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

Dear Sir,

Thank you for your interest in having your enlarged prostate treated at our facility. 2XU SKEDQKMSHUIRUPHGmU Prostate Artery Embolization (PAE) procedureV at the Vascular Institute of VirginiaDWWKWPHThe Vascular Institute of Virginia is a state of the art outpatient, imaging/surgical center. For more information about our facility, please visit our website at www.teamviv.com.

Based on the information you provide on the attached forms, RX SKEDQ will be able to determine if you are an appropriate candidate for the procedure. If so, a phone consultation will be arranged, at which time you will have an opportunity to ask questions and have any of your concerns addressed. If it is necessary for you to have any lab work or imaging done prior to performing the PAE procedure, we will email you prescriptions for those tests, so that you can have them done at a facility that is convenient for you. In addition to filling out the attached forms, please provide a photocopy of your driver's license or photo ID card and your health insurance card (front and back).

When you are ready to proceed, our financial coordinator will submit your information to your insurance company, for pre-authorization. We also have two cash options that can be discussed, if you decide to pay out of pocket.

For additional information regarding the procedure, please visit www.WHDPEom. If you have questions about our process, don't hesitate to contact our RIIEHWKHWDVSURGHORZ

/QDXNDUW
)URQ2IIEH0DQJHU
9DVFXD,QWWXWHRI9UJLQ

3KRH
)D
QR@teamviv.com

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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: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

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.

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 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, pay ent is e pected at the ti e of service unless other arrange ents have been ade prior to treat ent. If a pay ent plan is needed for your services, please contact our office to spea to our billing depart ent.

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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MEDICAL QUESTIONNAIRE

Name: _____

Age: _____

When was your last Influenza (Flu) Vaccination? _____
When was your last Pneumonia Vaccination? _____

List all previous surgeries:

_____
_____
_____
_____
_____

Pharmacy Name and Location: _____ Phone: _____

List all current medications and supplements:

Medication Name	Dose	Frequency/Schedule

PERSONAL MEDICAL HISTORY	FAMILY MEDICAL HISTORY	
Please check all that apply to you:	*Please check all that apply to your parents:*	
	MOTHER	*FATHER*
Diabetes	☐	☐
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Pacemaker	☐	☐
Stroke	☐	☐
Bleeding Problems	☐	☐
Heart Disease	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Kidney Disease	☐	☐
Liver Disease	☐	☐
HIV/AIDS	☐	☐
Seizures	☐	☐
Cancer If so, what type?	☐	☐

Cigarettes? # packs/day ☐ Previously ☐ Never ☐

Alcohol? # drinks/day ☐

Caffeine? # drinks/day ☐

Allergies: (list all medications, anesthetics, contrast agents, etc.)

REVIEW OF SYSTEMS

Patient Name:_____Patient DOB: _____

Do you have now, or have you had, any problems related to the following systems? Indicate Yes or No

GENERAL HEALTH	YES	NO
Fever	○	○
Chills	○	○
Weight change	○	○
HEIGHT: WEIGHT:		
EYES		
Glaucoma	○	○
Cataracts	○	○
Blurry Vision	○	○
Double Vision	○	○
CARDIOVASCULAR		
Chest Pain	○	○
Heart Attack	○	○
Irregular Heartbeat/A-fib	○	○
Peripheral Arterial Disease	○	○
High Blood Pressure	○	○
Angina	○	○
Congestive Heart Failure	○	○
Problem with Heart Valves	○	○
Rheumatic Fever	○	○
Pacemaker/Defibrilator	○	○
PSYCHOLOGICAL		
Anxiety	○	○
Depression	○	○
Difficulty Sleeping	○	○
Psychiatric Disorder	○	○
GENITOURINARY		
Change in Stream	○	○
Nocturia (getting up at night)	○	○
Urinary Frequency (>8 times/day)	○	○
Dysuria (burning with urination)	○	○
Blood in Urine	○	○
Urinary Tract Infection	○	○
Kidney Stones	○	○
Urinary Leakage	○	○
Kidney Disease	○	○
Currently on Dialysis	○	○
ENDOCRINE		
Excessive Thirst		○
Thyroid Condition		○
Diabetes	○	○

MUSCULOSKELETAL	YES	NO
Muscle Weakness	○	○
Joint Pain (Swelling)	○	○
Arthritis	○	○
History of Orthopedic Surgery	○	○
Chronic Back Pain	○	○
Chronic Neck Pain	○	○
NEUROLOGICAL		
Tremors	○	○
Dizzy Spells	○	○
Numbness/Tingling	○	○
Stroke	○	○
Weakness	○	○
Difficulty Walking	○	○
Loss of Bowel Control	○	○
Syncope/Fainting	○	○
Dementia	○	○
Seizures	○	○
HEMATOLOGIC/LYMPHATIC		
Blood Clotting Problem	○	○
Easy Bleeding/Bruising	○	○
Anemia	○	○
Enlarged Lymph Nodes	○	○
Transfusion History	○	○
Immune Deficiency	○	○
Hepatitis: Type_____	○	○
Cancer: Type_____	○	○
RESPIRATORY		
Wheezing	○	○
Chronic Cough	○	○
Shortness of Breath	○	○
Emphysema	○	○
Exposure to Tuberculosis	○	○
Sleep Apnea/CPAP use	○	○
Pneumonia	○	○
Do you use oxygen at home?_____Liters		○
GASTROINTESTINAL		
Nausea/Vomiting	○	○
Indigestion/Heartburn	○	○
Constipation	○	○
Diarrhea	○	○
Bloody or Dark Stools		○
Change in Bowels		○
Abdominal Pain		○
Gastric Ulcers		○

COMMENTS:

REVIEW OF SYSTEMS (CONTINUED)

SEXUAL HISTORY	YES	NO
Change in Sex Drive	○	○
Poor Sexual Performance/Lack of Erection	○	○

Have you had a PSA?

Date: _____ Result: _____

Have you had any of the the following prostate procedures? If yes, when?

- ☐ TURP _____
- ☐ Laser/Greenlight _____
- ☐ TUNA _____
- ☐ Microwave _____
- ☐ Urolift _____
- ☐ Prostatectomy _____
- ☐ Stent _____
- ☐ Other _____

AUA SYMPTOM SCORE

Last Name	First Name	Date

Please complete the questions below by choosing your response level and then putting the corresponding number in the blue box below that choice. *i.e. if your answer to question 1 is less than half the time enter the number 2 in the blue box. If it is almost always enter 5 in the blue box. Your scores will total automatically at the bottom. Complete the final question on how you feel by placing an X in the box next to the corresponding response.*

1. Incomplete emptying: Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?

Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	Your Score
0	1	2	3	4	5	

2. Frequency: Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?

Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	Your Score
0	1	2	3	4	5	

3. Intermittency: Over the past month, how often have you found that you stopped and started again several times when you urinated?

Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	Your Score
0	1	2	3	4	5	

4. Urgency: Over the past month, how often have you found it difficult to postpone urination?

Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	Your Score
0	1	2	3	4	5	

5. Weak-stream: Over the past month, how often have you had a weak stream?

Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	Your Score
0	1	2	3	4	5	

6. Straining: Over the past month, how often have you had to push or strain to begin urination?

Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always	Your Score
0	1	2	3	4	5	

7. **Nocturia: Over the past month or so, how many times did you get up to urinate at night from the time you went to bed until the time you got up in the morning?**

0	1	2	3	4	5+ times	Your Score
0	1	2	3	4	5	

TOTAL AUA SCORE _____

Quality of Life Due to Urinary Symptoms: If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that? *Place an X in the box next to the corresponding response.*

◯ Delighted ◯ Pleased ◯ Mostly satisfied ◯ Mixed ◯ Mostly dissatisfied ◯ Unhappy ◯ Terrible

The IIEF-5 Questionnaire (SHIM)

Patient Name:_____ DOB: _____

1. How do you rate your confidence that you can get and keep an erection?

Very Low	Low	Moderate	High	Very High
1	2	3	4	5

2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration?

Almost Never or Never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
1	2	3	4	5

3. During sexual intercourse, how often were you able to maintain an erection after you penetrated your partner?

Almost Never or Never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
1	2	3	4	5

4. During sexual intercourse, how difficult is it to maintain your erection to completion of intercourse?

Extremely Difficult	Very Difficult	Difficult	Slightly Difficult	Not Difficult
1	2	3	4	5

5. When you attempted sexual intercourse, how often is it satisfactory for you?

Almost Never or Never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than half the time)	Almost always or always
1	2	3	4	5

Please total your numerical score from above here: _____

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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:

- ☐ 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 <u>would like</u> 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**
- **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