4. Had difficulty performing the work or other activities (e.g. took extra effort) **Yes / No**

Conservative Management

**Please complete the following as accurate as possible due to insurance requirements for treatment authorizations*

1. Have you ever had vein treatment before? Yes / No *If yes, please indicate which treatment type, leg, and year.*

	Leg	Year		Leg	Year
☐ Vein Stripping			☐ Foam Sclerotherapy		
☐ Laser Ablation			☐ Sclerotherapy		
☐ Radio-frequency Ablation			☐ Other		

2. In the past 3 months, have you worn graduated compression stockings? Yes / No

When did you first start?

Do you have a prescription?

3. In the past 4 months, have you taken the following for leg pain?

Frequency Taken:	≥3 times per week	≤2 times per week		≥3 times per week	≤2 times per week
☐ Ibuprofen / NSAIDs	☐	☐	☐ Vein Supplements (e.g. horse chestnut, etc.)	☐	☐
☐ Tylenol	☐	☐	☐ Topical creams	☐	☐
☐ Aspirin	☐	☐	☐ Other pain medication	☐	☐

Health History

Please list all other health conditions/ medical problems

Year	Condition/ Medical Problem

Please list all surgeries or major hospitalizations

Current Medications- *List your prescribed drugs and over the counter drugs such as vitamins and supplements*

Medication Name	Medication Strength	Frequency Taken

Are you taking Coumadin, Plavix or any other prescribed blood thinners? Yes / No

Are you taking any type of F hormones (HRT, estrogen, testosterone, birth control)? Yes / No

Allergies

Allergy & Reaction	Allergy & Reaction	Allergy & Reaction

Social History

Do you smoke? Yes / No how often?

Do you drink alcohol? Yes / No how often?

Family Health History

Is there a FAMILY history of spider or varicose veins? Yes / No

Is there a FAMILY history of DVT or blood clotting disorders? Yes / No

Is there a FAMILY history of leg ulcers related to vein problems? Yes / No

If yes to any of the above, please indicate who in your family has vein problems:

WOMEN ONLY

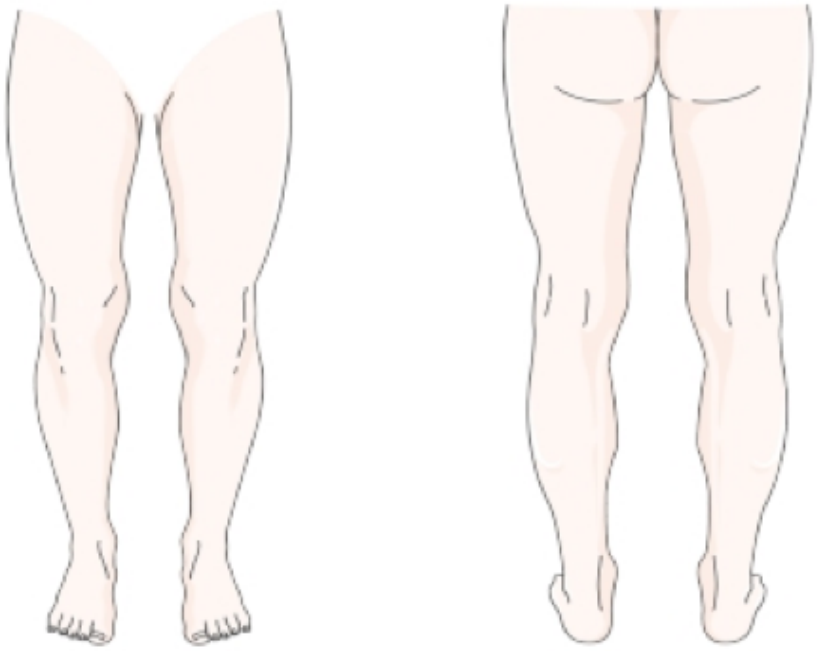
Number of pregnancies: Number of live births:

Are you currently pregnant? Yes / No Are you currently breastfeeding? Yes / No

Systems Review

Cardiovascular	Neurological	Hematological
☐ Congestive heart failure	☐ Migraine headache	☐ Blood clots
☐ Heart murmur	☐ Epilepsy/ Seizures	☐ Easy bruising or bleeding
☐ PAD	☐ TIA or Stroke	☐ Anemia
☐ Chest pain	☐ Fainting	☐ Malignancy: Type-
☐ MI (Heart Attack)	☐ Numbness	☐ Malignancy: Type-
☐ Vascular Surgery	**Dermatological**	**Infectious Disease**
☐ Heart or bypass surgery	☐ Eczema	☐ HIV +
Pulmonary	☐ Skin Rash	☐ Hepatitis B / C
☐ Shortness of breath	**Endocrine**	**Musculoskeletal**
☐ Asthma/ Wheezing	☐ Diabetes mellitus	☐ Fibromyalgia
☐ Cough	☐ Thyroid disease	☐ Muscle Pain

Please draw or shade the areas that are of concern to you



	VCSS	PROVIDER /MD TO FILL OUT			
Attribute	Absent (0)	Mild (1)	Moderate (2)	Right Leg	Left Leg
Pain	None	Occasional	Daily	☐	☐
Varicose Veins	None	Few	Multiple	☐	☐
Venous Edema	None	Evening only	Afternoon	☐	☐
Skin Pigmentation	None	Limited, old	Diffuse, more recent	☐	☐
Inflammation	None	Mild Cellulitis	Mod Cellulitis	☐	☐
Induration	None	Focal < 5cm	< 1/3 gaiter	☐	☐
No Active Ulcers	None	1	2	☐	☐
Active Ulcer Size	None	< 2 cm	2 – 6 cm	☐	☐
Ulcer Duration	None	< 3 months	3-12 months	☐	☐
Compression	None	Intermittent	Most Days	☐	☐

New Patient Registration Forms
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

This notice is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA). The Department of Health and Human Services established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, the law allows us to provide the minimum necessary information to only those we feel are in need of your health care information for treatment, payment or health care operations, in order to provide health care that is in your best interest. We will obtain written authorization form you for any other uses or disclosures of your health information. If you provide us with an authorization, you may revoke that written authorization in writing at any time, however we will not be able to take back any disclosures already made based on your original permission.

We also want you to know that we support your access to your personal medical records. Except under certain circumstances, you have the right to inspect and copy your medical and billing records. If you ask for copies, we may charge you a fee for copying and mailing. If you believe information in your records is incorrect or incomplete, you may ask for a correction. Under certain circumstances, we may deny your request.

You have the right to ask for restrictions on the ways in which we use and disclose your medical information beyond those imposed by the law your request must be in writing. We will consider your request but are not required to accept it.

Your have the right to ask for a list of instances when we have disclosed your medical information for reasons other than your treatment, payment or health care options. Your request must be in writing and must state the time period from which you want to receive a list of disclosures the time period may not be longer than six years and may not include dates prior to April 14, 2003. A fee may be charged if you ask for this information more than once every twelve months.

We reserve the right to change privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, and updated notice will be posted and a copy will be made available to you.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

Printed Name:_____

Signature: _____

Date: _____

New Patient Registration Forms

Patient Financial Responsibility

Please read the following below, and initial next to each statement.

☐ 1. I acknowledge that payment is requested at the time of service, unless a PPO, Medicare or an approved insurance carrier that we bill directly, insures me or other arrangements have been made. We highly recommend you to check your insurance coverage prior to your visit to ensure eligibility and coverage.

☐ 2. I hereby authorize La Jolla Vein Care to apply for benefits on my behalf for covered services rendered. I also assign my benefits and request that all payments from my insurance company be made directly to La Jolla Vein Care.

☐ 3. I agree to assume responsibility of full payment pending any remaining balance that is not covered by my insurance company. This includes but not limited to any deductibles, co-payments, and services not covered by my insurance. La Jolla Vein Care requests that financial arrangements be made at the time of your first visit. La Jolla Vein Care accepts cash, personal checks, Vista, MasterCard, American Express, and Flex/ Health Spending Accounts. I understand that there will be a $35.00 charge on all returned checks.

☐ 4. I certify that the information I have reported with regard to my coverage is correct. I further authorize La Jolla Vein Care to release to my insurance company and its agents any information related to this or any claim.

☐ 5. I acknowledge that three months without requested payment, my account will be sent to a collections department. Should collections be necessary, I understand that I am responsible for payment to the physician on demand, including reasonable attorney fees, incurred in collection payments due from patient services performed under this agreement.

☐ 6. I understand that although my insurance may approve any prior authorizations requested, they do not guarantee payment for any services rendered. If my insurance denies payment on any approved prior-authorization, I acknowledge that I am solely responsible for payment on any services rendered.

☐ 7. La Jolla Vein Care strongly advises you to check your insurance benefits prior to your appointment. We cannot provide you with information regarding out of pocket expenses when billing insurance. If you have any questions or concerns regarding your benefits and eligibility, please contact the member services department through your insurance carrier.

☐ 8. Please have your insurance cards and picture ID available to photocopy at the time of your visit. If we do not have an up-to-date insurance card on file, we will be unable to bill your insurance and you will be responsible for service fees at the time of your visit.

I, _____ acknowledge that I have read and fully understand the following statement above by signing at the line provided below.

_____ _____

Signature Date