Elmore Medical
Vein & Laser Treatment Center
The Central Valley's Vein Experts Since 1990
MARIO H. GONZALEZ, M.D.

_____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., who is a Diplomate of the American Board of Venous & Lymphatic Medicine and also a Board Certified Surgeon.

2. YOUR CONSULTATION VISIT WILL TAKE ABOUT TWO 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, 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. 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, R.N. Mrs. Hill is skilled and experienced with the diagnosis and sclerotherapy of varicose veins and spider veins. She has been an active member of the American College of Phlebology since 2005.

6. Cost of Treatment: The expected cost will be carefully explained to every patient at the time of initial consultation. 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.

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** _____

7131 N. Eleventh, Suite 101 Fresno, CA 93720 Phone 559-435-0717 Fax 559-435-9105 Web: elmoremedical.com

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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:
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? _____
_____

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)

		Dates				Dates
Diabetes	❑	_____	Asthma (Is it controlled? ❑Yes ❑No)	❑	_____
Cancer type:_____	❑	_____	Heart disease or heart attack	❑	_____
Thyroid disease	❑	_____	Migraine (aura? ❑Yes ❑No)	❑	_____
Jaundice or hepatitis	❑	_____	Easy bruising or free bleeding	❑	_____
High blood pressure	❑	_____	Bleeding or clotting disorder	❑	_____
			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 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 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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CIVIQ 20 – SELF QUESTIONNAIRE

BEFORE TX ❑ 3-6 MOS. POST TX ❑

PATIENT NAME:_____ Today's Date:_____ MR#:_____

Many people complain of leg pain. We would like to find out how often these leg problems occur and to what extent they affect the everyday like of those who have them.

Below is a list of symptoms, sensations and types of discomfort that you may or may not be experiencing and which might make everyday life hard to bear to a greater or lesser extent. **For each symptom, sensation or type of discomfort listed, we'd like you to answer in the following way:**

Please consider whether you have experienced what is described in each sentence, and if the answer is "yes", how **intense** it was. There are five response options. Please circle the one which best describes your situation.

Circle 1= if the symptom, sensation of discomfort described does not apply to you.
Circle 2,3,4,5 = if you have felt it to a greater or lesser extent.

QUALITY OF LIFE WITH VENOUS INSUFFICIENCY

1. During the past four weeks, have you had any **pain** in your **ankles** or **legs**, and how severe has the pain been? *Circle the number that applies to you.*

No pain	Slight pain	Moderate pain	Considerable pain	Severe pain
1	2	3	4	5

2. During the past four weeks, how much trouble have you had at **work** or with **your usual daily activities** because of your leg problems: *Circle the number that applies to you.*

No trouble	Slight trouble	Moderate trouble	Considerable trouble	Severe trouble
1	2	3	4	5

3. During the past four weeks, have you **slept poorly** because of your leg problems, and how often? *Circle the number that applies to you.*

Never	Rarely	Fairly often	Very often	Every night
1	2	3	4	5

During the past four weeks, how much **trouble** had you had **carrying out the actions and activities** listed below **because of your leg problems**? *Circle the number that applies to you.*

	No Trouble	Slight Trouble	Moderate Trouble	Considerable Trouble	Could not do it
4. Remaining standing for a long time	1	2	3	4	5
5. Climbing several flights of stairs	1	2	3	4	5
6. Crouching/kneeling down	1	2	3	4	5
7. Walking at a brisk pace	1	2	3	4	5
8. Traveling by car, bus, plane	1	2	3	4	5
9. Doing certain jobs at home (e.g. standing and moving around in the kitchen, carrying a child in your arms, ironing, cleaning the floor or dusting the furniture, house projects.)	1	2	3	4	5
10. Going out for the evening, socially	1	2	3	4	5
11. Playing a sport, exerting yourself	1	2	3	4	5

Leg problems can also affect your spirits. How closely do you following statements correspond to how you have felt during the past four weeks? *Circle the number that applies to you.*

	Not at all	A little	Moderately	A lot	Completely
12. I felt nervous/tense	1	2	3	4	5
13. I got tired quickly	1	2	3	4	5
14. I felt I was a burden	1	2	3	4	5
15. I always had to be cautious	1	2	3	4	5
16. I felt embarrassed about showing my legs	1	2	3	4	5
17. I got irritated easily	1	2	3	4	5
18. I felt as if I was handicapped	1	2	3	4	5
19. I found it hard to get going in the morning	1	2	3	4	5
20. I did not feel like going out	1	2	3	4	5

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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

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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 <u>FIRST SIGNAL LIGHT</u> north of Herndon. (If you get to Spruce, you've gone too far) <u>LEFT</u> on Eleventh, we are the second office building on the right hand side.