Vascular Institute of Virginia
14085 Crown Court, Woodbridge, VA 22193
1440 Central Park Boulevard, Suite 108, Fredericksburg, VA 22401
Phone : 703-763-5224 Fax : 703-763-5374
www.TeamVIV.com

REGISTRATION INFORMATION

To whom may we show our appreciation for referring you? _____

(Please fill out forms and return via email or print forms and bring them with you to the office.)

Name:_____

Ethnicity:_____

Language: ☐ English ☐ Spanish ☐ Other: _____

D.O.B.:_____/_____/_____ Social Security # _____-_____-_____

Address:_____P.O. Box: _____

City:_____State:_____Zip Code: _____

Please provide your contact information below and check box next to preferred method of communication:

☐ E-mail _____

☐ Home Phone: _____ ☐ Cell Phone: _____

May we leave a message? _____

Employer:_____Work Phone: _____

Primary Insurance:_____Guarantor/DOB:_____

Policy ID:_____Group #: _____

Secondary Insurance:_____ Guarantor/DOB: _____

Policy ID:_____Group #: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouse's Name:_____Spouse's Phone: _____

Please provide an emergency contact:

Emergency Contact:_____Relationship:_____

Emergency Contact Phone: _____

Primary Physician: _____ Phone: _____

Nephrologist:_____ Phone:_____

Podiatrist: _____ Phone:_____

Other: _____ Phone: _____

Signature:_____**Today's Date**: _____

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Patient Name: _____ MRN: _____

1. I understand that my health care provider wishes me to engage in a telemedicine visit.
2. My health care provider has explained to me how the video conferencing technology will be used. As such, a telemedicine visit will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit at any time.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes within our office.
5. I understand that billing will occur from my practitioner for my telemedicine visit.
6. I have had a direct conversation with my doctor, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____

Patient's/parent/guardian signature Date

_____ _____

Witness signature Date

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PATIENT FINANCIAL RESPONSIBILITY DISCLOSURE STATEMENT

Your signature below forms a binding agreement between the Vascular Institute of Virginia (VIV – the provider of medical services) and the Patient who is receiving medical services, or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills.

All charges for services rendered are due and payable at the time of service.

If your co-pay is based upon a percentage, and you do not have a secondary policy, please be prepared to pay your percentage.

PLEASE FAMILIARIZE YOURSELF WITH THE RULES AND REQUIRNMENTS OF YOUR INSURANCE.

MEDICAL INSURANCE: We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.

The patient or person signing on behalf of the Patient as the Responsible Party must:

- Inform VIV of the current address and phone number for the patient and the responsible party.
- Present all current insurance cards prior to each office visit.
- Verify at each visit that the information is current.
- Pay any required copay, deductible and non-covered services at the time of the visit.
- Pay any additional amount owing within 30 days of receiving a statement from our office. (When VIV receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you).

Returned Check Policy

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $25.00 Service Charge. Once notice is received of the returned check, VIV will send out a letter to notify the Responsible Party of the returned check. If a response is not made within 15 days from the letter date by the Patient or the Responsible Party, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance – in addition to the $25.00 Check Service Charge.

Self-Pay

If you do not have health insurance, payment is expected at the time of service unless other arrangements have been made prior to treatment. If a payment plan is needed for your services, please contact our office to speak to our billing department.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services, or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name (Please Print)_____

Patient Signature_____ Date_____

Responsible Party Name (Please Print)_____

Responsible Party Signature_____ Date_____

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RELEASE OF MEDICAL INFORMATION

Patient Name: _____

I authorize any licensed physician, medical practitioner, pharmacist, psychiatrist, psychologist or other mental health care provider, hospital, clinic or other medical or medically-related facility, insurance or reinsuring company, consumer reporting agency or employer having information available as to diagnosis, treatment of me and any non-medical information about me, to give any and all such information to Vascular Institute of Virginia.

_____ _____/_____/_____

Signature of patient or authorized representative Date

_____

Printed name

I authorize the following to have access to my medical records and discuss all issues pertaining to my care, treatment, and all other applicable information. I also give permission for my physician to give test results and discuss my medical condition with the below names person/persons.

Name:_____Relationship: _____

Name:_____Relationship: _____

Name:_____Relationship: _____

Name:_____Relationship: _____

_____ _____/_____/_____

Signature of patient or authorized representative Date

_____

Printed name

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices

_____ _____
Signature of Patient/ Patient Representative Date

_____
Relationship to Patient

Documentation of Good Faith Efforts
To obtain patient's acknowledgement that they received provider's Notice of Privacy Practices
(For use when acknowledgment cannot be obtained from the patient.)

The patient presented to the office on_____and was provided with a copy of vascular Institute of Virginia's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- ϒ Patient refused to sign.
- ϒ Patient was unable to sign or initial because:

  _____
- ϒ Patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity.
- ϒ Other reason (describe below):

  _____

Signature of Employee Completing Form: _____

Date Signed: _____

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PATIENT'S RIGHTS AND RESPONSIBILITIES

RIGHTS OF THE PATIENT:

- Every patient has the right to courtesy, respect, dignity, privacy, responsiveness, and timely attention to his/her needs regardless of age, race, sex, national origin, religion, cultural, or physical handicap, personal value and beliefs.
- Every patient has the right to every consideration of his privacy and individuality as it relates to his/her social, religious and psychological well-being.
- Every patient has the right to confidentiality to confidentiality. Has the right to approve or refuse the release of medical information to any individual outside the facility, except in the case of transfer to another health facility, or as required by law or third party payment contract.
- Every patient has the right to express grievances of complaints without fear of reprisals.
- Every patient has the right to continuity of health care. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient sufficient opportunity to make alternative arrangements.
- Every patient is provided with complete information regarding diagnosis, treatment and prognosis, as well as alternative treatments or procedures and the possible risk and side effects associated with treatment. If medically inadvisable to disclose to the patient such information, the information is given to a person designated by the patient or to a legally authorized individual.
- Every patient has the right to make decisions regarding the health care that is recommended by the physician. Accordingly, the patient may accept or refuse any recommended medical treatment.
- Every patient has the right to appropriate treatment and care to include the assessment/managements of pain.
- Every patient has the right to understand facility charge. You have the right to an explanation of all facility charges related to your healthcare.
- Every patient has the right to all resuscitative measures; therefore we will not honor Advance Directives.
- Every patient has the right to participate.

RESPONSIBILITIES OF THE PATIENT:

- Patients are responsible to be honest and direct about matters that relate to them, including answering questions honestly and completely.
- Patients are responsible to provide accurate past and present medical history, present complaints, past illnesses, hospitalizations, surgeries, existence of advance directive, medication and other pertinent data.
- Agree to accept all caregivers without regard to race, color, religion, sex, age, gender preference, or handicap, or national origin.
- Patients are responsible for assuring that the financial obligations for health care rendered are paid in a timely manner.
- Patients are responsible to sign required consents and releases as needed.
- Patients are responsible for either actions if they should refuse treatment or procedure, or if they do not follow or understand the instructions given them by the physician or VIV employees.
- Patients are responsible for keeping their procedure appointment. If they anticipate a delay or must cancel, they will notify VIV as soon as possible.
- Patients are responsible for the disposition of their valuables, as VIV does not assume the responsibility.
- Patients are responsible to be respectful of others, or other people's property and the property of VIV.
- Patients are to observe safety and no smoking regulations.

PATIENT COMPLAINT OR GRIEVANCE:

- To report a complaint or grievance you may contact the facility Administrator or Clinical Manager at 703-763-5224 or by mailing to center address.
- Complaints and grievances may also be filed through: Virginia Department of Health Professions, Perimeter Center, 9960 Maryland Dr. Suite 300, Henrico, VA, 23233-1463
  Or online at
  www.dhp.virginia.gov/enforcements/complaints
  By Phone at 800-533-1560
- All Medicare beneficiaries may file a complaint or grievance with the Medicare Beneficiary Ombudsman Online at www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

By signing below, I am acknowledging that I have received the Patient Bill of Rights and how to file a grievance, should I have one.

Patient Signature: _____

Date: _____

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ADVANCED DIRECTIVES

Vascular Institute of Virginia recognizes the right of patients to actively participate in decisions regarding their medical care including the right to have an ADVANCE DIRECTIVE.

Competent adults have the right to make decisions about recommended medical treatments and to be fully informed of the risks, benefits, complications, and alternatives to the prescribed treatment. This decision-making right not only includes the right to accept the treatment, but also the right to forego (refuse) the treatment offered.

Treatments that patients may decide to withhold/withdraw include, but are not limited to, ventilator support, chemotherapy, surgery, feeding tube, dialysis, antibiotics, transfusions and the use of cardiopulmonary resuscitation (CPR).

Regardless of such a decision, the dignity, social, psychological and spiritual well-being of the patient will be respected at all times. In addition, all nursing and comfort measures to relieve pain and suffering and provide hygienic care will be provided to all patients at all times.

We strongly suggest that you review the information and discuss your wishes with your physician, family and other healthcare professionals. If you already have an ADVANCE DIRECTIVE please make sure you provide a copy to the center staff.

A patient has the right to review and revise his/her ADVANCED DIRECTIVE at any time.

Once you have had a chance to review the material, please give this form to a healthcare provider and he/she will notify your physician. Should you have any questions, the nurse manager is available to assist you.

- ☐ I have received information on ADVANCED DIRECTIVES and would like assistance in completing one.
- ☐ I have received information on ADVANCE DIRECTIVES and would not like to complete one at this time.
- ☐ I already have a signed ADVANCED DIRECTIVE and will provide a copy to the office to keep in my chart. I can change or remove my ADVANCE DIRECTIVE at any time.
- ☐ I am aware that my ADVANCE DIRECTIVE/DNR will not be honored in this facility due to State Regulations.

_____ _____
Patients or Surrogate Decision maker Signature Date

If signed by Surrogate, state relationship to patient: _____

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Transportation Necessity Form

I, _____, hereby certify, represent
(Please Print Patient Name)
and warrant that a financial hardship would result if it were necessary for me to obtain my own transportation to and from VIV of Woodbridge or Fredericksburg to receive care. I understand that VIV *only* provides transportation services for appointments that will result in a procedure requiring sedation. For this reason, I am unable to drive myself for at least 24 hours and I am financially unable to provide any other services for myself.

In accepting complimentary transportation from the Vascular Institute of Virginia, I agree to the following:

- **I understand that I will be billed by VIV and responsible for payment for the full round-trip cost of any transportation provided *if I cancel the appointment/ride AFTER the driver has arrived at my residence/pick-up address for my appointment.***
- **I understand that transportation will be provided from my place of residence/care to the Vascular Institute of Virginia (Woodbridge or Fredericksburg location) and back to my place of residence/care. Requests for outside stops will not be permitted. This includes stops for:**
  - **Meals/Drive-Thru**
  - **Groceries**

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- **Pharmacy**

- **I will treat all drivers and their vehicles with kindness and respect. Litter, profanity, any forms of abuse, etc. directed towards the driver will not be tolerated.**

Should any of the above guidelines be violated, the Vascular Institute of Virginia will immediately cease the provision of this complimentary service.

☐ **This form does not apply to myself or the patient if I am the patient's representative; therefore, VIV will not provide any transportation services for procedures done in the office.**
(Please check box and sign below if this statement applies)

_____
Signature of Patient or Representative

_____
VIV Representative

Date: _____/_____/_____

Revised 06/25/2019

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MEDICAL QUESTIONNAIRE

Name: _____

Age: _____ Sex: Male ☐ Female ☐

Pharmacy Information:

Pharmacy Name/Location: _____

Pharmacy Phone Number: _____

Do you have any general allergies or allergies to any medications? Yes ☐ No ☐

If yes, please list and describe reactions:_____ _____

_____

_____

List all previous surgeries: _____

_____

_____

List all current medications: _____

_____

_____

_____

_____

Do you smoke? Yes ☐ No ☐ How much? _____ How long? _____

Do you drink Alcohol? Yes ☐ No ☐ # Drinks /day: _____

Do you use Marijuana, Cocaine, or other recreational drugs? Yes ☐ No ☐

Do you use a: Cane ☐ Walker ☐ Wheelchair ☐

Are you or could you be pregnant? Yes ☐ No ☐

Date of last menstrual cycle? _____

Do you, or have you ever had cancer? Yes ☐ No ☐ Type? _____

Do you have a family history of cancer? Yes ☐ No ☐

If yes, what family member and what type? _____

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REVIEW OF SYSTEMS

Print Patient Name: _____ Patient DOB: _____

Do you have any problems now or have you had any related to the following systems? Indicate yes or no.

GENERAL HEALTH	YES	NO
Dentures		
Glasses/Contacts		
Hard of Hearing		
Height		
Weight		
EYES	**YES**	**NO**
Glaucoma		
Cataracts		
CARDIOVASCULAR	**YES**	**NO**
Open Heart Surgery Type:		
High Blood Pressure		
Chest Pain		
Heart Attack/MI		
Irregular Heart Beat		
Heart Murmur		
Pacemaker		
Defibrillator		
Congestive Heart Failure (CHF)		
Mitral Valve Prolapse		
Rheumatic Fever		
Peripheral Arterial Disease (PAD)		
Hyperlipidemia		
Atrial Fibrillation		
PSYCHOLOGICAL	**YES**	**NO**
Anxiety/Extreme Nervousness		
Depression		
Psychiatric Disorders		
GENITOURINARY	**YES**	**NO**
Blood in Urine		
Nocturia (getting up at night)		
Urinary frequency (>8 times/day)		
Urinary tract infection		
Urinary leakage		
Kidney stones		
Kidney disease		
Dialysis Days?		
ENDOCRINE	**YES**	**NO**
Diabetes Type 1 ☐ Type 2 ☐		
Thyroid disease		
Comments:		

MUSCULOSKELETAL	YES	NO
Muscle weakness		
Join pain (swelling)		
Arthritis		
History of orthopedic surgery		
Chronic back pain/injury		
Chronic neck pain/injury		
NEUROLOGICAL	**YES**	**NO**
Tremors		
Dizzy spells		
Numbness/Tingling		
Stroke/CVA		
Seizures		
TIA's		
HEMATOLOGIC	**YES**	**NO**
Blood clotting problem		
Easy bleeding/bruising		
Anemia		
Sickle Cell trait or disease		
Enlarged lymph nodes		
Blood transfusion history		
Immune deficiency		
Hepatitis A ☐ B ☐ C ☐		
HIV		
RESPIRATORY	**YES**	**NO**
Asthma		
Chronic cough		
Shortness of breath		
Emphysema/COPD		
Exposure to Tuberculosis		
Pneumonia		
Bronchitis		
Sleep apnea Do you use a CPAP?		
GASTROINTESTINAL	**YES**	**NO**
Abdominal pain		
Nausea/vomiting		
Indigestion/Heartburn/GERD		
Constipation		
Diarrhea		
Bloody or Dark Stools		
Ostomy bag		
Comments:		

Patient Signature: _____ MVI Rep Signature: _____

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OB/GYNECOLOGICAL HISTORY

What symptoms are you experiencing due to the presence of fibroids?
(Check the response that most closely reflects the severity of your symptoms)

	None	Mild	Moderate	Severe
Menstrual Cramping	◯	◯	◯	◯
Pelvic pain	◯	◯	◯	◯
Frequent urination	◯	◯	◯	◯
Abdominal bloating	◯	◯	◯	◯
Pain during intercourse	◯	◯	◯	◯
Other (Please describe):				

Which one item listed above describes your most significant symptom?

MENSTRUAL HISTORY

Are you post---menopausal? …… Yes ☐ No ☐

Are your periods regular (22---35 days)? …… Yes ☐ No ☐

Number of days in your cycle? _____

How many pads or tampons used during the heaviest day of your period? _____

Do you bleed between periods? …… Yes ☐ No ☐

Do you pass clots? …… Yes ☐ No ☐

Could you be pregnant? …… Yes ☐ No ☐

What was the first day of your last menstrual cycle? _____

Do you use birth control? …… Yes ☐ No ☐

If yes, what type? Check the appropriate box:

Injectable/Implantable ☐ Condoms ☐ Pills ☐ Tubal ligation ☐

Print Patient Name:_____Patient DOB: _____

GYN DISORDERS

Please indicate whether you have had any of the following gynecologic disorders:

Endometriosis Yes No

Pelvic Inflammatory Disease Yes No

Pelvic adhesions Yes No

Adenomyosis Yes No

Other (please describe):

PREVIOUS DIAGNOSTIC TESTS

Please indicate whether you have had any of the following diagnostic tests:

☐ Ultrasound Date performed: _____

☐ CAT scan Date performed: _____

☐ MRI Date performed: _____

☐ PAP smear Date performed: _____

☐ Endometrial biopsy Date performed: _____

PRIOR TREATMENT OF SYMPTOMS

Lupron injections within the last 3 months? Yes No

If yes, how many injections? _____ Date of last injection:

Oral contraceptives within the last 3 months? Yes No

Non-steroidal anti---inflammatory drugs (i.e. Advil) within the last 3 months? Yes No

Depo---provera within the last 3 months? Yes No

Other (Provera, Aygestin, Megase, Synarel) within the last 3 months? Yes No

Print Patient Name:_____Patient DOB: _____

GYN SURGICAL HISTORY

☐	Myomectomy	Date performed: _____
☐	Myolysis	Date performed: _____
☐	D & C	Date performed: _____
☐	Ovarian Cysterectomy	Date performed: _____
☐	Endometrial Ablation	Date performed: _____
☐	Tubal Ligation	Date performed: _____
☐	Oopherectomy	Date performed: _____

Place Patient Label Here