

**SANTA ANA SKIN CARE CLINIC
683-B HARKLE RD
SANTA FE, N.M. 87505**

FIRST NAME: _____ **LAST NAME:** _____

DATE OF BIRTH: ____/____/____

MAILING ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

WORK #: _____ **HOME #:** _____

SS#: _____

WHO REFERRED YOU TO OUR OFFICE? _____

Thank you for choosing our office for all of your skin care needs. If at any time you have questions regarding your treatment please feel free to call the office. Please note that treatment fees are due at the time of services, and medical insurance does not cover treatments because they are considered a cosmetic luxury. Also note that the results of products and procedures are not guaranteed. Also all products and services offered through Santa Ana Skin Care Clinic are **non-refundable**.

SIGNATURE OF
RESPONSIBLE PARTY

DATE

MEDICAL HISTORY FOR VEIN TREATMENT

Santa Ana Skin Care Clinic

(505) 954-4422

What is the reason for today's consultation? _____

What medications are you allergic to? _____

What medications do you take routinely? _____

Do you have Hep A, Hep B, HIV or AIDS? _____ If so which one? _____

Have you had any previous surgeries (general or cosmetic)? _____

If yes please explain. _____

Do you smoke? _____ If so how often? _____

How long have your varicose or spider veins been a problem? _____

What problems do you have with your leg veins? Circle all that apply.

Appearance

Pain

Burning

Aching/Cramping

Heaviness

Swelling

Have you ever had vein treatments before? _____ If so please explain. _____

Are you currently pregnant? Yes or No

How many children have you given birth to? _____ Youngest age _____

Did pregnancy make your veins look worse? Yes or No

Have you ever worn support stockings? Yes or No

Do you bruise easily? Yes or No

Are you taking blood thinners (including aspirin, ibuprofen, vitamin E, coumadin ect.)?

Yes or No If so what are you taking and how often? _____

Have you ever had blood clots in your legs? Yes or No

Have you ever had blood clots in your lungs? Yes or No

Are you continuing to develop new veins? Yes or No

Have you recently experienced any significant weight gain or weight loss? Yes or No

Is there anyone in the family with vein problems? Yes or No Who? _____

What is your regular exercise program? _____

Do you lift weights with your legs? Yes or No

Does your work or daily activities require prolonged periods of sitting or standing?

Yes or No

Do you have any of the following medical conditions? Circle all that apply.

Headaches/migraines

Neurological disorders

Seizures/black outs

Stroke

Thyroid disease

Back/neck problems

High or low blood pressure

Heart condition

Asthma/lung disease

Hepatitis/liver disease

Kidney/bladder disorders

Diabetes

Leg or ankle skin ulcers

Stomach problems

Arthritis

Cancer

Get skin rashes easily

Phlebitis

Form keloid scars

Other please explain _____

The information I have given above is true and correct to the best of my knowledge. I understand that the treatment proposed for me and the results I can expect are based on the accuracy of the information that I provide.

Signature of responsible party _____

INFORMED CONSENT FOR SCLEROTHERAPY OR PULSED LIGHT (LASER) VEIN TREATMENT

Introduction

This form provides you with the information you need to make an informed decision about having treatment to improve the appearance of your varicose leg veins and superficial telangiectasias (“spider veins”). There are two main methods of treating leg veins without surgery: **1) SCLEROTHERAPY** is the injection of medicine into the veins to cause them to shrink and disappear. **2) LASER OR INTENSE PULSED LIGHT (IPL)** are flashes of light against the skin designed to heat up and destroy the smallest veins. Presented here are realistic objectives of the treatment program, details about the procedure, potential benefits as well as possible risks, complications, and other alternatives available to you for vein therapy. Please read this form carefully and be sure you understand it completely before deciding to have treatment. If you have any questions please ask. After reading this form, please sign your name at the end of the form.

OBJECTIVES OF TREATMENT

The purpose of these treatments are to improve the appearance of the blood vessels in the legs which have enlarged over time and are now either blue and bulging, or appear as red or blue thready streaks beneath the skin's surface. Treatments have proven highly effective in minimizing or eliminating most unwanted veins when all instructions are carefully followed. This is not a cure for the process that forms veins, but a way to control veins that have already formed; new veins are likely to continue appearing with time. No medical treatment is always effective 100% of the time and not every vein may completely disappear. More than one treatment is usually necessary; these are usually spaced about a month apart. The actual number of treatments needed varies depending on the type, size, age and location of the veins to be treated. While proven effective in the vast majority of cases, *no guarantee can ever be made that a particular patient will benefit from these treatments.*

PROCEDURE

All treatments begin with a consultation to examine your legs to determine if your veins are suitable for treatment. Rarely an existing problem is found with blood flow in the largest veins deep inside the leg that may require surgical correction before any non-surgical treatment will be effective on the smaller veins. **SCLEROTHERAPY** is a time proven method where medicine (the sclerosing solution) is placed directly into the vein itself through tiny injections. The solution causes the walls of the vein to become irritated and “sticky”. With help from external compression by a leg bandage or stocking, the vein's own walls stick together and the vein is sealed off so blood no longer flows through it (like pinching a drinking straw between your fingers). Once the vein has closed, the body breaks down the vein and reabsorbs it through a natural process so it is no longer visible through the skin. These superficial veins are no longer needed for circulation and no longer having them is not harmful to the body. **INTENSE PULSE LIGHT (IPL)**

transmits a flash of light through the skin where it finds the vein and causes it to heat up. The heat generated causes the walls of the vein to break down like the injected medicine.

RISKS AND COMPLAINTS

Dr. Leonora Lopez, MD makes every effort to provide you with treatment that is safe and effective. However, as with any medical procedure, undesirable side effects may rarely occur. These may include but not necessarily limited to:

1. Discomfort

Most patients do not find the treatment uncomfortable or objectionable. The tiny needles used for injections are among the smallest made. Still, there may be a brief sensation of pain or burning at the injection site. The older “saline” injections tended to be more uncomfortable than the more modern agents we use today. IPL treatments feel like a brief sensation of heat or the feeling of snapping a rubber band. The area may feel tender after treatment but subsides within a few days.

2. Itching, Redness, & Swelling

You may experience mild itching along the vein or red bumps on the skin. This is a common temporary skin reaction to irritation taking place inside the vein and generally passes within a few hours. IPL can produce redness or swelling that may last from one hour to several days.

3. Superficial Wound or Skin Ulcer

IPL can cause a blister or crusting of the skin that heals in a few days. With injections, a tiny bit of the sclerosing solution may rarely leak into the skin outside the vein causing a blister that can become a shallow wound, or ulcer. These are usually the size of a pencil eraser and eventually heal, although they can leave a small white scar (salami spot).

4. Matting

Sometimes following treatment of a cluster of spider veins with injections or IPL, a network of new tiny veins may appear very near the ones that were already treated. These areas called “mats”, may appear as a blush of little threads and usually respond well to a repeat treatment like the first.

5. Infection

All equipment that penetrates the skin is sterilized. Infections after vein treatment are extremely unlikely, but can occur.

6. Allergic Reaction

Anyone may have an allergic reaction to any sclerosing solution, but it is very rare. In such a case, another solution can be substituted or a different treatment chosen.

7. Phlebitis

Abnormal severe inflammation of the vein, or phlebitis, occurs in less than one out of a thousand patients. More often, a lump may appear in a treated vein that may feel sore. This is simply a blood clot that forms as a normal part of treatment but generally poses no health risk. It can easily be removed in the office at the next visit if it does not disappear on its own.

Alternative Treatment

There are other alternatives besides having sclerotherapy, or laser (IPL). These include use of compression stockings alone, electrocautery, surgical removal of the

veins, or having no treatment at all.

Benefits of Sclerotherapy and Laser (IPL)

Sclerotherapy can effectively and dramatically improve the appearance, or totally remove even large unwanted veins, with only minimal risk, discomfort and cost, compared to surgery. Laser (IPL) may adequately treat the smallest veins that can not be easily injected.

Photography

The best way to measure results is by taking pictures before and after your treatment. Often we cannot otherwise realize the changes that have taken place. I authorize taking pictures and understand that photographs are important to my progress.

I certify that I have read and understand this entire document and it has been fully explained to me. I have been given the opportunity to ask questions and they have been answered to my satisfaction. I understand the risk and benefits of vein treatment, and other alternative methods of treatment. I understand that the best results are achieved from a series of several treatments and it is important to keep my scheduled appointments. I also agree to follow the doctor's instructions following each treatment as my results depend on my compliance. The fee structure has also been explained. I acknowledge that I have received no guarantee from anyone as to the results that may be obtained. I voluntarily give my consent to have this procedure performed on me.

Signature of Responsible Party

Date

PROCEDURE AGREEMENT FORM

- ____ Initials Prior to receiving treatment, I have been candid in healing any condition that may have bearing on this procedure, such as: pregnancy, recent facial surgery, allergies, cold sores/fever blisters use of medication, etc.
- ____ Initials I understand there may be some degree of discomfort, i.e.: stinging, pin pricking, hotness, tightness, etc.
- ____ Initials I understand there are no guarantees as to the results of this treatment, due to Many variables, such as: age, condition of skin, smoking, etc.
- ____ Initials I understand that I may or may not actually peel, that each case is individual.
- ____ Initials I understand that the treatments performed here are considered cosmetic, and there can be no guarantees of insurance payment.
- ____ Initials I understand that to achieve maximum results, I may need several treatments.
- ____ Initials I understand that although complications are very rare, they may still occur and that prompt treatment is necessary. In the event of any complications, I will immediately contact the doctor or aesthetician who performed the treatment.
- ____ Initials I agree to refrain from tanning booths while I am undergoing treatment, and during the 21 days following the end of treatment.
- ____ Initials I understand that direct sun exposure is prohibited while I am undergoing treatment, and the use of sun block with a minimum SPF 15 is mandatory.
- ____ Initials I have not had any other peel treatment of any kind within 14 days of this treatment. I understand I cannot have another treatment within 14 days of this treatment, whether the treatment is performed at this location or at any other location, unless directly expressed otherwise by the doctor or aesthetician.

I hereby agree to all of the above statements and have answered true and to the best of my knowledge. I give consent to have treatment performed on me. I further agree to follow all post care instructions as I am directed.

Patient Signature

Date

FINANCIAL POLICY

Please read our financial policy and indicate your agreement by your signature. We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. All patients must complete the appropriate information forms before seeing a skin care provider.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. (Unless other arrangements are made with the office manager.)

We accept cash, check, Visa, American Express, Discover and Master card.

Private pay patients: Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan or paid by cash, check, or credit card at the time of services.

Insured patients: If you have insurance we will help you receive maximum benefits. We will give you properly completed “super bills” so that you can file your own insurance and be reimbursed to the extent of your coverage. We only file claims to insurance companies that we are participating providers for. Filing a claim is not a guarantee of payment. Many of our services are considered to be a cosmetic luxury and are therefore not covered by insurance. You are responsible for the full payment of any denied claims.

Insurance: This is a contract between you and your insurance company. In many cases we are not a party to this contract. We will inform you if we are a party to your contract, and we will handle your claims according to our agreement with your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance usual and customary charges, etc. other than to supply actual information as necessary. You are responsible for timely payment on your account.

Missed appointments: Unless canceled or rescheduled at least 24 hours in advance, our policy is to charge \$50 for missed appointments. Please help us serve you better by keeping scheduled appointments.

Balance due terms: Your signature below indicates your agreement with our terms for any unpaid balance due. Unpaid balances due will begin accruing interest at the rate of 12% per annum, for balance due over 30 days. If it becomes necessary to employ an attorney or collection agency to collect an unpaid balance due, those fees will be added to the balance due. If you are unable to pay a balance due, please discuss payment arrangements with our office manager.

Please Note: All products and services offered through Santa Ana Skin Care Clinic are non-refundable.

Responsible Party Signature: _____ Date: _____

PRIVACY POLICY

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice summarizes how we handle your information, and provides further details of our privacy policies and procedures.

How we may use and disclose your information: We use health information about you for your treatment, to get paid for treatments, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for these reasons. Beyond those situations, we will ask for your written authorization before using or disclosing your health information. If you sign an authorization to disclose information, you can later revoke it to stop further uses or disclosures.

Your rights: In most cases you have the right to look at or get a copy of your health information that we use to make decisions about you. If you request copies, we will charge you a cost-based fee and these copies will be made within 30 days. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.

Our legal duty: We are required by law to protect the privacy of your health information; provide this notice about our privacy policies; follow the privacy practices that are described in this notice; and seek your acknowledgement of receipt of this notice. We may change our privacy policies at any time. Before we make significant changes in our privacy policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time.

Privacy complaints: If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services.

If you have any questions or complaints, please contact:

Elena Winters
683 B Harkle Road
Santa Fe, NM 87505

(505) 954-4422 ext 1004

Responsible party signature: _____ Date: _____

PROCEDURE CLAIM REVIEW FORM

Santa Ana Skin Care Clinic would like to make you aware that in the in the event that we should submit a claim to your insurance company for a procedure reviewed here at our clinic, your insurance provider always reserves the right to review and deny any claim they receive. We may be able to find out for you if the procedure does not require a pre-authorization, but these procedures are still subject to review and possible denial. The only time your insurance company is obligated to pay any amount is if they give you a confirmed pre-authorization number which we will keep in your chart making you not responsible for payment; unless the treatment amount is applied towards a deductible then you will still be held responsible for payment. Your signature below indicates you agree to abide by the policy in this form.

I _____ have read and understand the Insurance Procedure Claim Review Form.

