Elmore Medical
Vein & Laser Treatment Center
The Central Valley's Vein Experts Since 1990

MARIO H. GONZALEZ, M.D.

A MEMBER OF SANTÉ FOUNDATION MEDICAL GROUP
& PART OF SANTÉ HEALTH FOUNDATION

____has an appointment

on ____________________ at __________ ❑ am ❑ pm for evaluation of varicose veins.

Please fill out the enclosed forms and mail them back to us in the envelope provided as soon as possible.
Your consultation cannot take place until you have returned these forms with your signature.

1. Your initial evaluation will be done by Mario H. Gonzalez, M.D., and/or Ellen Kahn, RN, FNP. Dr. Gonzalez is a Diplomate of the American Board of Venous & Lymphatic Medicine and also a Board Certified Surgeon. Ms. Kahn is a Family Nurse Practitioner with specialized training in venous and lymphatic medicine. Dr. Gonzalez will be reviewing all charts and performing all medically necessary vein procedures.

2. YOUR CONSULTATION VISIT WILL TAKE ABOUT 1-2 HOURS. You will see a ten minute DVD that discusses the venous system and the treatment of varicose veins. You will have a thorough examination of your veins. Photographs may be taken since they are sometimes requested by the insurance companies.

3. A test to check for abnormal flow in your veins will need to be performed during your consultation or at another scheduled visit, especially in patients with bulging venous varicosities. This test is brief and painless and will be carefully explained to you. Additional cost may be incurred if the test is performed, which can be billed to most insurance plans.

4. The plan for your treatment will be presented to you prior to any recommended treatment or procedure. This will include the anticipated number of visits, the sequence in which the veins will be treated, and an estimate of the cost to you. Please understand that because every patient is unique, your actual treatment may not follow the anticipated plan exactly.

5. If you have large varicosities, your treatment will be performed by Dr. Gonzalez. If you have spider veins, your treatment will be performed by Joan Hill, RN or Ellen Kahn, RN, FNP. Mrs. Joan Hill has nearly 20 years of experience with the diagnosis and treatment of varicose veins and cosmetic spider veins. She has been treating spider veins since 2003.She has been an active member of the American College of Phlebology since 2005. Ms. Ellen Kahn is also skilled and experienced with the diagnosis and sclerotherapy of varicose and spider veins.

6. Cost of Treatment: The expected (estimate) cost will be carefully explained to every patient prior to scheduling any recommended treatment. Every insurance plan has a different set of rules about how treatments can be billed and how much they will pay. Patients will be expected to pay for treatment of veins that are determined cosmetic by insurance companies.

7. You are expected to pay at the time of each visit for the service rendered that day (co-pays and co-insurance for insured patients; payment in full for cash patients.) The office accepts VISA, MasterCard, American Express, Discover and Care Credit. Because insurance companies do not pay for the treatment of cosmetic veins, the office will not submit insurance claims for treatment of these veins. There will be a $25.00 returned check fee.

8. The Elmore Medical Vein and Laser Treatment Center was established in 1990. Our office offers the full spectrum of treatment options for your venous problems. We hope your experience at our office will be pleasant and enjoyable. We expect you to be well informed about your particular venous condition and the plan of treatment. We encourage you to ask questions of our staff at any time. We are dedicated to providing you with the highest quality and most up-to-date treatment of venous disease that is currently available.

Please Note: If your insurance requires a referral from your primary care doctor (if you have an HMO plan) you must make certain the referral is in our office before your scheduled appointment.

Signature ______________________________________ **Date** ______________

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PATIENT INFORMATION (please print) Race: ❑Caucasian ❑Hispanic ❑Other________________________

Name ____ ❑Male ❑Female Date of Birth ____________

Address ____ City _______________________ Zip __________

Home Phone #____________________ Cell Phone # ___________________ Email ________________________________

Marital Status: ❑Married ❑Single ❑Widowed ❑Divorced Preferred Language: ___________________________

Name of Spouse __________________________ Spouse's Phone # ________________ Spouse's Date of Birth: ________

Employment Information
(If patient is a minor, please give parent's information)

Patient's (Parent's) Employer ____ Work Phone # ________________

Employer's Address ____City _________________ Zip ________________

Spouse's (Parent's) Employer ____ Work Phone # ________________

Employer's Address ____City _________________ Zip ________________

Other Contact
(Nearest relative not living with you or friend to contact if necessary)

Name ____ Relationship ___________________ Phone # _____________

Referred by ____

Primary Care Physician ____ Phone # ______________

Address ____ City _____________________ Zip _________

Insurance Coverage

Insurance Company __________________________________ Provider Benefits Phone # _________________________

Policy Holder ___________________________ ID/Subscriber # _________________________ Group# ________________

Billing Address ____

2nd Insurance Company _________________________________ Provider Benefits Phone # _______________________

Policy Holder ___________________________ ID/Subscriber # _________________________ Group# ________________

Billing Address ____

I hereby authorize/request payment of my insurance benefits directly to Elmore Medical Vein & Laser Treatment Center. A photocopy of my signature shall be considered as the original. I understand that the patient is responsible to pay for all fees, regardless of insurance coverage. I give permission for my medical records necessary to process claims to be released to my insurance carrier(s).

Signature ____ **Date** ____________________
(Insured or authorized person)

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HEALTH INFORMATION (please print)

Name ____ Age ______ Height _____ ft. ____ in. Weight _______ lbs.

When did you first notice enlarged veins, pain or swelling? ________________________________

What is your occupation ____________________________ How many hours spent standing daily? ____ sitting? ____

Is one leg worse than the other? ❑ right ❑ left ❑ same

Have you had any surgery or injury to your legs, with swelling? ❑Yes ❑No

Please check all that apply

- Leg pain ❑
- Aches/discomfort ❑
- Pressure/congestion ❑
- Swelling? ❑R ❑L ❑
- Itching ❑
- Appearance ❑

Have you ever had these issues?

- Clots in legs (phlebitis) ❑
- Deep vein thrombosis ❑
- Lung clot (embolus) ❑
- Leg/ankle ulcers ❑
- Discoloration of skin on legs ❑
- Have you taken blood thinners? ❑
- Currently on blood thinners? ❑

Females only: Check box if "yes"

- Are you pregnant? ❑
- If so, due date? ____________
- Are you breastfeeding? ❑
- Currently taking hormones? ❑
- Currently on birth control pills? ❑
- Number of pregnancies? ________
- Number of deliveries? ________
- Dates of delivery? ________
- Pressure or heaviness in pelvic area? ❑Yes ❑No

List all operations, hospitalizations, or serious illnesses, including previous vein treatments: Dates:

____ __________

____ __________

List all allergies: *(No allergies? Write "none")*________________________________

Have you ever had previous injection therapy of your veins? ❑Yes ❑No Dates________________

Results of treatment: ________________________________

Have you had any vein treatment? ❑Yes ❑No Dates________________________

Results of treatment: ________________________________

Blood-related family members with vein problems: ________________________________

Do you have, or have you ever had any of the following? (If yes, please check the box and list the dates)

Condition		Dates	Condition		Dates
			Asthma (Is it controlled? ❑Yes ❑No)	❑	________
Diabetes	❑	________	Heart disease or heart attack	❑	________
Cancer type:________	❑	________	Migraine (aura? ❑Yes ❑No)	❑	________
Thyroid disease	❑	________	Easy bruising or free bleeding	❑	________
Jaundice or hepatitis	❑	________	Bleeding or clotting disorder	❑	________
High blood pressure	❑	________	Major injury or surgery on your legs	❑	________

If you have high blood pressure, it is controlled with medication? ❑Yes ❑No

Have you ever smoked? ❑Yes ❑No Still smoking? ❑Yes ❑No Chewing tobacco? ❑Yes ❑No

How much? ________________ How long? ________________ When did you quit? ________________

Do you exercise? ❑Yes ❑No How often? ❑Frequently ❑Seldom ❑Rarely ❑Never

Do you drink alcohol? ❑Yes ❑No How often? ❑Frequently ❑Seldom ❑Rarely ❑Never

In the past year, have you consumed more than 4-5 drinks in one occasion? ❑Yes ❑No If yes, how often? __________

Have you had a flu shot this season? ❑Yes ❑No If not, why? ❑Allergy ❑Refusal

Have you had a pneumonia vaccination? ❑Yes ❑No

Have you ever completed an Advanced Directive or Durable Power of Attorney for Healthcare? ❑Yes ❑No

If yes, please list the person you have appointed to make your healthcare decision: ________________

Signature ________________________________ **Date** ______________

(Insured or authorized person)

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POSSIBLE INSURANCE REQUIREMENTS PRIOR TO TREATMENT

- Some insurance companies are requiring that **patients have a trial of conservative or alternative therapies**, such as support stockings, exercise and leg elevation for a 3-6 month period before they will consider payment of recommended varicose vein treatments.
- *This can be any **cumulative** 3-6 month period in your life.*
- If you have not tried support stockings, you may want to begin wearing them prior to your initial visit with us, Wal-Mart, JCPenney, and most drug stores carry support stockings/socks that may fulfill this requirement.

Please answer the following questions in detail to help us obtain the necessary pre-certification from your insurance company for treatments that may be required. ***If you have not tried the conservative treatment for the required time as dictated by the insurance company, it may be necessary to delay your treatment until you have tried the alternative therapies.*** Please note that **pre-certification is not a guarantee of payment**, but a requirement prior to treatment by most insurance companies.

SUPPORT STOCKINGS

In your entire lifetime, have you ever tried/worn Support Stockings? ❑ YES ❑ NO

In all, **how long** did you wear support stockings? ________YEARS (How many?) ________MONTHS (How many?) ________DAYS (How many?)

What were your results of wearing stockings?____

EXERCISE AND LEG ELEVATION

Have you tried exercise or elevation of your leg(s)? ❑ YES ❑ NO

How long did you try leg elevation? ________YEARS ________MONTHS ________DAYS

How long did you try exercise? ________YEARS ________MONTHS ________DAYS

Was this helpful for your leg(s)?____

OTHER PREVENTATIVE MEASURES

Massage ❑ YES ❑ NO For how long? ______YEARS ______MONTHS ______DAYS
Diuretics ❑ YES ❑ NO For how long? ______YEARS ______MONTHS ______DAYS
Weight Loss ❑ YES ❑ NO For how long? ______YEARS ______MONTHS ______DAYS
Do you try to avoid prolonged sitting and/or standing for long periods? ❑ YES ❑ NO
Were any of these measures helpful for your leg(s)? ❑ YES ❑ NO

Do you have any of the following symptoms associated with your legs while sitting, or after standing and walking, especially at the end of the day? ❑ Aches & Discomfort ❑Swelling ❑Itching ❑Heaviness in legs ❑ None

Do you take medication for your leg pain or leg swelling? ❑ YES ❑ NO

If yes, what medications(s) do you take? ____

If yes, how long have you used medication? ______YEARS ______MONTHS ______DAYS

Check boxes of activities that you have to limit or sit down, because your legs become tired, ache, hurt, throb or feel heavy:

❑ Doing dishes ❑ Exercise ❑ Mowing the Lawn ❑ Dancing ❑ Walking
❑ Housework ❑ Standing at work ❑ Yard Work ❑ Shopping ❑ Hiking
❑ Vacuuming ❑ Sitting at work ❑ Climbing Stairs ❑ Running ❑ Other ______________
❑ NONE OF THESE APPLY

Patient Name (please print): ________________________________ Date of birth: ____________

________________________________ ________________________________
Patient Signature Date

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PATIENT'S DAILY MEDICATIONS

Date:_________________________ Please include any prescribed or over the counter medications.

Patient's Name: ____ **Date of Birth**:___________

Pharmacy:____________________________ **Location**:_______________________ **Ph#**:__________

☐ **CHECK BOX IF YOU DO NOT TAKE ANY MEDICATIONS/SUPPLEMENTS ON A DAILY BASIS.**

DRUG NAME	DOSAGE/mg.	FREQUENCY	PRESCRIBING MD	REASON YOU TAKE THIS?

Med List Reviewed
❑_______________
❑_______________
❑_______________
❑_______________
❑_______________
❑_______________
❑_______________
❑_______________

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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
PATIENT CONSENT FORM

To our patients: We appreciate your indulgence with these consent forms which are now required by new Federal regulations.

The Health Insurance Portability and Accountability Act has been established to help ensure that personal health information is protected for privacy and to provide a standard for health care providers to obtain their patients' consent for uses and disclosures of health information about the patient in order to carry out treatment, payment, and office procedures related to your health care.

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, we provide necessary information to those involved in your health care in order to provide health care that is in your best interest. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act. We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

We also want you to know that we support your full access to your personal medical records. You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in this document, at some future time you may in writing revoke this consent. You may not revoke actions that have already been taken which relied on this or previously signed consent. You have the right to request a copy of the full privacy practices notices.

I give my consent to have my picture taken at the beginning and during the course of my treatment. I understand that pictures will be used to assess and monitor the progress of my treatment, to provide proof of medical necessity to my insurance company, and may be used without my name for educational, teaching and promotional purposes.

I give my consent to Elmore Medical Vein & Laser Treatment Center to call or text (SMS message) in advance or receive a post-card reminder in the mail to remind me of my upcoming appointment, or to call to discuss test results, treatment plans, etc. You may try to reach me at home or at work. If I am not available to answer the phone I would like an employee of Elmore Medical Vein & Laser Treatment Center to text or leave me a brief message reminder. I am aware that if I do not appear at a scheduled appointment which I have not canceled with twenty-four hours advance notice; I can and may be billed $50.00.

I give my consent to have a summary of my evaluation and results of my testing and treatment sent to my primary care physician and other physicians involved in my healthcare.

Patient Signature:____________________________ Printed Name:________________________ Date:_________

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Spider Vein Treatments are considered cosmetic and most insurance companies will not cover these treatments. Elmore Medical will not bill insurance for any spider vein treatments. I understand that I am responsible for payment in full at the time of treatment, for cosmetic treatments. If for any reason my insurance should reimburse any portion of this treatment, Elmore Medical will promptly reimburse me what insurance pays, but will not accept that amount as payment in full.

This also applies to compression stockings. As a courtesy and convenience to our patients we provide compression stockings at a reasonable price. Elmore Medical does not bill insurance for stockings as some insurance companies allow less than our purchase price of the stockings. If insurance reimburses a portion of these stockings to Elmore Medical, we will reimburse the patient what insurance pays, but will not accept that amount as payment in full.

____ ______________________________

Patient Signature Date

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Dear Patient,

We kindly ask that you have **no lotion** on your legs when you come in for your consultation and treatments.
If you have lotion on your legs, it makes the ultrasound a more difficult process and may interfere with the ultrasound reading.
Thank you for your cooperation.

Mario Gonzalez, M.D.
Elmore Medical

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 CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entitles that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include surgeries, follow-up care, administering medication, etc.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your medical health plan for your medical services.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities. Auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care who assist in taking care of you. We will use and disclose your protected health information when we are required to do so by federal, state or local law. We may disclose your protected health information to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your protected health information if requested by a law enforcement official for any circumstance required by law. We may release your protected health information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directions to perform their jobs. We may release protected health information to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your protected health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your protected health information if you are a member of U.S. or foreign military forces (including veterans) and if required

by the appropriate authorities. We may disclose your protected health information to federal officials for intelligence and national security activities authorized by law. We may disclose protected health information to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose protected health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official. Disclosure for these purposes would be necessary: (a) for the Institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your protected health information for workers' compensation and similar programs.
Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect and copy your protected health information.
- The right to request an amendment to your protected health information.
- The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices or to file a complaint, please contact:
Elmore Medical Vein & Laser Treatment Center
Attn: Privacy Officer
7131 N. 11th Street, Suite 101
Fresno, CA 93720
(559)435-0717

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)

ELMORE MEDICAL VEIN & LASER TREATMENT CENTER
Mario H. Gonzalez, M.D.
7131 N. Eleventh, Suite 101
Fresno, CA 93720
(559)435-0717

We are located near Cedar and Herndon. Heading north on Cedar, Eleventh Street is the FIRST SIGNAL LIGHT north of Herndon. (If you get to Spruce, you've gone too far) LEFT on Eleventh, we are the second office building on the right hand side.