



**Patient Name:** \_\_\_\_\_ **Gender:**  Male  Female

**Date of Birth:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell:** \_\_\_\_\_ **Work:** \_\_\_\_\_

**Marital Status:**  Single  Married  Separated  Divorced  Widow

**Race:**

- American Indian or Alaska Native  Asian  Black or African American  
 Hispanic or Latino  Native Hawaiian or Other Pacific Islander  White  
 Decline to Specify

**Preferred Language:**  English  Spanish  Polish  Italian **Other:** \_\_\_\_\_

**Emergency Contact: Name / Phone Number:** \_\_\_\_\_

**Access to patient portal:**  Yes  No (selecting yes will enable you to access your medical summary notes)

**Email address:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Business Address:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## Health History Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Why are you here today? Where and what type of improvement is desired from laser hair removal?

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How did you hear about NJ Vein Care? \_\_\_\_\_

Are you on any medications either prescribed or over the counter? List Below  Yes  No

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Do you have any allergies to medication?  Yes  No  
If yes, please list drug and reaction

Do you smoke tobacco?  Yes  No  Quit Packs per day for how many years? \_\_\_\_\_

Do you consume alcohol?  Yes  No  Quit Drinks per week? \_\_\_\_\_

Other drugs? \_\_\_\_\_

Have you had any past surgical procedures?  Yes  No  
If yes, please list type and date

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Have you had any past hospitalizations?  Yes  No  
If yes, please list reason and date

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Do you have any of the following conditions? (Please check all that apply and describe below)

<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Heat Urticaria (Hives)
<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Blood Disorders
<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	Leg Pain	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	Skin Photosensitivity
<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	Swelling of Legs	<input type="checkbox"/>	Leg Ulcers	<input type="checkbox"/>	Autoimmune Disorders/Immunosuppression
<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Spider Veins	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Bacterial or viral infections

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Do you have any other medical conditions or illness not listed? \_\_\_\_\_

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Family History. (Check all that apply)

	Father	Mother	Sibling	Other
<input type="checkbox"/> Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Leg Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is there any other medical information that you would like to share?

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## Pigment Removal History Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

(For women) are you or could you be pregnant?	Yes	No
(For women) are menstrual periods regular, or have you ever been diagnosed with Polycystic Ovarian Disorder?	Yes	No
Do you have a history of light induced seizures?	Yes	No
If yes, please explain:		
Do you have or have you ever had any type of a skin disorders, such as eczema, vitiligo, melisma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos Syndrome, scleroderma, skin cancer: or any other skin condition?	Yes	No
If yes, please explain:		
Do you have a history of keloid scarring (extra-large scars) or hypertrophic scar formation?	Yes	No
Do you have a history of herpes I or II?	Yes	No
Do you ever get cold sores, skin eruptions, open sores or lesions?	Yes	No
In the last six (6) months, have you used any of the following: anticoagulants or blood-thinning medications; photosensitizing medications; or anti-inflammatory medications?	Yes	No
If yes, please list name of product and when last used:		
In the last three (3) months, have you used any of the following products: glycolic acid or other alpha hydroxy or beta hydroxy acid products: exfoliating or resurfacing products or treatments? Such as dermabrasion or a chemical peel?	Yes	No
If yes, please list name of product; and when used:		
Have you taken Tretinoin (like Retin-A, Renova) in the last 6 months?	Yes	No
If yes, when did you start? When did you stop?		
Have you taken Accutaine (or products containing isotretinoin) in the last 12 months?	Yes	No
If yes, when did you start? When did you stop?		
Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds or lamps in the last 4-6 weeks?	Yes	No
If yes, when did you start? When did you stop?		
Do you have or have you ever had any Botulinums, such as Botox or Dysport?	Yes	No
If yes, please list locations on or in the body and dates:		
Do you have or have you ever had any permanent make-up, tattoos, implants or fillers, including, but not limited to, collagen, autologous fat, Restylane, etc?	Yes	No
If yes, please list locations and dates?		
Have you had any type of treatment for unwanted facial/body hair in the past?	Yes	No
If yes; What type? When did you start? When did you stop?		
Have you had any complications with cosmetic treatments or surgery in the past?	Yes	No
If yes; What type? What complication?		



## SKIN TYPING WORKSHEET

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Score:	0	1	2	3	4
What is your eye color?	Light blue or Gray	Blue or Green	Hazel, Light brown	Dark brown	Brownish black
What is the natural color of your hair?	Red, Sandy red	Blonde	Dark blonde, Chestnut, Brown	Dark brown	Black
What is the color of your skin (unexposed areas)?	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown
Do you have freckles on sun-exposed areas?	Many	Several	Few	Incidental	None
What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering, followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never had burns
To what degree do you turn brown?	Hardly any or not at all	Light tan	Reasonable tan	Tan very easily	Turn dark brown quickly
Do you turn brown several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
When did you last expose yourself to the sun, tanning bed or self-tanning creams?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
How often is the area you want to have treated exposed to the sun?	Never	Hardly ever	Sometimes	Often	Always

Add above for Total Score:	Match your total score with the corresponding Skin Type:	Fitzpatrick Skin Type:
_____	0-7 8-16 17-25 26-30 Over 30	I II III IV V-VI



### Our Practice Financial Policy

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions, please discuss them with our office administrator.

**Full payment is due at the time of service for cosmetic procedures.** For your convenience we will accept cash, check, or credit card for payment.

**We also participate with Care Credit that can be used to finance both cosmetic and non-cosmetic procedures including deductibles and co-insurance.**

We are **not in network** with Medicaid or Managed Medicaid plans.

We are **not in network** with BCBS Advance EPO

We are **not in network** with Americhoice or Amerigroup

We are "in network" with Medicare, Horizon Blue Cross/Blue Shield of NJ, Aetna, United Health Care, Oxford, Magnacare, Amerihealth, Care Point, OSCAR, Qualcare and Cigna. **Patients are responsible for knowing if referrals are needed and obtaining referrals prior to an appointment at NJ VeinCare.**

If you have other medical insurance with "out of network benefits", we will work with you to obtain coverage for procedures performed due to medical necessity. We do accept "out of network benefits".

If in the event your health plan ultimately determines a service to be "not covered" or does not meet their criteria for medical necessity, you would be responsible for the complete charge.

Prior to any scheduled procedure we will provide patients with the CPT codes. **It is your responsibility to check with your insurance company to determine what your out of pocket costs will be.** Payment is due upon receipt of the Explanation of Benefits from your insurance company. It lists what you owe NJ Vein Care. **If payment to NJ VeinCare is not received within 60 days, interest at a rate of 1.5% per month will accrue. After 90 days, unless other arrangements have been made, your account will be sent to a collections agency.** This would result in an additional charge from the collections agency and/or legal fees over what you owe to NJ VeinCare.

A fee of \$30.00 will be charged on any checks returned by the bank for insufficient funds.

**Patients will be charged a fee of \$50.00 if they fail to cancel an appointment 1 day in advance. If a patient fails to give 1-day advance notice of cancellation for a cosmetic procedure, any discount that was given for the procedure may be forfeit.**

**I have read and understand the financial policy of NJ Vein Care and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.**

Print Name of Patient \_\_\_\_\_

Signature of Patient or Guardian \_\_\_\_\_ Date \_\_\_\_\_



## ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign, transfer, and set over directly to NJ VeinCare, LLC sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic or elsewhere. I authorize Gary B. Nackman, MD /NJ VeinCare, LLC to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Gary B. Nackman, MD /NJ VeinCare, LLC. I authorize Gary B. Nackman, MD /NJ VeinCare, LLC to release all medical information requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

Print Name of Patient \_\_\_\_\_

Signature of Patient or Guardian \_\_\_\_\_ Date \_\_\_\_\_



## PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1966 (HIPAA). I understand that by signing this consent I authorize you to use and disclosure my protected health information to carry out:

- Treatment (including direct and indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operation of your practice.

I have also been informed of and give the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Name of Patient \_\_\_\_\_

Signature of Patient or Guardian \_\_\_\_\_ Date \_\_\_\_\_





**You have the right:**

- To considerate and respectful care consistent with sound nursing and medical practices
- To be informed of the name of the physician responsible for coordinating your care
- To obtain from the physician complete, current information concerning your diagnosis, treatment, and prognosis in terms I can reasonably be expected to understand
- To receive from the physician information necessary to give informed consent prior to the start of any procedure or treatment
- To refuse treatment to the extent permitted by law and to be informed of the medical consequences of such action; You can still obtain alternative care.
- To privacy to the extent consistent with providing adequate medical care to you
- To privacy and confidentiality of all records pertaining to the your treatment, except as otherwise provided by law or third party payment contract, and to access to those records
- To review your medical records and if necessary have them explained to you
- To know what alternative care may be available to you
- To know what your treatment may cost

**You have the responsibility:**

- To provide all information about your past care, illness and medication to your physician
- To for being considerate to the needs of others in the office
- To provide all insurance information when requested, and following the requirements for your individual insurance plan for seeking treatment with the Doctor

Print Name of Patient \_\_\_\_\_

Signature of Patient or Guardian \_\_\_\_\_ Date \_\_\_\_\_