BASS MEDICAL GROUP

Valy Boulom, MD, RPVI
BASS Vascular Surgery

P: (408) 333-9580
F: (408) 663-5222

Dear New Patient,

Welcome and thank you for choosing Dr. Boulom for your vein and vascular needs! Dr. Boulom looks forward to providing you, the patient, with care of the highest quality. Using state-of-the-art technology, Dr. Boulom provides comprehensive, individualized treatments tailored to the specific needs of each of her patients.

Dr. Boulom and her staff members are devoted to making your appointments as pleasant and enjoyable as possible. We take great pride in our ability to provide you with optimal care designed for your unique needs.

Please bring the following items with you to your consultation:

- New patient registration forms (if you have already completed them)
- Complete list of current medications with dosage and amount you take daily
    - e.g. Ibuprofen, 1 tablet 400 mg, four times daily
- Current photo ID
- Current insurance cards

For the convenience of our patients, we offer our services in both San Jose and Morgan Hill.

Below is our office schedule:

Mondays:
3190 S. Bascom Ave, #170, San Jose, CA 95124

Tuesdays, Thursdays, and Fridays:
18525 Sutter Blvd, #140, Morgan Hill, CA 95037

Our ultrasound technician, Joseph “Joe” Matthews, also provides his services at both of our locations. You can contact him at (408) 829-6486.

Below is our ultrasound schedule:

Tuesdays:
3190 S. Bascom Ave, #170, San Jose, CA 95124

Saturdays:
18525 Sutter Blvd, #140, Morgan Hill, CA 95037

Feel free to contact our office at (408) 333- 9580 with any questions or concerns you may have. We look forward to meeting you and providing you with a very pleasant experience.

With warm regards,
Dr. Boulom’s team

HIPAA / NOTICE OF PRIVACY PRACTICES

Understanding your Health Record/Information

State and federal laws permit us to use or disclose your health information to the following:

- Another specialist or physician who is involved in your care
- Your insurance company, for the purpose of obtaining payment for our services
- Our staff, for the purpose of entering your information into our computerized system
- Your treatment may involve sharing information with various entities for authorization, referrals, and test scheduling. This often involves sending information via fax, permitted by law. We have documented verification ensuring the confidentiality of fax transmissions.
- If this practice is sold, your health information will become property of the new owner.
- We may release some or all of our health information when required by law. Except as described above, this practice will not use or disclose your health information without your authorization.
- We utilize a shared Electronic Medical Record (EMR) accessible to our physicians, staff, and select Muir Medical Group IPA physicians for streamlined patient referrals and coordinated care. External release of EMR information requires explicit patient consent or as otherwise specifically permitted or required by law.

Your Health Information Rights

Your health record belongs to you, though legal exceptions exist unless otherwise required by law that your health record is the physical property of the healthcare practitioner or facility that compiled it. You have the right to limit information use, request a disclosure account, choose alternative communication methods or locations, and withdraw authorizations. You have the right to request in writing to inspect and/or receive a copy of your health information. Our office will charge a fee to cover copying and mailing of these records to you if they exceed a total of 25 pages.

We will use your information to contact you. For example, we may mail you an appointment schedule or call or text you with information regarding your care. If you are not at homem this information may be left on your answering machine or with the person who answered the phone. In an emergency, we may disclose your health information to a family member or another person designated responsible for your care.

Please designate who our offices CAN disclose your health information to, by checking the boxes below:

☐ OKAY to leave health information on answering machine / voicemail / text messages

☐ DISCLOSE TO ALL

☐ DISCLOSE TO THE SPECIFIC PERSONS LISTED BELOW:

_____

☐ DO NOT RELEASE ANY INFORMATION to anyone other than myself (the patient).

HIPAA / NOTICE OF PRIVACY PRACTICES pg. 2

Questions and Complaints

We reserve the right to change our privacy practices and the conditions of this notice at any time and without prior notice. In the event changes, an updated notice will be posted, and our office will notify you of the changes in writing. You have the right to file a complaint with the Department of Health and Human Services, 200 Independent Avenue, S.W. Room 509F Washington, DC 20201. Our office will not retaliate against you for filing a complaint. However, before filing a complaint or for more information of assistance regarding your health information privacy, please contact our Privacy Officer, Jenny Aivazian at (925) 932-6330.

Acknowledgement

Your signature acknowledges that you have received a read a copy of our Privacy Practices Notice. This document will remain as part of your records and is not a contract, authorization, release or consent form.

Patient or Legal Representative Signature: _____ Date: _____
Patient Name: _____ DOB: _____

If the person signing is not the patient, please provide:
Name: _____ Relationship to patient: _____

BILLING AND FINANCIAL POLICY pg. 1

Legal Notice

I, the patient, or the patient's representative, understand that all medical doctors at Bay Area Surgical Specialists, Inc. are licensed and regulated by the Medical Board of California. I can verify this by contacting the Medical Board at (800) 633-2322 or via the internet at their website: ww.mbc.ca.gov.

Insurance Information

I am responsible for providing Bay Area Surgical Specialists, Inc. with up-to-date insurance information and promptly informing them of any coverage changes affecting prior services. Patients must verify if the practice and physician are contracted providers. BASS and/or its representatives will make every effort to assist you, but ***BASS will not be held accountable for understanding every insurance plan.***

Co-payments, Co-Insurance, Deductibles, and Authorizations

- Our office is not directly involved in processing payments. If you have any billing questions, need to discuss your account and/or set up financial arrangements please contact our billing department at (925) 627-3424
- I acknowledge my responsibility to pay any co-payments, co-insurance, or deductibles. Three statements will be issued for outstanding balances after insurance payment, and failure to pay by the third statement may lead to the account being sent to a collection service, with the patient bearing associated collection, interest, or legal expenses.

BASS MEDICAL GROUP

Valy Boulom, MD, RPVI
BASS Vascular Surgery

BILLING AND FINANCIAL POLICY pg. 2

- I understand that the clinic will verify my insurance eligibility for surgery, but until claims are processed deductible amounts and co-insurance amounts prior to surgery cannot be determined. I further understand that a surgery co-payment may be collected upfront and that ***any fees I am quoted are estimated*** based on 1) anticipated surgery to be performed and 2) current information provided by my insurance carrier.
- I acknowledge the clinic will obtain the necessary authorizations, which are ***not a guarantee of payment***, prior to surgery, and that I am responsible for all changes not paid by my insurance carrier. I am responsible for all changes not paid by my insurance carrier. I am responsible for all charges not covered by my insurance, including delays exceeding 90 days or denial of insurance coverage. If my insurance seeks a refund, I'm financially responsible for those changes.

Cancellation and No-Show Fees

- For ultrasound imaging test appointments, a ***cancellation or no-show fee of $50.00 per test*** scheduled will be billed directly to me if I do not provide a ***24-hour cancellation notice.***
- For follow-up appointments, a ***cancellation or no-show fee of $25.00*** will be billed directly to me if I do not provide a ***24-hour cancellation notice.***
- A ***cancellation or no-show fee of $250.00*** will be billed directly to me if I do not provide a ***24-hour cancellation notice*** for the following procedures: sclerotherapy, radiofrequency ablation, VenaSeal closure.
- A ***cancellation or no-show fee of $500.00*** will be billed directly to me if I do not provide a ***24-hour cancellation notice*** for a phlebectomy procedure.

✶ **All cancellation fees must be cleared with our financial department before the next appointment.**

Methods of Payment Accepted

For your convenience, we accept Mastercard, AMEX, Visa, debit, and HSA cards for co-payments.

Other Fees

There is a $20.00 fee (per form) to complete paperwork associated with a patient's care.

Acknowledgement

I, as the responsible party, acknowledge my financial responsibility for all charges, regardless of insurance delays or denials. I authorize Bay Area Surgical Specialists, Inc. to seek benefits, receive payments directly, and disclose my clinical record to insurance companies for billing purposes. I agree to cover collection costs, attorney fees, and other incurred expenses for outstanding patient responsibility. If insurance payments are sent to me, I commit to promptly forwarding them to Bay Area Surgical Specialists, Inc. **By signing, I confirm that I have read the above policies as pertains to the physicians of Bay Area Surgical Specialists, Inc.**

Patient or Legal Representative Signature: _____ Date: _____

Patient Name: _____ DOB: _____

If the person signing is not the patient, please provide:

Name: _____ Relationship to patient: _____

PATIENT MEDICAL RECORDS RELEASE AUTHORIZATION

By signing this form, I authorize the release of confidential health information about me to the physician and the use of my records by the physician listed below:

BASS Medical Group
Dr. Valy Boulom, MD, RPVI
18525 Sutter Blvd, Suite 140
Morgan Hill, CA 95037
Phone Number: (408) 333-9580
Fax Number: (408) 663-5222

Please identify the information to be released:

☐ ALL RECORDS

☐ Specific records related to:

_____

Acknowledgement

By signing, I acknowledge that the identified information may be used by or released to the physician/facility listed above. I understand I have the right to revoke this authorization at any time, I understand if I revoke this authorization, I must do so in writing and present my revocation to the office.

Patient or Legal Representative Signature: _____ Date: _____

Patient Name: _____ DOB: _____

If the person signing is not the patient, please provide:

Name: _____ Relationship to patient: _____

BASS MEDICAL GROUP

Valy Boulom, MD, RPVI
BASS Vascular Surgery

NEW PATIENT REGISTRATION

Patient Details

Patient Name: _____
Last First Middle

Preferred Name (if applicable): _____ DOB: _____ SSN: _____

Permanent Address: _____
Street Apt # City ZIP Code

Please check your preferred method(s) of communication:
Home Phone: _____ ☐ Call Cell Phone: _____ ☐ Call ☐ Text

Email: _____

Legal Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Ethnicity: ☐ Non-Latino/Non-Hispanic ☐ Latino/Hispanic ☐ Decline to specify

Race: ☐ American Indian/ Alaska Native ☐ African American/ Black ☐ Native Hawaiian/ Pacific Islander ☐ Asian ☐ Caucasian/ White ☐ Decline to specify

Preferred spoken language: ☐ English ☐ Spanish ☐ Vietnamese ☐ Other: _____
Preferred written language: ☐ English ☐ Spanish ☐ Vietnamese ☐ Other: _____

Emergency Contact Name: _____ Phone: _____

Relationship to Patient: _____

Insurance Information

Primary Insurance Carrier: _____
Subscriber to Insurance: ☐ Self ☐ Spouse ☐ Parent ☐ Company ☐ Other: _____
Subscriber Information: ☐ Same as above (self) ☐ Subscriber information below

Subscriber Name: _____ DOB: _____ Legal Sex: ☐ Male ☐ Female

Secondary Insurance Carrier: _____
Subscriber to Insurance: ☐ Self ☐ Spouse ☐ Parent ☐ Company ☐ Other: _____
Subscriber Information: ☐ Same as above (self) ☐ Subscriber information below

Subscriber Name: _____ DOB: _____ Legal Sex: ☐ Male ☐ Female

BASS MEDICAL GROUP

Valy Boulom, MD, RPVI
BASS Vascular Surgery

Patient History

Patient Name: _____ DOB: _____
Last First Middle

Referring Doctor: _____ City: _____
Last First

Primary Care Doctor: _____ City: _____
Last First

Reason for Visit: _____

Is this work related? ☐ No ☐ Yes, date of injury: _____ Claim #: _____

Preferred Pharmacy: _____
Name Street City ZIP Code

Medications

☐ No medications taken
☐ See attached list
☐ Current medications and vitamins listed below

Name of Medication	Dose	Frequency

Allergies

☐ No known drug allergies
☐ All drug allergies listed below

Name of Drug	Reaction

Past Medical History

Please check whether you have or have had any of the following conditions:

Diabetes	☐ Y	☐ N	COPD/ Emphysema	☐ Y	☐ N
High blood pressure/ Hypertension	☐ Y	☐ N	Asthma	☐ Y	☐ N
High cholesterol	☐ Y	☐ N	Stroke	☐ Y	☐ N
Coronary artery disease	☐ Y	☐ N	Dementia (e.g. Alzheimer's)	☐ Y	☐ N
Congestive heart failure	☐ Y	☐ N	Parkinson's Disease	☐ Y	☐ N
Atrial fibrillation	☐ Y	☐ N	Hepatitis B	☐ Y	☐ N
Cancer	☐ Y	☐ N	Hepatitis C	☐ Y	☐ N
Type: _____			HIV	☐ Y	☐ N

Other Conditions: _____

BASS MEDICAL GROUP

Valy Boulom, MD, RPVI
BASS Vascular Surgery

Patient Name: _____ DOB: _____
Last First Middle

Past Surgical History

Please list all prior surgeries.

Surgery	Year	Surgery	Year

Family History

Please list any significant medical problems in your family (e.g. heart disease, heart attack, stroke, hypertension, high cholesterol, coronary artery disease, kidney disease, diabetes varicose veins, vascular disease, cancer, etc.).

Mother	☐ Alive ☐ Deceased	Cause of death (if applicable):
	Please list any significant medical problems:	
Father	☐ Alive ☐ Deceased	Cause of death (if applicable):
	Please list any significant medical problems:	
Sister	☐ Alive ☐ Deceased	Cause of death (if applicable):
	Please list any significant medical problems:	
Brother	☐ Alive ☐ Deceased	Cause of death (if applicable):
	Please list any significant medical problems:	
Family History	Please list any significant medical problems:	

Social History

Do you drink alcohol? ☐ Never ☐ Not currently ☐ Yes

Do you smoke? ☐ Never ☐ Former ☐ Some days ☐ Every day
↳ If former, how many years did you smoke? _____ What year did you quit? _____

Do you use recreational drugs? ☐ Never ☐ Not currently ☐ Yes

Have you ever used intravenous drugs? ☐ No ☐ Yes

Occupation: _____ ☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed

Who lives in your home with you? _____

Valy Boulom, MD, RPVI
BASS Vascular Surgery

Patient Name: _____ DOB: _____
Last First Middle

Review of Systems

Please check all that you are currently experiencing:

Constitutional
- ☐ Fever
- ☐ Headache
- ☐ Unexplained weight loss
- ☐ Neurological

Neurologic/ Psychiatric
- ☐ Numbness
- ☐ Tingling
- ☐ Weakness
- ☐ Dizziness
- ☐ Memory loss
- ☐ Seizures
- ☐ Anxiety
- ☐ Spinal cord injury
- ☐ Headache
- ☐ Difficulty sleeping

Dermatologic
- ☐ Rash
- ☐ Boils/ infections

Immunologic
- ☐ Hay fever
- ☐ Food allergies

Cardiovascular
- ☐ Chest pain
- ☐ Irregular pulse
- ☐ Heart attack
- ☐ Heart valve problem

Gastrointestinal
- ☐ Abdominal pain
- ☐ Nausea/ vomiting
- ☐ Indigestion/ heartburn
- ☐ Diarrhea
- ☐ Constipation

Metabolic/ Endocrine
- ☐ Excessive thirst
- ☐ Too hot
- ☐ Too cold

Genitourinary
- ☐ Cloudy urine
- ☐ Nausea

Vascular
- ☐ Cool extremity
- ☐ Pain in limb
- ☐ Varicose vein

Hematologic
- ☐ Easy bruising/ bleeding
- ☐ Blood clots in arms/ legs
- ☐ Anemia

Musculoskeletal
- ☐ Joint pain
- ☐ Back pain
- ☐ Artificial joints

ENT
- ☐ Runny nose
- ☐ Difficulty hearing

Please share any additional information you feel we should know:

Patient or Legal Representative Signature: _____ Date: _____
Patient Name: _____ DOB: _____

If the person signing is not the patient, please provide:
Name: _____ Relationship to patient: _____

Thank you for filling out our new patient packet! Please take the time to confirm that all forms are filled out with the appropriate information (e.g. demographics, medications, allergies, etc.) and signed.