LaserLight
VEIN TREATMENT CENTER

Joel S. Erickson, MD

Welcome to Laser Light Treatment Center

Your appointment is on _____.

In: Santa Rosa

830 Second Street, Suite A.
Santa Rosa, CA. 95404
707-757-9363

Novato

165 Rowland Way, Suite 308
Novato, CA. 94945
415-892-9550

This form is to introduce you to our facility and to help us better serve you.

Please fill out the following:

Name _____.

Preferred phone number to confirm your appts or call back? _____.

Can we leave a message at this number? _____.

EMAIL for promotions and newsletter: _____.

Occupation:_____.

How did you hear about us? Please be specific._____.

_____.

_____.

Please advise any additional requests for privacy below:

_____.

Your treatments at Laser Light Treatment Center are reserved exclusively for you. Please kindly give us 24 hours' notice before your scheduled appointment if you need to cancel or reschedule to avoid being charged $50.00.

Signature: _____.

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Last Name:	**First Name:**	**MI:**
Address:		
Date of Birth:	**Height:**	**Weight:**
Occupation:	**Marital Status:**	**Durable Power of Attorney?** Y or N
EMERGENCY CONTACT: (Name and Number)		
Exercise Habits (Pick one):	Sedentary Occasional	Regular
Alcohol Intake (Pick one):	None Rare Occasional	Daily or Regularly
DESCRIBE YOUR SMOKING HABITS (cigarettes and others):		
ALLERGIES TO DRUGS AND CHEMICALS (list):		
MEDICATIONS (List of drug names or attach list if preferred):		
MAJOR INJURIES OR OPERATIONS (LIST):		

RECENT HEALTH ISSUES (LAST 6-12 MONTH	**YES**		**PAST MEDICAL HISTORY**	**YES**
Visual Loss			Coronary Artery disease	
Hearing Loss			Heart arrythmia	
Blood clots in legs			Valve or other heart disease	
Coughing up blood			Lung disease	
Vomiting blood			Sleep apnea	
Blood in stool			Tuberculosis (TB)	
Constipation or Diarrhea			Peptic ulcer disease	
Blood in urine			Arthritis (any type)	
Headaches			Degenerative disk disease	
Sleep disturbances			Spinal Stenosis	
Edema			Eye problems	
Joint or back pains			Prostate disease	
Unexplained weight loss			Kidney disease or stones	
Blood transfusion or anemia			Thyroid disease	
Swollen Lymph nodes			Cancer (if yes, type?)	
Rashes			Depression	
Emergency Room Visit			Stroke or TIA	
Nose or Gum Bleeding			Carotid or other artery disease	
Chest pain or short of breath			Other disease	
Palpitations				
Leg pain				

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PAYMENT POLICY --- READ, THEN SIGN THREE TIMES ON NEXT PAGE

Your health insurance policy is an agreement between you and your insurance company. The policy lists a package of medical benefits such as tests, drugs, and treatment services. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. You are encouraged to email or call our insurance specialist, Edy Powers: edy@laserlight.org or 415-892-5550. Upon your request, we will review what your plan covers and estimate what portion will be your financial responsibility.**

1. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

2. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

3. **Proof of insurance.** All patients must complete our patient information form **before** seeing the doctor. We must obtain a current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

4. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

5. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

6. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

7. **Missed appointments.** Our policy is to charge $50.00 for missed appointments not canceled within 24 hours of your appointment time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions/concerns.

Signatures are required on the ~~back~~ next of this page

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CONSULTATION POLICY: Dr Erickson charges a fee for his initial evaluation of venous disease. Therefore, you must decide if you wish to use your insurance benefits for payment of fees charged for your initial evaluation. Your other option is to pay, in advance, an agreed-upon fee for the evaluation.
If you choose to not use your insurance benefits: Dr Erickson, upon completion of the evaluation, will discuss findings with you and present you with a written "Vein Treatment Plan" that states the services that he will provide to you and the price of these services.
If you choose to use your insurance benefits: Dr. Erickson, upon completion of the evaluation, will advise you if your insurance benefits are likely to be authorized to pay for treatments. Insurance authorization policies require written reports and specific ultrasound measurements of the veins, which takes extra time and effort. Your insurance carrier will be billed for Dr Erickson's consultation and ultrasound evaluation.

I have read and understand the payment policy and the consultation policy:

X_____ _____
Signature of patient or responsible party **Date**

Name of Insured: _____
ID or SSN: _____
Primary Insurance: _____
Secondary Insurance: _____

Assignment of Benefits:
I authorize payment of medical benefits to Joel S. Erickson, M.D., Inc, for services provided at Laser Light Treatment Center. This assignment will remain in effect until revoked by me in writing.

X_____ _____
Signature of patient or responsible party **Date**

Release of Information
I authorize the release of any medical information necessary to process insurance claims and I understand that a copy of my original signature is acceptable and remains in effect until revoked by me.

X_____ _____
Signature of patient or responsible party **Date**

HIPAA PRIVACY POLICY

READ AND SIGN BELOW

At the practice of Joel S. Erickson, M.D., your privacy is a very important part of our mission and plays a very big factor in your experience. Dr. Erickson and his staff adhere to the highest standards of respecting and protecting patient privacy and confidentiality of your health care information. Additionally, the team complies with all state and federal regulations regarding the privacy of individual healthcare information, in accordance with HIPAA Health Insurance Portability and Accountability Act.

As of April 14th, 2003, we are required by law to offer you a copy of the "Notice of Privacy Practices" regarding your Personal Health Information (PHI). Please request this document at anytime.

Your PHI, also known as your medical record, serves as:

- Basis for planning your care and treatment(s)
- Means of communication among the many healthcare professionals who contribute to your care
- Legal documents describing the care you received
- Means by which you or a third-party payer can verify that services billed were provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of the state and the nation
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

The "Notice of Privacy Practices" details the following:

- How we may use/disclose your PHI to carry out treatment, payment or health care operations
- How you may request copies of your healthcare information
- How you may verify the accuracy of this information
- How you may request an accounting of certain external disclosures of your PHI.

I understand that as a part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure of these permitted uses, included disclosures via fax.

Please acknowledge that you have been offered a "Notice of Privacy Practices" by signing below:
"I have been offered a "Notice of Privacy Practices" by the office of Joel S. Erickson and I understand and accept these terms of this consent.

_____ _____

Patient or Responsible Person Sign & Print ***Date***