SAN FRANCISCO
VEIN & VASCULAR INSTITUTE
A BASS Medical Group Affiliate

Daniel R. Nathanson, MD
Marc A. Levine, MD
Michael S. Hong, MD
Jennifer Nathanson, NP

PATIENT REGISTRATION FORM

Name: _____, _____ Date of Birth ____/____/_____
(Last Name) (First Name)

Address: _____
(Street) (Apt #) (City) (State) (Zip Code)

Home#: _____ Cell#: _____ Fax#: _____ Email: _____

Driver's License #: _____ Gender: _____ Marital Status: _____

Occupation: _____ Work Phone#: _____

Employer: _____ Address: _____

Emergency Contact: _____ Relationship: _____ Phone#: _____

Primary Care Physician: _____

Nephrologist: _____ Cardiologist: _____

Dialysis Location: _____ Dialysis Date(s): _____

PRIMARY INSURANCE:

Insurance Company: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____ Relationship to Subscriber: _____

SECONDARY INSURANCE:

Insurance Company: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____ Relationship: _____

PLEASE PRESENT ALL OF YOUR INSURANCE CARDS TO THE FRONT DESK. IN ADDITION, HIPPA LAW REQUIRES WE VERIFY YOUR IDENTITY & MUST OBTAIN A COPY OF YOUR PHOTO I.D. FOR PLACEMENT IN OUR CHART.

Your co-payments are due at the time of your visit as per contract with your health plan. Your insurance will be billed by our Affiliate, Bay Area Surgical Specialist. All services that require payment are due on the date of service. Payment options are: Cash, Check or Credit Card.

Please review the backside of this form for our FINANCIAL AGREEMENT. Your signature is required on both pages.

Thank you for in trusting your care with our office. We look forward to assisting in your care.

_____ _____
Signature **Date**

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PATIENT HISTORY FORM

Date of Visit: _____ Referring Doctor: _____

Name: _____ Primary Care Doctor: _____

Date of Birth: ___/___/_____ Nephrologist: _____

Reason for visit: _____ Cardiologist: _____

Dialysis Center: _____ Dialysis Days: _____

MEDICATIONS

Please list all current medications, including vitamins:

Name of medication	Dose	Frequency

ALLERGIES

Please list all drug allergies:

Drug	Reaction

PAST MEDICAL HISTORY

Please check whether you have or have had any of the following conditions:

Diabetes	◯ Yes	◯ No	High cholesterol	◯ Yes	◯ No
High blood pressure/Hypertension	◯ Yes	◯ No	COPD/emphysema	◯ Yes	◯ No
Coronary artery disease	◯ Yes	◯ No	Asthma	◯ Yes	◯ No
Congestive heart failure	◯ Yes	◯ No	Stroke	◯ Yes	◯ No
Chronic renal failure	◯ Yes	◯ No	Dementia (e.g., Alzheimer's)	◯ Yes	◯ No
Atrial fibrillation	◯ Yes	◯ No	Parkinson's Disease	◯ Yes	◯ No
Cancer	◯ Yes	◯ No	Hepatitis B	◯ Yes	◯ No
Type: _____			Hepatitis C	◯ Yes	◯ No
Type: _____			HIV	◯ Yes	◯ No

Others:

NAME _____ **DOB** ___/___/_____

PAST SURGICAL HISTORY			
Please list all prior surgeries:			
Surgery	**Year**	**Surgery**	**Year**

FAMILY HISTORY			
Please answer the following questions about your family members:			
Father	◯Alive ◯Deceased	Age (or age at death):	Cause of death:
	Medical problems:		
Mother	◯Alive ◯Deceased		
	Medical problems:		
Sister	Please list any significant medical problems (if any):		
Brother	Please list any significant medical problems (if any):		
Family History	Please list any significant medical problems (if any):		
Additional Space for Family History:			

SOCIAL HISTORY		
Drinks Alcohol	Do you drink alcohol? ◯Yes ◯No	
	If Yes, how often? ◯Daily ◯Weekly ◯Monthly ◯Socially ◯Rarely	
	◯Beer ◯Wine ◯Liquor Amount?	When was your last drink?
Tobacco Use	Do you smoke? ◯Yes ◯No If Yes, how many packs per day?	
	How many years did you smoke?	What year did you quit?
Drug Use	Do you currently use recreational drugs? ◯Yes ◯No	Have you in the past? ◯Yes ◯No
	Have you ever used intravenous drugs? ◯Yes ◯No	
Caffeine Use	If Yes, what kind? ◯Coffee ◯Soda ◯Chocolate ◯Tea ◯Other?	
	How many cups? _____ How many sodas? _____	
Employment	Occupation (past or present):	
Social History	Marital Status: ◯Single ◯Married ◯Widowed ◯Divorced	
	Who lives in your home with you? _____	
	Do you have children? _____ If so, how many? _____	
Miscellaneous	Have you ever received a blood transfusion? ◯Yes ◯No	

NAME _____ **DOB** ___/___/_____

REVIEW OF SYSTEMS

Please check whether you have any of the following problems, either CURRENTLY or REPEATEDLY:

Constitutional
- Fever ◯Yes ◯No
- Headache ◯Yes ◯No
- Unexplained weight loss ◯Yes ◯No
- Other: _____

HEENT
- Runny Nose ◯Yes ◯No
- Difficulty hearing ◯Yes ◯No
- Other: _____

Neurologic/Psychiatric
- Numbness ◯Yes ◯No
- Tingling ◯Yes ◯No
- Weakness ◯Yes ◯No
- Dizziness ◯Yes ◯No
- Memory loss ◯Yes ◯No
- Seizures ◯Yes ◯No
- Anxiety ◯Yes ◯No
- Spinal cord injury ◯Yes ◯No
- Headache ◯Yes ◯No
- Difficulty sleeping ◯Yes ◯No
- Other: _____

Metabolic/Endocrine
- Excessive thirst ◯Yes ◯No
- Too hot ◯Yes ◯No
- Too cold ◯Yes ◯No
- Other: _____

Respiratory
- Shortness of breath ◯Yes ◯No
- Wheezing ◯Yes ◯No
- Cough ◯Yes ◯No
- Other: _____

Immunologic
- Hay Fever ◯Yes ◯No
- Food allergies ◯Yes ◯No
- Other: _____

Cardiovascular
- Chest Pain ◯Yes ◯No
- Irregular pulse ◯Yes ◯No
- Heart attack ◯Yes ◯No
- Heart valve problem ◯Yes ◯No
- Other: _____

Musculoskeletal
- Joint pain ◯Yes ◯No
- Back pain ◯Yes ◯No
- Artificial joints ◯Yes ◯No
- Other: _____

Gastrointestinal
- Abdominal pain ◯Yes ◯No
- Nausea/vomiting ◯Yes ◯No
- Indigestion/heartburn ◯Yes ◯No
- Diarrhea ◯Yes ◯No
- Constipation ◯Yes ◯No
- Other: _____

Hemotologic
- Easy bruising or bleeding ◯Yes ◯No
- Blood clots in arms or legs ◯Yes ◯No
- Anemia ◯Yes ◯No
- Other: _____

Vascular
- Cool Extremity ◯Yes ◯No
- Pain in limb ◯Yes ◯No
- Varicose Veins ◯Yes ◯No
- Other: _____

Genitourinary
- Back pain ◯Yes ◯No
- Cloudy urine ◯Yes ◯No
- Nausea ◯Yes ◯No
- Other: _____

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PATIENT CONSENT FORM

The U.S. Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal healthcare information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain healthcare providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment or healthcare 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 your privacy. When appropriate, we provide the minimum necessary information to only those we feel that are in need of your healthcare information. This includes information about treatment, payment, and/or healthcare operations in order to provide healthcare that is in your best interest.

We also want you to know that we support your fully supervised access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that interact only with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or healthcare operations.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, if you refuse to disclose your personal health information (PHI), we have the right to refuse to treat you. If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions, and to revoke consent in writing.

Print Name: _____ **Signature:** _____

Date: _____ **Witness:** _____

COMPLIANCE ASSURANCE INFORMATION FOR OUR PATIENTS

To our Valued Patients:

The misuse of personal health information (PHI) has been identified as a national problem causing patients' inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training to understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA), with particular standards of ethics and integrity in performing services for our patients.

It is our policy to determine appropriate use of PHI properly, in accordance with governmental laws, rules and regulations. We want to ensure that our practice never contributes in any way to the growing problems or improper disclosure of PHI. As part of this plan, we have implemented a compliance program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients, without any thought of penalization if they feel that an event is any way compromises our policy or integrity. More so, we welcome your input regarding any service problem, so that we may remedy the situation promptly.

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PATIENT OR RESPONSIBLE PARTY FINANCIAL AGREEMENT

I, the responsible party, certify that the information I have provided is true and correct to the best of my knowledge. I understand that I am financially responsible for all charges regardless of delays in insurance payment or denial of insurance coverage.

It is my responsibility to understand and personally verify with my insurance if the providers and/or practice is a contracted member with my insurance company as well as an In-Network provider.

I hereby authorize San Francisco Vein & Vascular Institute/Bay Area Surgical Specialists, Inc. to apply for authorization and receive payments directly on my behalf for medical services to be rendered. They may also disclose any, all or part of my clinical medical record to the insurance company covering my medical services for the purpose of satisfying charges billed.

I further agree to pay all collection costs, attorney fees and any other costs that may be incurred in the attempt to collect outstanding patient responsible debt.

I also understand, that if any insurance payments are sent directly to me, it is my responsibility to forward these monies directly to San Francisco Vein & Vascular Institute/Bay Area Surgical Specialists, Inc. immediately upon receipt.

I, the patient or the patient's representative, understand that all medical doctors at San Francisco Vein & Vascular Institute/Bay Area Surgical Specialists, Inc. are licensed and regulated by the Medical Board of California. I can verify this by contacting the Medical Board at (800) 633-2322 or via the internet at their website: www.mbc.ca.gov.

Signature of Patient, Parent or Legal Guardian	Relationship to Patient	Date

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PATIENT RESPONSIBILITIES

The purpose of this policy is to outline the patient's responsibilities regarding their appointments, cooperation and information provided for insurance claims as determined by rules and regulations.

- It is the patient's responsibility to know their patient's rights and responsibilities.
- It is the patient's responsibility to fully participate in the decision involving your healthcare and to accept the consequences of these decisions if complications occur.
- It is the patient's responsibility to report whether you clearly understand the planned course of treatment and what is expected of you.
- It is the patient's responsibility to keep your appointment, and when unable to do so, notify the facility and your physician in the appropriate timely manner.
- It is the patient's responsibility to provide caregivers with most accurate and complete information regarding present complaints, past illnesses and hospitalization, medication,unexpected changes in the patient's condition or any other health matters.
- It is the patient's responsibility to follow up on your physician's instructions, comply with treatment plans, take medication when prescribed and ask questions concerning your healthcare that you feel are necessary.
- It is the patient's responsibility to inform SFVVI of all medications and dosage currently taken or prescribed to them, including over the counter products as well as dietary supplement, and any allergies or sensitivities.
- It is the patient's responsibility to observe rules of the facility during your stay and treatment and, if instructions are not followed, forfeiting the right to the patient's care in the facility.
- It is the patient's responsibility to be considerate of others and the facility and to identify any patient safety concerns.
- It is the patient's responsibility to provide the facility with current insurance information and for promptly fulfilling your financial obligation to the facility.
- It is the patient's responsibility to provide the responsible adult to transport you from the facility and remain with you for 24 hours if required by the facility or physician.
- Patients are to behave respectfully toward all health care professionals and staff, as well as other patients and visitors.

Signature _____ Date/Time _____

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PATIENT RIGHTS

As a patient, you have the following rights regarding your treatment:

1. Receive safe, considerate and respectful care, without discrimination, and respect for your cultural, psychosocial, spiritual and personal values, beliefs and preferences; free from mental, physical, sexual or verbal abuse and neglect, exploitation or harassment.

2. Participate in and make informed decisions about your care and pain management, including being able to request or refuse treatment.

3. Have your condition, treatment, pain alternatives and outcomes explained in a manner that you understand. A patient who does not speak English shall have access to an interpreter service.

4. Be provided, to a degree known, complete information concerning your diagnosis, evaluation, treatment and prognosis. When it is medically inadvisable to give such information to you, the patient, the information is provided to a person designated by you or to a legally authorized person.

5. Expect timely and appropriate assessment and treatment of physical pain and emotional or spiritual discomfort.

6. Receive safe, high quality, medical care without discrimination that is compassionate and respects personal dignity, values, beliefs and preferences and contributes to a positive self-image. To be treated without fear of or infliction of mistreatment, neglect, verbal, physical, mental or sexual abuse.

7. Exercise your rights without regard to sex, race, color, religion, ancestry, national origin, age, disability, medical condition, marital status, sexual orientation, gender identification, and educational background, and economic status, source of payment for care or fear of reprisal.

8. Know the names and role of your caregiver (e.g., doctor, nurse, technician, etc). You have a right to request information and/or credentials about physicians providing your care. A list of public websites is available upon request.

9. Be fully informed of the scope of services available at the facility, provision for the after-hours and emergency care and related fees for services rendered and to be a participant in decisions regarding the intensity and scope of treatment.

10. Expect privacy in treatment and care and confidentiality of all communications and records and to approve or refuse the release of medical records to any individual outside our facility, except as required by law or contract.

11. Be informed of any human experimentation or other research/educational projects affecting his or her care or treatment and the right to refuse participation in such experimentation or research without compromise to the patient's usual care.

12. Refuse treatment to the extent permitted by law and be informed of the medical consequences of such a refusal. The patient accepts responsibility for the refusal of treatment or not following the instructions of the physician or facility. Patients may change physicians if not happy with the service provided by their current physician.

13. Formulate and be given an opportunity to receive information regarding advance directives. Regardless of the contents of any advance directive or instructions from health care surrogate or attorney, if an adverse medical event occurs during a patient's treatment, personnel will initiate resuscitative and/or stabilizing measures and further evaluation. If a copy of your advance directive was provided to us, it will be sent to the acute care hospital.

14. File a grievance. Each patient has the right to present complaints or grievance to any employee; by completing the Patient Satisfaction Survey, in writing or by calling:

Daniel R. Nathanson, Medical Director
San Francisco Vein & Vascular Institute
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One Daniel Burnham Court Suite 205C
San Francisco, CA 94109

The grievance committee will review each grievance and provide you with a written response within 10 days. The written response will contain the name of the person to contact at the facility, the steps taken to investigate the grievance, the results of the grievance process and the date of completion of the grievance process.

You have the right to file a complaint with the state Department of Public Health regardless of whether you use the facility's grievance process. Consumer complaint forms are available in English and Spanish upon request.

Medical Board of California
Central Complaints Unit
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
916-263-2424

You have the right to file a complaint with the California Board of Nursing regardless of whether you use SFVVI's grievance policy. A complaint form Is available upon request.

Board of Registered Nursing
Attn: Complaint Intake
PO Box 944210
Sacramento, CA 94244-2100
916-322-3350

ACKNOWLEDGEMENT

This acknowledges that you have received and read a copy of or Patients' Rights Notice. This document is not a contract, authorization, release, or consent form. This document will remain a part of your records.

SIgned _____ Date _____

PRINT NAME _____ Relationship To Patient _____

If person signing is not the patient, please note the name of Patient: _____

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IMPORTANT FACTS

Medications:

It is critical that we know ALL MEDICATIONS YOU TAKE. You must bring a Complete List of your medications that includes the following information: **1. Strength 2. Dose-how many you take daily**
If you are unable to provide a list of your medications you should bring all medications in a bag with you to your appointment with our office.

Insurance Information:

DO WE HAVE YOUR CURRENT INSURANCE CARD ON FILE?

You must bring all your Insurance Cards to EVERY appointment with our office. Many Insurance Plans require a Referral & Prior Authorization to see our doctors. **Our Office requires the referral & Prior Authorization before you come to the office.**

Your Treating Doctors:

Our office will require to have the NAMES of your treating doctors; Primary Care, Nephrologist, Cardiologist & Dialysis Center for our medical chart. The care you receive in our office is often coordinated with other doctors & it is important that we have those names and phone numbers. Please bring that information to your appointment.

HIPPA Guidelines:

Our office must follow the HIPPA Privacy Guidelines, therefore, we will verify your identity. Please bring a valid, current photo ID with you to your appointment with our office.