CENTER FOR VASCULAR MEDICINE™

301-486-4690

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: _____

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PATIENT DEMOGRAPHICS

PATIENT INFORMATION – *(Please Complete All Fields)*					
NAME (LAST, FIRST, MIDDLE INITIAL)			**BIRTH DATE**	**SEX**	
STREET ADDRESS			**CITY**	**STATE**	**ZIP**
PRIMARY PHONE # ○ Text ○ Call	**ALT PHONE #** ○ Text ○ Call		**EMAIL**		
PREFERED CONTACT METHOD: ○ Text ○ Call ○ Email	**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

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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) _____

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

Diabetes	Kidney disease	Depression or Anxiety
High blood pressure	Stroke or Mini-stroke	HIV
High cholesterol	Arthritis	Hepatitis (A,B or C)
Heart disease	Asthmas or COPD	Sleep Apnea
Blood clots (legs/lungs)	Acid reflux	Other (please specify):
Bleeding / Clotting disorder	Cancer (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) _____

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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 _____

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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

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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

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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)**

MARYLAND

(P) 301.486.4690 (F) 301.441.8809

ANNAPOLIS 108 FORBES STREET 2ND FLOOR, ANNAPOLIS, MD 21401
COLUMBIA 8860 COLUMBIA 100 PARKWAY, SUITE 400, COLUMBIA, MD 21044
EASTON 401 PURDY STREET, SUITE 204, EASTON, MD 21601
GLEN BURNIE 1600 CRAIN HIGHWAY SOUTH, SUITE 410, GLEN BURNIE, MD 21061
GREENBELT 7300 HANOVER DRIVE, SUITE 104, GREENBELT, MD 20770
PRINCE FREDERICK 301 STEEPLE CHASE DRIVE, SUITE 401, PRINCE FREDERICK, MD 20678
SILVER SPRING 10750 COLUMBIA PIKE, SUITE 605, SILVER SPRING, MD 20901
WALDORF 12107 OLD LINE CENTER, WALDORF, MD 20602

NORTH CAROLINA

(P)980-249-3360 (F) 301-441-8809

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GASTONIA 860 SUMMIT CROSSING PLACE, SUITE 120, GASTONIA, NC 28054

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