



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

(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 check box next to preferred method of communication below:

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: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

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

Primary Physician: _____ Phone: _____

Nephrologist: _____ Phone: _____

OB/GYN: _____ Phone: _____

Other: _____ Phone: _____

Signature: _____ **Today's 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.

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 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 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.

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 Vasular 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 acknowledgement 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:

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

- _____
- Patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity.
 - 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 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.

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: ____/____/____



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MEDICAL QUESTIONNAIRE

Name: _____

Age: _____ Pharmacy Name/Location: _____

Pharmacy Phone Number: _____

Sex: Male Female

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

If yes, please list and describe reaction: _____

List all previous surgeries: _____

List all current medication: _____

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 your 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? _____

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	MUSCULOSKELETAL	YES	NO
Dentures	<input type="radio"/>	<input type="radio"/>	Muscle Weakness	<input type="radio"/>	<input type="radio"/>
Glasses/Contacts	<input type="radio"/>	<input type="radio"/>	Joint Pain (Swelling)	<input type="radio"/>	<input type="radio"/>
Hard of Hearing	<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>	<input type="radio"/>
Height:			History of Orthopedic Surgery	<input type="radio"/>	<input type="radio"/>
Weight:			Chronis Back Pain/Injury	<input type="radio"/>	<input type="radio"/>
EYES			Chronic Neck Pain/Injury	<input type="radio"/>	<input type="radio"/>
Glaucoma	<input type="radio"/>	<input type="radio"/>	Comments:		
Cataracts	<input type="radio"/>	<input type="radio"/>	NEUROLOGICAL		
CARDIOVASCULAR			Tremors	<input type="radio"/>	<input type="radio"/>
Open Heart Surgery	<input type="radio"/>	<input type="radio"/>	Dizzy Spells	<input type="radio"/>	<input type="radio"/>
Type			Numbness/Tingling	<input type="radio"/>	<input type="radio"/>
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	Stoke/CVA	<input type="radio"/>	<input type="radio"/>
Chest Pain	<input type="radio"/>	<input type="radio"/>	Seizures	<input type="radio"/>	<input type="radio"/>
Heart Attack/MI	<input type="radio"/>	<input type="radio"/>	TIA's	<input type="radio"/>	<input type="radio"/>
Irregular Heart Beat	<input type="radio"/>	<input type="radio"/>	Comments:		
Heart Murmur	<input type="radio"/>	<input type="radio"/>	HEMATOLOGIC/LYMPHATIC		
Pacemaker	<input type="radio"/>	<input type="radio"/>	Blood Clotting Problem	<input type="radio"/>	<input type="radio"/>
Defibrillator	<input type="radio"/>	<input type="radio"/>	Easy Bleeding/Bruising	<input type="radio"/>	<input type="radio"/>
Congestive Heart Failure (CHF)	<input type="radio"/>	<input type="radio"/>	Anemia	<input type="radio"/>	<input type="radio"/>
Mitral Valve Prolapse	<input type="radio"/>	<input type="radio"/>	Sickle Cell trait or Disease	<input type="radio"/>	<input type="radio"/>
Rheumatic Fever	<input type="radio"/>	<input type="radio"/>	Enlarged Lymph Nodes	<input type="radio"/>	<input type="radio"/>
Peripheral Arterial Disease (PAD)	<input type="radio"/>	<input type="radio"/>	Blood Transfusion History	<input type="radio"/>	<input type="radio"/>
Hyperlipidemia	<input type="radio"/>	<input type="radio"/>	Immune Deficiency	<input type="radio"/>	<input type="radio"/>
Atrial Fibrillation	<input type="radio"/>	<input type="radio"/>	Hepatitis	<input type="radio"/>	<input type="radio"/>
PSYCOLOGICAL			Type		
Anxiety/ Extreme Nervousness	<input type="radio"/>	<input type="radio"/>	HIV	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	RESPIRATORY		
Psychiatric Disorders	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>
GENITOURINARY			Chronis Cough	<input type="radio"/>	<input type="radio"/>
Blood in Urine	<input type="radio"/>	<input type="radio"/>	Shortness of Breath	<input type="radio"/>	<input type="radio"/>
Nocturia (getting up at night)	<input type="radio"/>	<input type="radio"/>	Emphysema/COPD	<input type="radio"/>	<input type="radio"/>
Urinary Frequency (>8 times/day)	<input type="radio"/>	<input type="radio"/>	Exposure to Tuberculosis	<input type="radio"/>	<input type="radio"/>
Urinary Tract Infection	<input type="radio"/>	<input type="radio"/>	Pneumonia	<input type="radio"/>	<input type="radio"/>
Urinary Leakage	<input type="radio"/>	<input type="radio"/>	Bronchitis	<input type="radio"/>	<input type="radio"/>
Kidney Stones	<input type="radio"/>	<input type="radio"/>	Sleep Apnea	<input type="radio"/>	<input type="radio"/>
Kidney Disease	<input type="radio"/>	<input type="radio"/>	Do you use a CPAP?	<input type="radio"/>	<input type="radio"/>
Dialysis	<input type="radio"/>	<input type="radio"/>	Comments?		
Days			GASTROINTESTINAL		
Comments:			Abdominal Pain	<input type="radio"/>	<input type="radio"/>
			Nausea/Vomiting	<input type="radio"/>	<input type="radio"/>
			Indigestion/Heartburn/GERD	<input type="radio"/>	<input type="radio"/>
ENDOCRINE			Constipation	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	Diarrhea	<input type="radio"/>	<input type="radio"/>
Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/>			Bloody or Dark Stools	<input type="radio"/>	<input type="radio"/>
Thyroid Disease	<input type="radio"/>	<input type="radio"/>	Ostomy Bag	<input type="radio"/>	<input type="radio"/>
Comments:			Comments:		

Patient Signature: _____ VIV Representative Signature: _____



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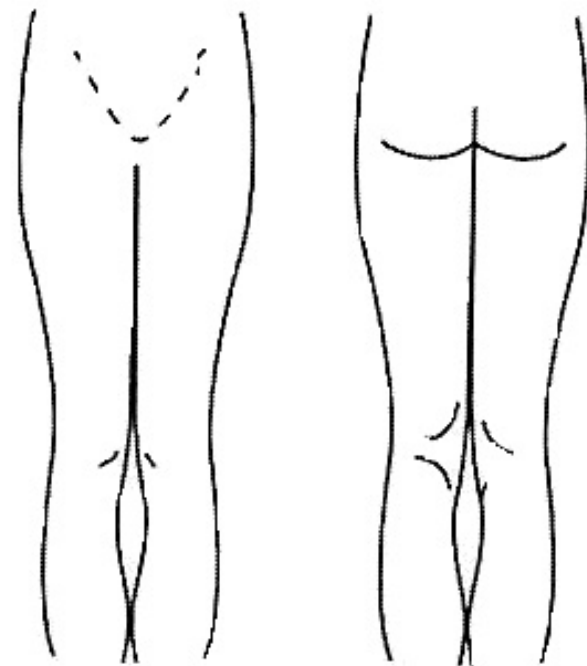
Screening for Arterial Disease

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain or kidneys become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

 Patient Name

 Date

Question	Yes	No
Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when walking?		
If you answered "Yes", please answer the following:		
Does the pain ever begin when standing or sitting still?		
When standing still does the pain continue for more than 10 minutes?		
Is the discomfort relieved with rest?		
Where do you get this pain or discomfort? Mark the diagram to your right with a "X"		
Do you experience any pain at rest in your lower leg(s) or feet?		
Do you experience foot or toe pain that often disturbs your sleep?		
Are your toes or feet pale, discolored or bluish?		
Do you have skin wounds or ulcers on your feet or toes that are slow to heal (8-12 weeks)?		
Has your doctor ever told you that you have diminished or absent pedal (foot) pulses?		
Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)?		
Do you have varicose veins?		



Pulse Checks	
R DP _____	L DP _____
R PT _____	L PT _____
Doppler Needed? _____	

Have you worn/been prescribed compression stockings? _____
 If so, for how long? _____

 Patient signature

 VIV Representative/ Date



VENOUS INSUFFICIENCY SCREENING

Do you experience any of the following symptoms in your legs? (Check all that apply and check the affected leg.)

<input type="checkbox"/> Aching/Pain RT <input type="checkbox"/> LT <input type="checkbox"/>	<input type="checkbox"/> Heaviness RT <input type="checkbox"/> LT <input type="checkbox"/>	<input type="checkbox"/> Fatigue/Tiredness RT <input type="checkbox"/> LT <input type="checkbox"/>	<input type="checkbox"/> Itching/Burning RT <input type="checkbox"/> LT <input type="checkbox"/>
<input type="checkbox"/> Throbbing RT <input type="checkbox"/> LT <input type="checkbox"/>	<input type="checkbox"/> Cramping RT <input type="checkbox"/> LT <input type="checkbox"/>	<input type="checkbox"/> Restlessness RT <input type="checkbox"/> LT <input type="checkbox"/>	<input type="checkbox"/> Swelling RT <input type="checkbox"/> LT <input type="checkbox"/>

Symptoms occur with: (Check all that apply.)

Standing Sitting Walking Sleeping After Walking/Activity

How have you tried to alleviate your leg discomfort? (Check all that apply.)

Compression Stockings Leg Elevation Rest breaks
 Exercise/Weight loss Analgesics Other _____

Have you ever worn compression stockings or support hose? Yes No

If yes, what type and for how long? _____

Does your job or daily life require prolonged periods of standing? Yes No

How many hours a day do you stand? _____

How many rest breaks do you require a day? _____

Have you ever been diagnosed with or treated for:

Blood Clot Phlebitis Bleeding Vein Venous Ulcer Varicose Vein

If yes, please describe the treatments and when they were received: _____

Are you currently pregnant or breastfeeding? Yes No

Have you ever been diagnosed with or treated for Migraine PFO

Please list your primary care physician or the physician who referred you: _____

For Office Use Only

Assessment: _____

Right Leg CEAP: _____ **Left Leg CEAP:** _____

Plan: _____

Provider: _____ **Date:** _____