



CHUBACK MEDICAL GROUP
A TRADITION OF EXCELLENCE

New Patient Demographics

Full Name: _____ Date of Birth: _____ Gender: _____

Full Address: _____ City: _____ State _____ Zip _____

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

Spouse/Next of Kin Name: _____ Number: _____

Emergency Contact: _____ Number: _____

Employer Name: _____ 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: _____



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: No past surgical history

Past Varicose Vein Surgery w/ Stripping _____ YES or NO _____ **Year** _____

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 _____

Allergies: No known allergies Sotradecol/Sodium tetradecyl Polidocanol/Asclera
 Epinephrine Latex Sotradecol Saline Lidocaine Penicillin

Other: _____



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:** _____

SS#: _____

I, _____ **hereby authorize Chuback Medical Group 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. Office visits History & Physical
- b. Emergency Department Reports All clinical reports -including but not limited to:
- c. Discharge Summary Cardiac, Laboratory, Radiology
- d. Operative Reports 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, the 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: _____



Release of information

Patient Name: _____ Date: _____

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

Please print the e-mail where you would like to be contacted about your appointments, ultrasound results, other healthcare information or special offers.

I am fully aware that e-mail is not a secure means of communication

Please print the telephone number where you want to receive calls about your appointments, ultrasound results, or other healthcare information, if other than your home phone number.

I am fully aware that a cell phone is not a secure and private line

Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail?

YES _____ NO _____

Do you currently have a Power of Attorney (POA) or Living Will?

YES _____ NO _____

Patient/Guardian/POA Signature: _____

Date: _____



Acknowledgement of Receipt of Notice of Privacy Practices

The Chuback Medical Group 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 Medical Group

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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Acknowledgement of Disclosures

I, _____ acknowledge that Chuback Medical Group 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 Medical Group 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 Medical Group 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 Medical Group:

Name:
 Practice name:
 Mailing address:
 Telephone number:

- 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:

Patient Name:

Providers:

**John A. Chuback, MD
Jaime A. Bastidas, MD
Kristen Socha, MS, PA-C**



Financial Policy

Thank you for choosing **Chuback Medical Group** 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 Medical Group all of my rights and benefits under any insurance contract for payment for services rendered to me by Chuback Medical Group.

Please initial each statement

_____ I authorize Chuback Medical Group 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 Medical Group.

_____ 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 Medical Group and forwarded to their office.

_____ I understand that Chuback Medical 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 authorize Chuback Medical Group 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 Medical Group 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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Please share with us . . .

Here at Chuback Medical Group, we are passionate about helping you improve your total health and well-being. Tell us about any other areas of concern that you may have. Together we can achieve a new, incredible you.

Check any concerns that apply to you:

- Facial Lines and Wrinkles
- Facial Volume Loss
- Thin Lips
- Facial Rejuvenation
- Hand Rejuvenation
- Excessive Sweating
- Sun/Age Spots
- Suspicious Lesions
- Cellulite
- Unsightly Varicose Veins
- Unsightly Spider Veins
- Unwanted Hair
- Unwanted Fat
- Body Contouring
- Breast Augmentation/Reduction
- Buttock Augmentation/Reduction
- Tummy Tuck/Liposuction
- Skin Tightening
- Weight Loss
- Eyelash Enhancement
- Drooping Eyelids
- Hair Loss/Thinning Hair
- Other: _____