**NEW PATIENT INSTRUCTIONS – CENTER FOR VASCULAR MEDICINE**

This information is provided to assist you in preparing for your initial appointment with us at Center for Vascular Medicine (CVM).

Please complete the following documents prior to your visit and bring them with you. This will help expedite the registration process.

1. **Patient Demographics Form –** This includes your personal and insurance information for us to register you with our practice.
2. **Patient Medical Information –** this captures your pertinent medical history and health information; please document all medications and supplements you may be taking at this time and any allergies you may have.
3. **Patient Privacy and HIPAA Protection Form –** this explains our compliance with the Health Insurance Portability and Accountability Act (HPIAA) Privacy regulations, and that our *Notice of Privacy Practices* is available for review. We require your acknowledgement of certain authorizations and consents.

**Most importantly,** when you come for your visit, please be sure to bring the following documents as we need copies of them for our records:

* A photo ID, such as: Driver’s License, State ID, Military ID, etc
* Your current insurance card(s) and Co-Payment, if appliable. The amount is available under “Specialist” either on your insurance card or on your insurance plan’s website.
* Your referral slip from your Primary Care Physician if required by your insurance plan. Please note, some insurance plans require an electronic referral be submitted by your PCP through the insurance website prior to your visit with CVM.

**Note:** *Your initial consultation and scan will take approximately two hours, so please plan accordingly. Please drink plenty of fluids, dress warmly, and bring loose fitting shorts (if possible) to facilitate your examinations.*

**We look forward to seeing you at our office soon. If you have any questions or need any assistance regarding the above information, please do not hesitate to contact us at any time.**

Your appointment is on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ @ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At our CVM office in: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT DEMOGRAPHICS**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **PATIENT INFORMATION *– (Please Complete All Fields)*** | | | | | | |
| **NAME (LAST, FIRST, MIDDLE INITIAL)** | | | **BIRTH DATE** | | **SEX** | |
| **STREET ADDRESS** | | | **CITY** | | **STATE** | **ZIP** |
| **PRIMARY PHONE #** | **ALT PHONE #**   * Text * Call * Text * Call | | **EMAIL** | | | |
| **PREFERED CONTACT METHOD:**   * Text * Email * Call | **MARITAL STATUS** | | **RACE/ETHNICITY** | | **PREFERRED LANGUAGE** | |
| **EMERGENCY CONTACT PERSON** | | | **RELATION** | | **EMERGENCY CONTACT #** | |
| **PRIMARY CARE PHYSICIAN (PCP)** | | **ADDRESS** | | **PHONE #** | | **FAX #** |
| **REFERRING PHYSICIAN (IF NOT PCP)** | | **ADDRESS** | | **PHONE #** | | **FAX #** |
| **ANOTHER PHYSICIAN THAT YOU WOULD LIKE RECORDS FAXED TO:** | | | | | | |
| **EMPLOYER INFORMATION** | | | | | | |
| **EMPLOYER NAME** | **ADDRESS** | | | | **PHONE** | |
| **PRIMARY INSURANCE – *(You Can Omit This If You Have Your Insurance Cards)*** | | | | | | |
| **INSURANCE NAME** | **POLICY HOLDER (IF NOT SELF)** | | **POLICY HOLDER DOB** | | **RELATIONSHIP TO PATIENT** | |
| **POLICY #** | **GROUP #** | | ***SPECIALIST* COPAY AMOUNT** | | **POLICY HOLDER EMPLOYER** | |
| **SECONDARY INSURANCE *– (If Applicable)*** | | | | | | |
| **INSURANCE NAME** | **POLICY HOLDER (IF NOT SELF)** | | **POLICY HOLDER DOB** | | **RELATIONSHIP TO PATIENT** | |
| **POLICY #** | **GROUP #** | | ***SPECIALIST* COPAY AMOUNT** | | **POLICY HOLDER EMPLOYER** | |

SIGNATURE OF PATIENT/GUARDIAN DATE

**PATIENT MEDICAL INFORMATION**

Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date \_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_

Height \_\_\_\_\_\_\_\_ ins. Weight \_\_\_\_\_\_\_\_ lbs. Pharmacy Name and # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Chief Complaint/Reason for Visit** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of First Symptoms \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear compression stockings? Y/N If Yes, when did you start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS – Include Dosage**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES – Include Reaction**

Latex Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Shellfish/Seafood Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contrast/Dye Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY**

**Have you ever smoked?** Yes / No Packs per day \_\_\_\_\_\_\_\_ Years \_\_\_\_\_\_\_

**Do you currently smoke?** Yes / No Packs per day \_\_\_\_\_\_\_\_ Years \_\_\_\_\_\_\_

**Do you use alcohol?** Yes / No Packs per day \_\_\_\_\_\_\_\_ Years \_\_\_\_\_\_\_

**MARITAL STATUS (please circle)**  Married Single Divorced Widowed

**PAST FAMILY HISTORY**: Please indicate if any family members have had any of the following and who:

High blood pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Stroke \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cancer (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High cholesterol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Varicose veins \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any of the following? (please circle)**

Diabetes

High blood pressure

High cholesterol

Heart disease

Blood clots (legs/lungs)

Bleeding / Clotting disorder

Kidney disease

Stroke or Mini-stroke

Arthritis

Asthmas or COPD

Acid reflux

Cancer (please specify)

Depression or Anxiety

HIV

Hepatitis (A,B or C)

Sleep Apnea

Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEART DISEASE**

Atrial Fibrillation Yes / No Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CABG Yes / No Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stents Yes / No Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of MI / Heart Attack Yes / No Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pacemaker / Defibrillator Yes / No Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you Currently on Dialysis** Yes / No

If yes, please provide name of dialysis center and physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you have had blood clots in your legs**, please specify the number of times \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PREVIOUS SURGERIES**

**Date Type of Surgery**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Total** **Pregnancies** (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_ **Total** **Births** (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF PATIENT/GUARDIAN DATE

**HIPAA POLICIES**

**Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

HIPAA permits CVM to discuss information with your family o others involved in your care or payment. To protect your information, *please enter the names of specific individuals that you want to grant access* in the table below. Your healthcare providers are automatically included.

|  |  |  |
| --- | --- | --- |
| **“Designee” – Print Name** | **Relationship to Patient** | **Contact Phone** |
|  |  |  |
|  |  |  |
|  |  |  |

**I give permission for messages to be left at the following contact methods:**

Home Phone Yes / No Preferred method of contact

Cell Phone Yes / No Preferred method of contact

Work Phone Yes / No Preferred method of contact

**RELEASE OF INFORMATION FOR PAYMENT OF SERVICES**

I authorize this office to release all information necessary for payment of services rendered, including medical records. I authorize any payers to pay benefits directly to this office. Any insurance requirements such as referrals or prior authorization are strictly patient responsibility. I understand that I am financially responsible for all services regardless of insurance benefits and am required to update my demographics and insurance with this office as necessary. I agree to promptly pay for the services rendered for me, or the above-named patient. If I fail to meet my financial commitment to Center for Vascular Medicine and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account.

**Initial** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**

We use information that you provide us, including heath information, to carry out treatment, payment, and operations. Please refer to our “Notice of Privacy Policy” for a more complete description. You have the right to review the notice before signing. The terms of our Privacy Policy may change. You may obtain a revised notice from our office by calling (301) 486-4690. You have the right to restrict the use of your health information to carry out treatment, payment, or health care operations. We are not required to agree to the restriction. If we do agree to any restrictions, the agreement is binding to us. You have the right to revoke this consent at any time by notifying us in writing. Our address is as follow: 7474 Greenway Center Drive Suite 900, Greenbelt, MD 20770. I hereby consent to Center for Vascular Medicine contacting my physician’s office to release pertinent information for future follow-up care. I hereby consent to the use and disclosure of my individually identifiable health information for treatment, payment, and operations.

**Initial** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHOTOGRAPH/VIDEO RELEASE:**

I consent for **medical photographs and/or video** to be taken of me by staff at The Center for Vascular Medicine. I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication, as well as to ensure patient safety. By consenting to these medical photographs and/or video, I understand that I will not receive payment from any party. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me.

**Initial** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF PATIENT/GUARDIAN DATE

**PHOTOGRAPHY/VIDEO/AUDIO RELEASE FORM**

**Purpose**: Center for Vascular Medicine (CVM) routinely collects patient **testimonials** as a part of our mission to provide state-of-the-art, compassionate, and cost-effective patient care. These testimonials are used to educate our community on the quality care that they can receive at our facilities.

I, (PRINT NAME) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby grant permission to the Center for Vascular Medicine to take and publish images, video and/or sound recordings of me in news releases and/or education and promotional materials in any medium of expression without limitation and without compensation to me of any kind. I further agree that my name and identity may be revealed in descriptive text or commentary in connection with the image(s) and/or recordings. \_\_\_\_\_\_\_ (INITIAL HERE ONLY IF PERMISSION TO IDENTIFY THE SUBJECT IS GRANTED). I agree that all such images and sound records shall remain the property of the Center for Vascular Medicine with exclusive right to their publication and that the Center for Vascular Medicine may assign the rights granted herein.

SIGNATURE OF PATIENT/GUARDIAN DATE

**Patient Financial Responsibility & Authorization form**

*Thank you for choosing Center for Vascular Medicine as your healthcare provider. We are honored by your choice and committed to providing you with the highest quality healthcare. We ask that your read, initial and sign this form to acknowledge your understanding of our patient financial policies, which are as follows:*

\_\_\_\_\_\_\_\_\_\_\_\_ **INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS**. I hereby authorize and direct payment of my medical benefits to Center for Vascular Medicine on my behalf for any services furnished to me by the providers.

\_\_\_\_\_\_\_\_\_\_\_ **AUTHORIZATION TO RELEASE RECORDS.** I hereby authorize Center for Vascular Medicine to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

\_\_\_\_\_\_\_\_\_\_\_ **Individual Financial Responsibility**. I understand that I am financially responsible for my health insurance deductible, coinsurance or noncovered service.

\_\_\_\_\_\_\_\_\_\_\_ **No Show charge.** There will be a no-show fee of $35 charged for any appointment that is not kept or cancelled at least 24 hours prior to the appointment. A credit card will be required to secure rescheduled appointments.

\_\_\_\_\_\_\_\_\_\_\_\_ **Time of Service payment.** Co-payments are due at time of service.

\_\_\_\_\_\_\_\_\_\_\_\_ **Referrals.** If my plan requires a referral, I must obtain it prior to my visit.

\_\_\_\_\_\_\_\_\_\_\_\_ **Non covered charges.** In the event, my health plan determines a service to be “not payable”, I will be responsible for the complete charge and agree to pay the costs of all services provided.

\_\_\_\_\_\_\_\_\_\_\_ **Uninsured patients**. If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.

*By my signature below, I acknowledge that I have received and read the financial policy provided by Center for Vascular Medicine.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient, Authorized Representative or Responsible Party Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient Date

**Referral Remittance Agreement**

\*Please initial all the following\*

**Important information about referrals**

Referrals need to come from your current PCP if you want your plan to cover or help pay for your care when:

* In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don’t get a referral first, the plan may not pay for the services.
* A specialist refers you to another specialist
* You’re going to see a specialist who’s not in your plan’s network
* You were seeing a specialist before enrolling in an HMO plan and you want to continue seeing that specialist
* You change your PCP while getting care from a specialist; your new PCP may need to issue a new referral

**Some other things you should know about referrals:**

* Referrals expire. You’ll have anywhere from 90 days to one year to see the doctor you were referred to, depending on the specialty

**\_\_\_\_\_\_** I am aware that my insurance provider \_\_\_\_\_\_\_\_\_\_\_\_requires a referral from my primary care physician for all specialist services.

**\_\_\_\_\_\_** I agree to obtain a referral for all services rendered on \_\_\_\_\_\_\_\_\_\_\_\_\_.

**\_\_\_\_\_\_** I am aware that I will be held financially responsible for services rendered on \_\_\_\_\_\_\_\_\_\_\_, if I do not supply the required referral. \*services rendered will be subject to CVM’s self-pay discount of $240.00. \*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(Print Name)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(Signature)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(date)**

**INDIANA**

**MUNSTER** **9339 CALUMET AVENUE UNIT D, MUNSTER, IN 46321**





