

Edward G. Mackay, M.D.

Patient Information

Name: _____

Date: _____

Address: _____

City/State/Zip: _____

Telephone: Home: () _____ Work: () _____

Cell: () _____ E-mail address: _____

Employer: _____ Position: _____

Birth Date: _____ Marital Status: Married Single Divorced Widowed

Social Security No.: _____ Name of Spouse: _____

Driver's License No.: _____ Spouse Occupation: _____

How Did You Hear About Us?

Another Patient - Name? _____
Tribune

Physician Referral - Name? _____

Magazine-Which one? _____

Verizon Yellow Pages
 Billboard- Palm Harbor St Pete
 Newspaper- St Pete Times Tampa

Florida Healthcare News
 Other? _____

Insurance Information: (PLEASE PRESENT YOUR CARD AT CHECK IN FOR VARICOSE VEINS ONLY-WE NEED A COPY)

NO INSURANCE MEDICARE COMMERCIAL/PPO HMO OTHER _____

Who To Contact In Case of Emergency:

Name: _____ Relationship: _____

Telephone: Home _____ Work _____ Cell _____

Lifetime Authorization: I request that payment of authorized insurance benefits be made on my behalf for services rendered to me by Edward G Mackay, M.D.P.A. I also request that payment be made directly to the provider. I authorize this practice to act on my behalf and to provide any medical information about me to Medicare and/or insurance providers in order to determine payment for services received from Edward G. Mackay, MD, PA. and/or his associates.

Patient Signature: _____ **Date:** _____

Dr. Mackay teaches vein treatments to Physicians in this facility. I understand and consent to a Physician observer(s) in the room when notified in advance. I understand that Physicians will ONLY be observing the procedure(s). I Refuse I agree _____ Patient Initials

Dr. Edward G. Mackay, M.D.

Patient Medical History

Name: _____ Date: _____

Height: _____ Weight: _____ Sex: male female Age: _____

Reason for Visit: spider leg veins varicose veins laser hair removal photorejuvenation
veins on face sun damaged skin restylane rosacea
other: _____

If you are interested in laser hair removal check the area(s) you wish to have treated:

face chest back arms legs armpits bikini line other _____

Personal Physician (name & number): _____

OB/Gyn (name & number) : _____

Previous Treatment(s) tried for this problem (by whom): _____

Medical History: (list diseases and what age) _____

High Blood Pressure	Heart Disease	Hepatitis	Endocrine Dysfunction
Diabetes	HIV / AIDS	Overweight	Arthritis
Poor circulation	Gout	Cold Sores or Herpes Simplex Infection	

Have you ever been treated for arthritis or rheumatism? _____

If yes, what was used for your treatment? Please specify any treatment with metals such as gold or silver.

Present Health: Are you currently under the care of a physician for any medical illness or condition? If yes, please explain: _____

Date of Last Medical Check-Up / Physical Exam: _____

Surgeries / Hospitalizations : (List all procedures, admissions, and ages) _____

Current Medications / Vitamins / Herbal Supplements: _____

Are you currently taking:

Contraceptives / Fem. Hormones	yes no	Anticoagulant (blood thinner)	yes no
Aspirin	yes no	Digoxin	yes no
Steroids	yes no	Antibiotics during dental work	yes no

Topical Medications / Preparations used: _____

Allergies to Medications: no yes. If yes, please list substance and reaction _____

Are you allergic to local anesthetics such as EMLA / Xylocaine / Tetracaine ? yes no LATEX ? yes no

THIS SECTION IS TO BE COMPLETED BY VEIN PATIENTS ONLY:

Cardiovascular: (Check symptoms which you have now, or have had in the past):

weakness	chest pain	edema (swelling of hands, face, feet)
heart attack (MI)	stroke (CVA)	change in rate or rhythm of heart beat
congestive heart failure (CHF)		cramping or pain in legs when walking

Explain: _____

Chief Complaint : Spider veins Varicose veins

Other, please describe: _____

Age you first noticed veins: _____

Do you have or have you had:

Unsightly Veins	right	left	Aches and Pain (legs)	right	left
Heaviness or Tired Legs	right	left	Ankle Edema (swelling)	right	left
Itching	right	left	Night Cramps	right	left
Bleeding from the Vein	right	left	Dermatitis (rash)	right	left
Restless Legs	right	left	Burning:	right	left
Discoloration of the Skin	right	left	Throbbing	right	left
Ulceration (break down of the skin & open sore)	right	left			

Other - Please describe: _____

Are You Developing New Veins/Noticed a Deterioration Recently? yes no

Bleeding or Clotting Disorders (excessive bleeding): yes no

Do your symptoms adversely affect your daily life? yes no

What have you tried to make your legs feel better? Nothing Support Stockings Elevate Legs Soak Legs

Have You Ever Had any of the following?

	right	left	Date	By Whom
Vein Evaluation	_____	_____	_____	_____
Venogram, Ultrasound or Other Tests	_____	_____	_____	_____
Superficial Phlebitis	_____	_____	_____	_____
Inflammation of Vein (skin over vein becomes red, warm, & tender)	_____	_____	_____	_____
Deep Thrombo-Phlebitis (blood clot)	_____	_____	_____	_____
Pulmonary Emboli (blood clot to lungs)	_____	_____	_____	_____

Previous Treatment Modalities?

Elasto-Compression (support stockings)	right	left	_____	_____
Ligation Surgery (vein tied off)	right	left	_____	_____
Stripping Surgery (removal of the vein from ankle to groin or behind knee to Achilles)	right	left	_____	_____
Local Excision (remove the bulging veins)	right	left	_____	_____
Electrocautery (electric needle)	right	left	_____	_____
Laser (special light directed at the vein)	right	left	_____	_____
Sclerotherapy (injection treatment of salt solution or medicine into the veins)	right	left	_____	_____

Family History of Varicose or Spider Veins or Leg Ulcers: NO YES

If yes, specify: _____

Edward G. Mackay, M.D.
Office Policy

We are dedicated to providing you with the best care possible. If you have medical insurance we are committed to helping you receive your maximum allowable benefits.

☐ Payment for service is due at the time services are rendered. We accept cash, checks, MasterCard, Visa, Discover & American Express.

☐ Returned checks are all subject to a \$35.00 service fee. Repayment will be required in cash, money order or credit card only.

☐ Filing of Insurance

- **Sclerotherapy (Spider Veins)-** We will be happy to provide you with copies of forms to assist you in filing insurance claims for spider vein sclerotherapy. Since this treatment is strictly cosmetic, it is not covered by most insurance carriers. Therefore, our office does not file insurance for spider vein sclerotherapy.
- **Surgery and diagnostic procedures-** As a courtesy to you, we will assist with your insurance for surgical and diagnostic procedures. We verify your benefits via phone and when necessary, will obtain pre-authorization prior to your procedure. Insurance providers do not “guarantee” payment, even with a pre-authorization prior to surgery or treatment. We must emphasize that as a medical provider, our relationship is with you; not your insurance company. Your active participation is necessary when denials occur or payments are delayed from your insurance provider. A credit card number is required to schedule all varicose vein procedures filed with insurance. At 90 days any unpaid balance becomes your responsibility. If your insurance fails to pay, your credit card will be billed any unpaid balance at 90 days.
- **Medicare- all procedures considered “medically necessary,” will be filed to Medicare Part B (not Medicare HMO plans).** If you have secondary insurance, we will file the claim forms on your behalf. If you do not have a supplemental policy to Medicare, you will be responsible for 20% of the Medicare allowable charges at the time of service. You may also be responsible for your annual Medicare deductible.

As the Patient, You Have the Ultimate Financial Responsibility Payment is expected at the time services are rendered by this practice. In the case that insurance may pay a portion of your charges, your estimated payment (considering expected insurance coverage) is required to be paid at the time of service. In the event that your insurance provider denies payments or pays less than expected, you are responsible for any balance on your account 60 days from the date of service. The Insurance company’s decisions and payment amounts are not within our control; however, we are happy to assist you in the insurance appeal process. If it becomes necessary to collect your unpaid account using a collection agency, you will also be responsible for any charges incurred as a result of collection activity (usually 35 - 50% of unpaid amount) as well as any other legal or court fees incurred.

Missed or Canceled Appointments-The timeliness of treatment is important for you to achieve optimal results. We accommodate patient schedules as best we can. In consideration of this and our other patients, this office requires **a 48 business hours notice for cancellation of an appointment.** This notice provides time for us to work other patients into the schedule. Failure to provide notice will result in a \$50 missed appointment charge. This policy is strictly enforced.

{Please initial _____}

Agreement

I, (print name) _____, have read and understand the cancellation policy and the terms & conditions of my financial obligation and agree to honor the office policies outlined above.

Patient signature

Date

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

ACKNOWLEDEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of the office of Edward G. Mackay, MD, our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

We reserve the right to change our practices and make new provisions for all protected health information we maintain. Should our information practices change, we will post the changes in our reception area. At your request we will provide you with a revised copy.

I understand that as part of treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e., referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law.

If you have any questions regarding our *Notice of Privacy Practices*, please discuss with one of our staff members.

I fully understand the information of this consent:

Patient/Parent/Guardian Signature

Date: _____

INABILITY TO OBTAIN ACKNOWLEDEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to attempt to get acknowledgement and the reason why it could not be obtained.

Signature of provider representative: _____ Date: _____