CHUBACK VEIN CENTER
A TRADITION OF EXCELLENCE IN VEIN CARE

New Patient Demographics

Full Name: _____Date of Birth: _____ Gender: _____

Address:_____City:_____State_____Zip_____

Home Phone: _____ Cell Phone: _____ Marital Status:_____

Email Address:_____ Receive appointment reminders? [ ] YES [ ] NO

Spouse/Next of Kin Name: _____ Number: _____

Emergency Contact: _____ Number: _____

Primary Insurance: _____ Group No: _____ Member ID: _____

Guarantor's Name: _____ Guarantor's DOB: _____

Insurance Address: _____

Secondary Insurance: _____ Group No: _____ Member ID: _____

Guarantor's Name: _____ Guarantor's DOB: _____

Insurance Address: _____

Primary Care Physician: _____ Phone No: _____

Primary Care Physician Address: _____

Referring Physician (*if any*): _____ Phone No: _____

Referring Physician Address: _____

Preferred Pharmacy: _____ Phone No: _____

Who can we thank for your visit: _____

Signature: _____ Date: _____

John Chuback, MD, RVI, RPVI, RPhS, FACS
Diplomate American Board of Surgery - Diplomate American Board of Thoracic Surgery - Diplomate of American Board of Phlebology
205 Robin Road, Suite 333 - Paramus, NJ 07652
t (201) 261 1772 - f (201) 261 1776
www.chubackveincenter.com

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Please select your reason for today's visit

Also, any other concerns that apply to you:

□ Unsightly Varicose Veins
□ Unsightly Spider Veins
□ Suspicious Lesions
□ Facial Lines and Wrinkles
□ Facial Volume Loss
□ Thin Lips
□ Excessive Sweating
□ Eyelash Enhancement
□ Facial Rejuvenation

□ Other:_____

Here at Chuback Vein Center, we are passionate about helping you improve your total health and well-being.
Together we can achieve a new, incredible you.

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Patient Medical History

Patient Name: _____ Date: _____

Medical History (*place X where applicable*)

____ High blood pressure ____High cholesterol ____Coronary Artery Disease____ Deep Vein Thrombosis ____ Stroke

____ Renal Insufficiency Syndrome ____ Diabetes ____ Thrombophlebitis ____ Aneurysm ____ Eczema ____ Thyroid Disorder

____ Peripheral Vascular Disease ____ Peripheral Neuropathy Other *(please explain)*:_____

Family History: ☐ No knowledge of family history

Clotting Disorder Y or N Family member? _____ Bleeding Disorder Y or N Family member? _____

Coronary Artery Disease Y or N Family member? _____ Stroke Y or N Family member? _____

Aneurysm Y or N Family member? _____ Varicose Veins Y or N Family member? _____

Other family history: _____

Surgical History (Veins): **Year**

☐ Past Varicose Vein Surgery w/ Stripping YES or NO _____

Surgical History (Other)

☐ No past surgical history Please list surgery and approximate date

_____

_____

Social History:

Tobacco Use Y or N _____ packs per day Alcohol Use Y or N _____ frequency

Sun Exposure Y or N _____ how often? Are you currently pregnant/breastfeeding? Y or N

Living Situation: *(please circle one)* With Spouse With Family Alone Nursing Home

Current Medications: *(please include dosage and frequency)* ☐ Not currently on any medication

Blood thinners YES or NO Birth Control YES or NO

Accutane YES or NO Retin A YES or NO

Other Medications NOT listed:_____

_____

Allergies: ☐ No known allergies ☐ Sotradecol/Sodium tetradecyl ☐ Polidocanol/Asclera ☐ Penicillin

☐ Epinephrine ☐ Latex ☐ Sotradecol ☐ Saline ☐ Lidocaine

Other allergies NOT listed:_____

_____

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Authorization for Release of Medical Information

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows this office to release your protected health information to a person or organization that you choose.

Patient Information:

Name: _____ **DOB**: _____

I, _____ hereby authorize Chuback Vein Center to:

☐ Release my medical information
☐ Obtain my medical information

I authorize the following person(s) and/or organization to release/obtain the information:

Name of Person/Medical Office: _____

Address: _____

Phone Number: (_____) _____-_____

Reason for release of information: _____

Information to be released:

a. O Office visits
b. O Emergency Department Reports
c. O Discharge Summary
d. O Operative Reports

O History & Physical
O All clinical reports -including but not limited to:
O Cardiac, Laboratory, Radiology
O Other _____

I understand that my treatment information released under this consent may be re-disclosed by the recipient of the information and may no longer be protected by Federal law.

This authorization will expire in one year from date signed, or sooner by choice, in which case this authorization will expire on _____. I understand that I may revoke this authorization at any time by notifying, in writing, Chuback Vein Center.

Authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy information to be used or disclosed, as provided by federal and state law.

Patient Signature: _____ Date: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

The Chuback Vein Center reserves the right to modify the privacy practices outlined in the notice. I have received a copy of the Notice of Privacy of Privacy Practices for Chuback Vein Center

_____ _____
Patient Name Patient Signature

_____ _____
Signature of Patient Representative* Relationship to Patient*

_____
Date

*Required if the patient is a minor or an adult who is unable to sign this form

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HIPAA Authorization Form for Family Members/Friends

Please list the family members or other persons, whom Chuback Vein Center may inform about your general medical condition, diagnosis, and billing information.
(You may write "no one," You may revoke this permission in writing at any time.)

Name(s) ***Relationship***

_____ _____

_____ _____

_____ _____

_____ _____
Patient Name Patient Signature

_____
Date

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Financial Policy

Thank you for choosing **Chuback Vein Center** for your medical and surgical needs. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your overall treatment plan. The following is a statement of our *Financial Policy*, which we require every patient to read and sign prior to any treatment.

I_____, assign Chuback Vein Center all of my rights and benefits under any insurance contract for payment for services rendered to me by Chuback Vein Center.

Please initial each statement

_____I authorize Chuback Vein Center to file insurance claims on my behalf for service rendered.

_____I request that payment from my insurance company be made directly to Dr. John A. Chuback.

_____I direct that any and all payments go directly to Chuback Vein Center.

_____I agree that in the event I receive any checks, or other payments subject to this Agreement, such payments will be held, endorsed to the Chuback Vein Center and forwarded to their office.

_____I understand that Chuback Vein Center will not bill me in excess of what my insurance plan allows and that I am responsible for any charges that my insurance company deems my responsibility.

_____I understand that Chuback Vein Center is prohibited from waving any member cost share portions deemed by my insurance company. This includes but is not limited to my deductibles and co-insurance. I understand that Chuback Vein Center's obligation is to remain in compliance with NJ state law mandating member cost share payment. {***The Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act P.L. 2018, C.32 (N.J. S.A. 26:2SS-1 to -20***}

_____I authorize Chuback Vein Center to release in writing or verbally, any medical information regarding treatment which may be needed for my care, or for processing medical insurance claims. This includes information directly related to obtaining precertification or predetermination of covered benefits by my insurance company.

_____I authorize Chuback Vein Center to appeal any claims, precertification, and/or predetermination cases on my behalf.

_____I certify that the insurance information that I have provided is correct.

_____I agree that if I do not have health insurance, payment for services is due at the time services are rendered, unless payment arrangements have been approved in advance.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns regarding the above information. I have read the Financial Policy and I understand and agree to the Financial Policy.

Patient Name: _____Signature: _____Date: _____

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Acknowledgement of Disclosures

I, _____acknowledge that Chuback Vein Center and the providers listed below are out-of-network with my health insurance plan. I also acknowledge the following disclosures:

- Prior to scheduling my appointment, I was informed that Chuback Vein Center was out-of-network and that the amount or estimated amount to be billed for services is available to me upon request;
- Upon request, Chuback Vein Center will disclose in writing the amount or estimated amount that it will bill you for the services and the CPT codes associated with the services (absent unforeseen medical circumstances that may arise);
- My out of network financial responsibilities may be in excess of the copayment, deductible, or coinsurance and I may be responsible for any costs in excess of those allowed by their carrier; and
- I should contact my carrier for further information or consultation on these costs.

- The following healthcare providers may perform anesthesiology, laboratory, pathology, radiology, or assistant surgeon services in connection with the care to be provided by Chuback Vein Center:

Providers: John A. Chuback, MD and Kristen Socha, MS, PA-C

Name: Bioreference Laboratories Inc
Mailing address: 481 Edward H. Ross Drive
Elmwood Park NJ 07407
Telephone number: (800)-229-5227

- I should contact the coordinated care providers listed above directly to determine if they participate with my carriers and for information on the costs for their services.
- I should also contact my carrier for more information or consultation on the costs for the services of the coordinated care providers.

I acknowledge that I am knowingly and voluntarily accepting responsibility for any out-of-network financial responsibility associated with the health care services that I receive.

_____ _____
Patient Signature: Date:

_____ Providers: **John A. Chuback, MD**
Patient Name: **Kristen Socha, MS, PA-C**

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Photographic/Media Consent Form

INFORMATION

I hereby consent to the use of my personal images taken by photography and/or video recording.

I acknowledge these may be used on Chuback Vein Center's print ads, website(s), digital/photo album, and/or presentations, YouTube, Facebook, Instagram, and other social media.

I further acknowledge that my images or video may be used for the purpose of displaying results of treatments or procedures, as well as for educational purposes. I also acknowledge that my images or video may be taken live and in real time while observed by governing bodies for accreditation and/or certification purposes.

I understand no treatment will be denied me for failure and/or refusing to execute this consent form.

I also understand that my consent shall be in full force and in effect until it is withdrawn by me in writing to the office of Chuback Vein Center at any of their current practice locations.

CONSENT FORM

I, _____

Name of person giving consent & parent/guardian if under 18 years of age

Consent to the use of photographs or video footage for use in Chuback Vein Center's print ads, website(s), digital/photo album, and/or presentations, YouTube, Facebook, Instagram, and other social media.

I further understand that this consent shall be in full force in effect until it is withdrawn by me at anytime upon written notice.

I give consent voluntarily, and I have received a signed copy of this consent form.

_____ _____

Signature of person giving Consent Signature of parent/guardian < 18

Date: _____ Expiry Date: 1 Year from Signature

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