NAPA VASCULAR & VEIN CENTER

Jeffrey L. Brooks, M.D.
(707) 252-4955

Welcome to our practice!
First, let us thank you for choosing Napa Vascular & Vein Center as your healthcare provider. We are dedicated to providing premier vascular assessment and treatment services in the region.

As a convenience for our patients, we offer the opportunity for you to review our policies and complete new patient paperwork at home and bring it with you to your scheduled appointment. At your first appointment, our staff will answer any questions you may have regarding this information and review the completed paperwork with you.

The First Appointment
Please arrive 10 minutes early so that we can complete your registration process and answer any questions prior to your visit with the physician.

Patients should complete, sign, and bring with you the:
- Patient Registration Form
- Notice of Privacy Practices
- Medication Form
- Venous Health History
- Your insurance cards (the receptionist will make a copy)

What to expect:
If you have questions that you would like answered before your appointment, please call us at (707) 252-4955. Otherwise, please bring a list of your questions with you to discuss with Dr. Brooks during your appointment.

Payment and Billing:
If your insurance (usually an HMO type) requires a referral from your primary care physician, a written referral or authorization number must be in our office prior to your visit. Please call us several weeks in advance if you need assistance obtaining this authorization. We will be happy to help you.

If you have a co-payment arrangement with your insurance company, please let us know what it is and be prepared to pay this amount at the time of your visit. If you do not have insurance and are taking independent financial responsibility for your services, please come prepared to pay. We accept cash, checks or credit cards.

How to reach us:
If you have any questions prior to your appointment, please call (707) 252-4955. If you must cancel your appointment, **please notify us at least 24 hours (72 hours for vascular testing or ultrasound) prior to the scheduled appointment time.**

We look forward to meeting you -
Jessica, Zena, Rosa & Saira - The Patient Care Team with Napa Vascular & Vein Center

NAPA OFFICE:
3260 Beard Road, Suite 5
Napa, CA 94558
(707) 252-4955

VACAVILLE OFFICE:
1360 Burton Drive, Suite 160
Vacaville, CA 95687
(707) 252-4955

NAPA VASCULAR & VEIN CENTER

Jeffrey L. Brooks, M.D.
(707) 252-4955

First Name: _____Last Name:_____ MI: ____

Address: _____

City: _____State:_____ Zip:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Email:_____

Social Security:_____ DOB:_____ Sex:_____

Insurance Information: (Please provide your cards to receptionist to copy)

Primary Insurance Name:_____

Subscriber Name:_____ Relationship to Subscriber:_____

Subscriber ID#:_____ Subscriber Grp#:_____

Secondary Insurance Name:_____

Subscriber Name:_____ Relationship to Subscriber:_____

Subscriber ID#:_____ Subscriber Grp#:_____

Billing Information:

Responsible Party: _____Relationship:_____

Name:_____

Address:_____City:_____

State:_____ Zip:_____Ph#: _____

IN CASE OF EMERGENCY PLEASE CONTACT:_____
PHONE #:_____

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr.Brooks all insurance benefits, if any, otherwise payable to me for services rendered I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____Date: _____

NAPA VASCULAR & VEIN CENTER

Jeffrey L. Brooks, M.D.
3260 Beard Rd. Suite 5 Napa, CA. 94558
Tel: (707) 252-4955 Fax: (707) 252-0525

Name: _____ **Date: _____**
DOB: _____

ALLERGIES:

MEDICATION LIST

MEDICATION NAME	DOSAGE

NAPA VASCULAR & VEIN CENTER

General Authorization to Use or Disclose Health Information

Patient Name: _____ **Phone #**: _____

Date of Birth _____ **SS#:** _____

1. I authorize the use or disclosure of the above named individual's health information as described below
2. The following are authorized to make the disclosure: _____
   Address:_____
3. The type of information to be used or disclosed is as follows:

Date(s) of Service: _____

☐ **Entire Medical Record** _____ *(Initial)*

I understand that if my record contains sensitive information such as mental health information, drug and alcohol abuse information or HIV related information, separate authorizations will be required as below.

☐ **Psychiatric information**: _____ _____
Signature *Date*

☐ **Drug/Alcohol information**:_____ _____
Signature *Date*

☐ **Results of HIV test**: _____ _____
Signature *Date*

4. The information identified above may be used by or disclosed to the following:

Jeffrey L. Brooks, MD 3260 Beard Road, Napa, CA 94558 Tele: 707.252.4955 Fax: 707.252.0525

5. This information for which I'm authorizing disclosure will be used for the following purpose:
   ☐Sharing with other health care providers as needed
   ☐Other (please describe): _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical record department. I understand that the revocation wi11 not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
7. Unless I specify differently, this authorization will expire six months from the date signed below
8. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
9. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment

_____ _____ _____

Signature of patient or legal representative **Date** **If signed by legal representative, relationship to patient**

I have been offered a copy of this Authorization Form ☐ Accept ☐ Refuse

The patient has given verbal authorization to release the above identified information. I have witnessed the verbal authorization. The patient has been informed of the nature of the authorization and freely gives his or her consent.

_____ _____
Signature of witness Date

_____ _____
Signature of witness Date

NAPA VASCULAR & VEIN CENTER

JEFFREY L. BROOKS, M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____