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.
4. **Photograph/Video Release Form –** This outlines our policy regarding the use of photography and videography during your medical appointment.
5. **Referral Remittance Agreement Form –** This outlines the important information about referrals. We require your acknowledgement of company policy if an insurance referral is needed for your appointment.

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)
- Your referral slip from your Primary Care Physician (if required by your insurance plan)

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 on (301) 486-4690.

Your appointment is on: _____ @ _____

At our CVM office in: _____

CENTER FOR VASCULAR MEDICINE™

PATIENT DEMOGRAPHICS

PATIENT INFORMATION – *(Please Complete All Fields)*					
NAME (LAST, FIRST, MIDDLE INITIAL)		BIRTH DATE	SEX		
STREET ADDRESS		CITY	STATE	ZIP	
HOME PHONE #	CELL PHONE #	EMAIL			
WORK PHONE #	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

CENTER FOR VASCULAR MEDICINE™

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) _____

CENTER FOR VASCULAR MEDICINE™

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) _____

SIGNATURE OF PATIENT/GUARDIAN DATE

CENTER FOR VASCULAR MEDICINE™

Patient Consent, Assignment of Benefits and Acknowledgement Form

Patient Name: _____ DOB: _____

Please read and acknowledge the following consents, assignment, and authorizations.

Consent for Diagnostic, Medical and/or Surgical Treatment: I wish to be evaluated and treated by the Center for Vascular Medicine (CVM). I hereby agree and give my consent to the providers/staff of CVM to order, prescribe and provide diagnostic, medical, and surgical treatment to me that they judge is appropriate in diagnosing and/or treating my medical condition(s).

Assignment of Insurance Benefits and Authorization to Pay Insurance Benefits: I authorize CVM to apply for benefits for services rendered to me or the patient under my health insurance policies providing benefits. I assign and authorize payment of benefits from my insurance plan(s) to CVM and grant permission to contact my employer or health plan(s) regarding insurance information and coverage of my health benefits.

No Show/Cancellation Policy: To accommodate scheduling of patient care and provide timely appointments, our practice has a No Show/Cancellation Policy. Any missed or no-show appointments for diagnostic scans or visits that are not canceled 24 hours prior to the appointment time may be charged a $35.00 fee. Our office reserves time for your care in good faith; please extend the same courtesy by contacting our office at least 24 hours prior to your appointment time to cancel or reschedule an appointment – Thank You.

Patient Financial Agreement and Payment Policy: I understand that CVM will bill my health insurance plan(s) for care I receive. I agree that payments from my health plan(s) will go directly to CVM. I understand that CVM can bill me directly when: (1) I choose to have care that my health plan covers but I do not secure needed referral or an approval for the care from my health plan; (2) I choose not to use my health coverage and agree to pay for the care myself; (3) CVM does not participate with my health plan and I agree to pay for 'out-of-network' care; (4) I receive care for service(s) or supplies that are non-covered by my health plan(s); or (5) I am uninsured and agree to pay for the medical services rendered to me at the time of service. I further agree to pay for all related collection costs related to my financial responsibility.

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, and noncovered service.

I understand and agree to the above consents, assignments, and authorizations: (Please sign and date below:)

_____

SIGNATURE OF PATIENT/GUARDIAN DATE

HIPAA Policies:

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

"Designee"- Print Name	Relationship to Patient	Contact Phone

Patient Care Communication Methods - Mail, Email, Text, Phone and Online Portal

HIPAA allows CVM to communicate with patients related to their care through the mail, emails, text, and phone. We also encourage patients to access secure Patient Portal to access your account information and send messages to CVM staff. If you would like to discontinue or "opt-out" of a specific method, please inform CVM staff of your preferences.

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

Notice of Privacy Practices

We use information that you provide us, including health 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 follows: 7500 Greenway Center Drive Suite 201, Greenbelt, MD 20770. I hereby consent to The 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.

SIGNATURE OF PATIENT/GUARDIAN DATE

Photograph/Video Release:

I, _____, hereby acknowledge and agree to the following terms regarding the use of photography or videography during my medical appointment:

1. I understand that the medical consultation and treatment provided to me are confidential and protected by privacy laws.

   Initial_____

2. 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 some may recognize me.

   Initial_____

3. I agree not to take any photographs or videos during my medical appointment without explicit consent from all individuals present, including healthcare providers and staff.

   Initial_____

4. I understand that the unauthorized capture of visual or audio recordings during my medical appointment could compromise the privacy and confidentiality of other patients, healthcare providers, and staff members.

   Initial_____

5. I acknowledge that any violation of this agreement may result in termination of my medical appointment and potential legal consequences.

   Initial_____

By signing below, I confirm that I have read and understood the terms outlined in this consent form regarding the use of photography and videography during my medical appointment.

_____

Signature of Patient/Guardian Date

CENTER FOR VASCULAR MEDICINE™

Referral Remittance Agreement

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.

Please initial all the following* <u>If your current insurer does not require an insurance referral, you can omit your initials below. However, we do require a dated signature to acknowledge your understanding of CVM's policy if your insurer changes and requires a referral.</u>

1. I am aware that my insurance provider _____requires a referral from my primary care physician for all specialist services.

   Initial_____

2. I agree to obtain a referral for all services rendered on _____.

   Initial_____

3. 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.*

   Initial_____

_____ (Print Name)

_____ (Signature) _____ (Date)

Referral Disclosure Form

You have been referred to the Center for Vascular Medicine for the evaluation and treatment of venous disease. Attached is a list of practices in the area that provide these services. You have the right to receive care from any practice and at any location of your choosing. You are not required to select a practice from the list provided. We will be pleased to assist you with scheduling an appointment at the practice you choose.

Please be aware that two physicians who are owners of Center for Vascular Medicine, LLC, Sanjiv Lakhanpal, M.D., and Khanh Nguyen, D.O., also have ownership interests in Center for Vein Restoration, LLC, and therefore derive financial benefit from patients receiving services at that practice.

I have read the foregoing statements and have received a copy of the attached list of practices. I understand that I have the right to have health care services at any practice I choose.

Patient Signature: _____

Patient Name: _____

Date: _____

Maryland & Virginia

Dr. James Laredo
Vascular Surgery
Inova Medical Group

Dr. Eddie Fernandez
Emergency Medicine
Center for Vein Restoration

Dr. Frank Sbrocco
OBGYN
Center for Vein Restoration