



Jeffrey J. Gilbertson, MD, FACS
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Dear Patient:

Welcome to VeinCare.

You have been scheduled for an appointment with our physicians at one of our two locations:

1. Downtown Boise by St. Lukes, 333 N. 1st St. #280, Boise, ID 83702
2. Meridian VascularCenter, 977 S. Progress Way, Meridian, ID 83642.

If you are unsure of your appointment time, date or location, please contact our office by phone at (208) 333-8346.

In an effort to expedite the time you will spend in our office, please complete the following forms prior to your scheduled appointment. To avoid confusion and duplication of records, we ask that you complete the attached information sheets with your full legal name.

Please Note: If you use a name different than the one on your insurance card, please inform us. Also, if your legal name is hyphenated, please use it each time you contact our office....Thank you.

The following items will be needed for your initial appointment:

1. Patient Information and Consent Sheet.
2. Patient Health History Exam Form (*fully completed*).
If there is not enough room on the form, please attach a separate list of allergies, medications (include dosage amount and frequency) and/or your medical and surgical history, if necessary.
3. Authorization to Release Medical Records (*fully completed*)
4. All insurance cards (*primary and all secondary coverage*)
5. Picture identification card

If you have other questions about the forms or about your scheduled appointment, please call (208) 333-8346. If you are unable to keep your scheduled appointment, please call to cancel or re-schedule.

Thank you,

The Staff at VeinCare

333 North First Street, Suite 280, Boise, ID 83702
Phone 208-333-8346 Fax 208-345-1213 Billing 308-342-1108

A division of Cardiovascular & Chest Surgical Associates, P.A.

www.cardvasc.com/veincare



333 North 1st Street, Suite 280
Boise, ID 83702
208-345-6545

PATIENT INFORMATION AND CONSENT

Date _____ Doctor _____ Account # _____

Last Name _____

Social Security # _____

First Name _____

Sex _____ (M)ale (F)emale

Address _____

Marital Status:

Single Married Divorced Separated Widow Minor

City _____ State _____ Zip _____

Home Phone () _____

Employer _____

Work Phone () _____

Family Physician _____

Cell Phone () _____

Referring Physician _____

e-mail _____

Emergency Contact _____

Date of Birth _____

Relationship _____ Phone _____

If married, Spouse's Name _____

BILLING INFORMATION

Do you have medical insurance? Yes No

PRIMARY INSURANCE COMPANY

SECONDARY INSURANCE COMPANY

Name _____

Name _____

Address _____

Address _____

ID # _____

ID # _____

Group # _____

Group # _____

Subscriber _____

Subscriber _____

Birth Date _____

Birth Date _____

Responsible Party _____

Phone _____

As patient or legal guardian of patient, I agree to be fully responsible for all charges for services rendered. I authorize my doctor or his agent to submit claims to Medicare or my insurance carriers for charges incurred. I authorize my Medicare or insurance benefits to be paid directly to the doctor. I understand that there is a possibility of non-coverage by my insurance companies or Medicare. If they determine that any service is deemed "medically unnecessary" I agree to assume responsibility for denied payment. I further authorize this office to obtain and release my medical records to and from other physicians. Medical facilities, insurance companies and Medicare to facilitate my health care and appropriate payments.

Signature _____

Date Signed _____

Name _____

Age _____

MEDICAL HISTORY

Do you now or have you ever had any of the following (circle):

- | | | |
|---------------------|------------------------|----------------|
| Heart disease | Bleeding disorders | Stomach ulcers |
| High blood pressure | History of blood clots | Lupus |
| Diabetes | Asthma | Arthritis |

Have you ever worn prescription strength compression stockings? Yes No Duration: _____

Do you have any medical conditions not listed above? (Please explain)

SURGICAL HISTORY

Operation	Year	Operation	Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY

Do any members of your immediate family have, now or in the past, any of the following conditions?

	Relationship
High blood pressure	_____
Heart disease	_____
Stroke	_____
Diabetes	_____
Varicose Veins	_____
Blood clots in legs or lungs	_____
History of anesthetic complications	_____

PERSONAL HABITS

Have you ever smoked?	Yes	No	Do you regularly drink alcohol?	Yes	No
# of years smoked?	_____		Beer/Wine:	_____	drinks per week
# of packs per day	_____		Liquor:	_____	drinks per week
# of years since you quit?	_____				

Occupation: _____

MEDICATIONS

List all medications you currently take

<u>Brand name</u>	<u>Dosage & Frequency</u>	<u>Brand name</u>	<u>Dosage & Frequency</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any allergies to medications? Yes No **If yes, please list below**

<u>Medication</u>	<u>Explain reaction</u>
_____	_____
_____	_____
_____	_____

SYSTEMS REVIEW

Normal Weight _____ lbs. Any recent change in weight? Yes No

Please circle any signs or symptoms that apply to you

Skin:

- Moles that have changed appearance
- Easy bruisability
- History of skin cancer
- Non-healing sores

Cardiovascular:

- Chest pain
- Rapid heart rate or palpitations
- High cholesterol

Respiratory:

- Shortness of breath
- Chronic cough
- Wheezing

Neurologic:

- Dizziness
- Difficulty with coordination
- Numbness or loss of sensation

Extremities

- Pain or stiffness in joints
- Cramps in legs with walking
- Swelling in ankles

Women Only:

- How many times have you been pregnant? _____
- How many children? _____
- Are you now taking birth control pills? Yes No
- Could you be pregnant now? Yes No

Name:

CARDIOTHORACIC & VASCULAR ASSOCIATES

FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

Dear Patient:

Thank you for choosing the physicians at Cardiothoracic & Vascular Associates as your healthcare provider. We appreciate the opportunity to provide you with professional specialized care.

The following is our financial policy. We believe having financial matters clear from the onset is preferable to encountering difficulties later on. If you have any questions or concerns about our payment policies, please do not hesitate to talk with our billing department.

Payment for services is due at the time service is rendered. We accept cash, checks, debit cards, MasterCard, Visa and Discover. We will submit an insurance claim on your behalf if we have all your insurance information. If your insurance carrier changes, please notify the Billing Department immediately.

You must understand the following:

1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you—not your insurance company. Please make sure our receptionist has all of your correct information on file when you sign in at each visit.
2. Prior to your surgery you will meet with our patient representative to review your surgical charges. Please understand this is only an estimate and your procedure could change once the physician begins the surgery. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Fees for these services, along with unpaid deductibles, coinsurance and co-payments, are due at the time of treatment.
3. You are responsible for knowing your insurance benefits. Does your insurance require a referral? Do our physicians participate in your plan? What facilities participate in your plan? If we can be of any assistance, please let us know and we will be happy to help you.
4. Accounts not paid within 90 days may be forwarded to a billing company where additional fees may be accrued.
5. CVA reserves the right to charge a \$20 service fee for checks returned due to insufficient funds.
6. If you have inadequate or no insurance coverage, advance planning for payment before surgery will be required. The fee for surgery will normally include your postoperative office visits for a period up to 90 days.
7. You are responsible for any and all collection fees, legal fees and court costs associated with efforts to collect payment on your account.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems with our Billing Department so that we can assist you in the management of your account.

Print Patient Name

Date

Patient Signature