Dr. Mackay
Vein & Circulation Specialist

PATIENT REGISTRATION

www.drmackay.com

PATIENT INFORMATION – PLEASE PRINT

Patient Name _____
Last First Middle

Sex: ☐ M ☐ F Date of Birth_____ Social Security # _____

Address_____ Apt. _____ City_____

_____ State_____ Zip _____

Home Phone _____ Cell Phone _____

Email Address_____ I agree to receive appointment reminders via text message. Yes ☐ No ☐

Employer_____ Work Phone _____

Please check one: Married ☐ Single ☐ Partner ☐ Divorced ☐ Widowed ☐ Separated ☐

EMAIL AUTHORIZATION

I hereby agree to allow Dr. Mackay to contact me by email with e-newsletters, special offers, appointment reminders and updates regarding health-related services provided by Dr. Mackay. I understand that Dr. Mackay will not share the information provided above with any outside parties.

☐ Yes ☐ No Please provide email address above.

REFERRAL

How did you hear about us?

☐ Referred by Patient: _____ (First Name / Last Name)

☐ Referred by a Physician: _____ (First Name / Last Name)

☐ Newspaper / Post card: _____

☐ Internet Search Engine: _____

☐ TV Commercial ☐ Coupon Offer: _____

☐ Other source: Please list_____

☐ Clinic Sign

☐ Insurance Plan Directory

☐ Community or company health fair

☐ social media: _____

☐ Return Patient

☐ Hospital Referral

EMERGENCY CONTACT INFORMATION

Emergency Contact_____ Relationship _____

Phone_____ Address_____ City_____ State_____ Zip _____

HEALTH INSURANCE INFORMATION

Please provide a copy of your insurance card to the receptionist.

☐ Medicare ☐ Commercial / PPO ☐ HMO ☐ Other_____ ☐ No Insurance

Do you have an Advance Directive? Yes: _____ No: _____

Patient Service Agreement

CONSENT FOR SERVICES

By signing this agreement, I give consent to the physicians, medical staff and employees of Edward G. Mackay, M.D. to provide health care services. _____ (Patient Name), _____ (Date of Birth)

Photo Consent: For documentation purposes, Dr. Mackay requires before and after photographs of the treated area(s) in all medical records. Understanding that we will keep your identity confidential, I also grant permission for Edward G. Mackay, M.D., P.A. the use of my vein images to help promote healthy vein care for: ☐ Educational Purposes ☐ Electronic Publishing ☐ Print Publishing

SIGN: Patient Signature:_____ Date: _____

FINANCIAL RESPONSIBILITY

I authorize that all benefits from insurance companies or any other third-party payer will be paid directly to Edward G. Mackay, M.D. for services rendered by the health care providers employed by Edward G. Mackay, M.D. 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, M.D., P.A. and/or his associates. **I understand that I am financially responsible for all charges whether or not paid by insurance or any other third-party payer.** I agree to pay all co-payments at the time of service, all deductibles, co-insurance, and all non-covered services regardless of the amount paid by my insurance or any other third-party payer.

SIGN: Patient Signature:_____ Date: _____

SPIDER VEIN SCLEROTHERAPY / COMPRESSION STOCKINGS

Most varicose vein procedures are covered by insurance. However, **Sclerotherapy of Spider Veins** is considered a cosmetic procedure and is NOT covered by any insurance company. The patient is responsible for payment and it is collected at the time of service for each treatment performed. If you are having surgical procedures done, sclerotherapy of spider veins is a completely separate service and not included in fees quoted for the varicose vein procedures.

Compression Stockings: If you are having a procedure performed that requires you to wear compression stockings, please understand that these are NOT covered by insurance. Although we recommend our brands for the best outcome, you may request a prescription to purchase stockings elsewhere. Also, many insurance companies have begun to require the use of compression stockings prior to approval of varicose vein treatment.

I have read and understand the above information and accept full financial responsibility.

SIGN: Patient Signature:_____ Date: _____

AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION

I authorize Edward G. Mackay, M.D. to release any medical information pertaining to my diagnosis and treatment to 1) any requesting physician or medical facility providing my medical care; 2) my insurance plan, employer (if employer-funded plan), Medicare, or other payer/provider of medical benefits which may or will pay for part of my medical expenses. I understand that release of this information may be required in order to obtain payment for medical expenses. This authorization applies to all information regarding my care.

SIGN: Patient Signature:_____ Date: _____

I authorize discussion and release of my general medical condition and diagnosis (including treatment, payment and health care operations) with: ☐ Spouse ☐ Other

Name:_____ Relationship:_____ Telephone:_____

Name:_____ Relationship:_____ Telephone:_____

HIPAA NOTICE OF PRIVACY PRACTICES

We respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information in reference to your treatment, payment or health care operations, in order to provide health care that is in your best interest in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). My signature confirms that I am aware of my rights to privacy regarding my protected health information.

☐ Copy given to patient

SIGN: Patient Signature:_____ Date: _____

Dr. Mackay
Vein & Circulation Specialist

Financial Policy

The Doctor and staff at our office would like to welcome you to our practice. We strive to provide you with excellent medical care and our goal is to make your visits as convenient as possible.

By signing below, you confirm that you have read and understand the following:

- It is your responsibility to inform our office of any address, telephone, or insurance changes.
- Your account is to be kept current – accordingly, all self-pay or insurance co- payments, co-insurance, and deductibles will be collected at the time of service. Payable by check, Visa, MasterCard, Discover, American Express, or Care-Credit (If applicable).
- If you do not have your payment(s), your appointment may be rescheduled.
- You may be asked to schedule another appointment for issues other than the reason for your original appointment.
- A returned check will result in a $50.00 service charge ***and*** all future appointments being pre-paid will be required in the form of cash or credit card.
- You will only be sent a statement if your balance exceeds $5.00. Refunds will be issued if there are no pending insurance claims.
- There will be a $15.00 charge for the completion of paperwork (ex; Disability, FMLA, etc.)
- Any unpaid patient balances older than 30 days may be subject to 1.5% interest per month.
- There will be a **50.00 missed appointment fee** charge for any appointment cancelled without 24 hours notice.
- For our patients submitting through their Insurance companies, because everyone's plan is different, you will be charged the amount of the surgical supplies/equipment for cancelling a surgery with less than 48 business hours' notice. The amount will vary depending on which surgery you were scheduled for.
- If your account is turned over to a collection agency, you will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 35% of your outstanding balance, court costs, and attorney fees.

If you have Health Insurance Coverage:

We will submit your claims, however, ***we must emphasize that as a medical provider, our relationship is with you, not your insurance company.*** Although we attempt to verify your specialist benefits with your insurance policy, please be advised this is only an estimate of your coverage based on the information given to us at the time of inquiry.

I understand that I am financially responsible for any and all charges rendered at the time of visit. If my insurer sends payment to me for services provided to me by Dr Mackay or his associates, I understand it is my responsibility to forward that payment to Dr Mackay.

By signing below, you confirm that you have read and understand the following:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment.
- If your insurance policy requires a referral from your Primary Care Physician, it is your responsibility to obtain it and have it faxed to our office prior to your appointment.
- Not all services are a covered benefit with all insurance plans.
- It is your responsibility to be aware of what service(s) are being provided to you and if it is a covered benefit under your insurance policy.
- You are responsible for any non-covered charges not payable by your insurance policy.
- Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibility from the date services are rendered.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, please do not hesitate to ask us. ***We are here to help you.***

I have read and understand the above Financial Policy and agree to meet all financial obligations.

SIGN: X

_____	_____	_____
Patient Name (please print)	***Patient Signature***	***Date***
_____	_____	_____
Responsible Party (please print) (If other than patient)	Responsible Party Signature	Date

Dr.Mackay
Vein & Circulation Specialist

MEDICAL HISTORY

Name: _____ **Date of Birth:** _____ **Age:** _____

Ethnicity: _____ **Preferred Language:** _____

Gender: _____ **Height:** _____ **Weight:** _____ **lbs**

What concerns have brought you to us today? _____

MEDICAL HISTORY: DO YOU HAVE or HAVE YOU EVER HAD any of the following: (please elaborate on lines below)

Arthritis	Depression	High Blood Pressure	Other medical history: ____
Asthma	Deep Vein Thrombosis (DVT)	High Cholesterol	_____
Anemia	Diabetes	Kidney Disease	_____
Autoimmune Disorder	GERD	Liver Disease	_____
Bleeding Disorder	Gastric Ulcers	Pulmonary Embolism (PE)	Hospitalizations in past:
Clotting Disorder	Heart Problems _____	Skin Cancer_____	(please list all, except surgeries)
COPD / Emphysema	_____	Stroke / TIA	_____Year___
Cirrhosis	Headaches / Migraines	Seizures	_____Year___
Crohn's / Ulcerative Colitis	HIV / AIDS	Thyroid Disease	_____Year___
Cancer_____	Hepatitis		_____Year___

MEDICATION LIST: You may use the reverse side of this page for additional medications if needed.

Medication Name	Dose (mg) / Frequency	Reason for taking

ALLERGIES: You may use the reverse side of this page for additional allergies if needed.

I AM ALLERGIC TO – list below: (medications, foods, anesthetics (Lidocaine, EMLA, Tetracaine), Latex)	**REACTION:** (rash, itching, anaphylaxis, shortness of breath)

SURGICAL HISTORY: (circle all past surgeries and year performed -please elaborate on lines below)

Vein procedures (Stripping, Ablations, Phlebectomy, Sclerotherapy) _____	Hysterectomy_____
_____	Knee replacement_____
Arterial procedures_____	Plastic surgery_____
Appendix_____	Skin cancer_____
Breast _____	Thyroidectomy_____
Gallbladder_____	Tonsillectomy_____
C-section_____	Other (list here): _____
Heart_____	_____
Hip replacement_____	_____
	_____

NAME: _____

FAMILY HISTORY: (check all that apply or elaborate in box)

	Mother	Father	Sibling(s)	Children
Varicose Veins				
Bleeding Disorder				
Clotting Disorder				
Cancer (please write type)				
Aneurysm				
Stroke / TIA				
Alzheimer's/Dementia				
High Blood Pressure				
High Cholesterol				
Heart Problems				
Other (please list)				

Has anyone in your family ever had a Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE)? **YES** **NO**

Any additional family medical history of note? _____

VACCINATION STATUS:

Influenza (Flu) vaccination:	YES / NO	Approximate date of last dose: _____
Pneumonia vaccination:	YES / NO	Approximate date of last dose: _____
COVID vaccination:	YES / NO	Approximate date of last dose: _____

SOCIAL HISTORY:

Smoking history: (please circle) Current smoker Former smoker Never smoker

If you are a current smoker, how old were you when you started smoking? _____How many packs/day? _____

If you are a former smoker, how many years did you smoke? _____

How many years ago did you quit? _____ How many packs/day? _____

Alcohol history: Did you have a drink containing alcohol in the last 1 year? **YES** **NO**

How many days a week do you typically have a drink containing alcohol? _____

How many drinks containing alcohol do you have on a typical day in the last year? _____

FEMALE HISTORY: Number of pregnancies: _____ Number of live births: _____ Number of miscarriages: _____

Are you currently pregnant or breast feeding (if yes, please let provider know at every visit)? **YES** **NO**

PRIMARY CARE / FAMILY PHYSICIAN: Name: _____

Telephone Number: _____ Do we have permission to send records to your doctor? **YES** **NO**

PHARMACY NAME: _____ Telephone Number: _____

Address: _____

VEIN HISTORY: (please circle all that apply and which leg)

Varicose Veins:	R / L	Burning:	R / L	Ulcers / Open sores:	R / L
Aching / Pain:	R / L	Restless legs:	R / L	History of Phlebitis:	R / L
Heaviness:	R / L	Cramping:	R / L	Symptoms increase with standing / sitting:	R / L
Fatigue:	R / L	Discoloration:	R / L	Pain in the legs with walking / activity:	R / L
Swelling:	R / L	Bleeding varicosities:	R / L	Other: _____	R / L
Itching:	R / L	Poor wound healing:	R / L	_____	

SIGNATURE: I hereby affirm that the information submitted is true to the best of my knowledge and is provided here in good faith.

SIGNATURE: _____ **DATE:** _____