Virginia Interventional & Vascular Associates
1201 B Sam Perry Blvd. Suite 265
Fredericksburg, VA 22401
540-654-9118 / Office
540-654-9116 / Fax

How did you hear about us? (Circle One) **Physician** **Family/Friend** **Internet (Please Specify)** ____________________
Radio **Telephone Book**
Newspaper **Community Event (Please Specify)** ___________

Patient Name____ Social Security#______________________________
Last First MI

Home Address: ____
Street City State Zip

Home Phone #___________________________ Cell # ____________________________Work #____________________________

DOB_______ / _______ / _______ Age ________ Sex _______ Email Address_____________________________________

Preferred Pharmacy _______________________________ Pharmacy Location/Phone#______________________________

Emergency Contact__________________________________Relationship_________________________Phone__________________

Primary Doctor ____ Referring Doctor____

INSURANCE INFORMATION

Primary____ Subscriber #____

Secondary____ Subscriber #____

Subscriber's Name________________________ Gender____ DOB _______________Social Security #_________________________
(If Other Than Patient)

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO OBTAIN OR RELEASE PATIENT INFORMATION

I hereby authorize the physician's office to release such information as may be necessary for claims to the insurance companies listed above. I also hereby authorize payment directly to Virginia Interventional Vascular Associates for any benefits otherwise payable to me, but not to exceed the regular charges for this period. I understand that I am financially responsible to the above physicians for charges not covered by this assignment. Patients not covered by insurance are responsible at the time of service for charges incurred or arrangements for payment must be made with the business office.

I also authorize the physicians' office to release or obtain such information as may be necessary to assist in my medical treatment. If this account has to be turned over to an attorney / collection agency, the undersigned agrees to pay all cost of collections, including attorney fees, interest, and court costs. This form will be placed in your chart and be applicable until such information is changed.

SIGNATURE
____DATE____

D.O.B. ____

Today's Date: _________________________________
Referring Physician: ____________________________
Reason for visit: _______________________________

Allergies: ___Latex ___Iodine ___Shellfish
____
____
____

Medications:

Name	Dosage	Frequency	Name	Dosage	Frequency

Please fill in each bubble completely. ● Example

Social History

Marital status	O Single	O Married	O Divorced	O Widowed
Employment Status	O Employed	O Unemployed	O Retired	
Smoking	O Yes	O No		
Alcohol	O Yes	O No		
Recreational drugs	O Yes	O No		

Past Medical History

Anemia	O Yes	Hepatitis C	O Yes
Hepatitis B	O Yes	HIV	O Yes
Stroke	O Yes	Diabetes	O Yes
Heart Murmur	O Yes	Cancer	O Yes
Thyroid Disease	O Yes	Leg Ulcers	O Yes
High Blood Pressure	O Yes	Deep Vein Thrombosis	O Yes
Kidney Stones	O Yes	Renal Dysfunction	O Yes
Seizures	O Yes	Heart Disease	O Yes
Asthma	O Yes	Rheumatic Fever	O Yes
Migraines	O Yes		

Virginia Interventional and Vascular Associates
1201B Sam Perry Blvd., Suite 265
Fredericksburg, VA 22401
(540) 654-9118 Fax (540) 654-9116

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I understand that under the Health Information Portability and Accountability Act (HIPAA) which became effective April 14, 2003, I have certain rights to privacy regarding my protected health information (PHI). I understand that this information legally can and will be used to:

- Conduct, plan, and direct my treatment and care among multiple providers
- Obtain payment from third party payers
- Conduct normal healthcare operations
- Provide information to referring physicians or medical professionals providing treatment

In addition to the above, an adult individual may authorize that his or her PHI may also be disclosed to family members or others. This authorization permits Virginia Interventional and Vascular Associates and Virginia Vascular Imaging to discuss my Personal Health information (PHI) to **ONLY** those individuals I have listed below:

1. ______________________________ Relationship___________________________
2. ______________________________ Relationship___________________________
3. ______________________________ Relationship___________________________
4. ______________________________ Relationship___________________________

I may elect to have this authorization expire on a date I specify in the future. The date I have entered below represents the date I wish this authorization to expire:

DATE OF AUTHORIZATION EXPIRATION: ____/____/____

_____ Check to the left if you do not wish this authorization to expire. However, you do retain the right to revoke this authorization at any time by sending a letter to:

Virginia Interventional and Vascular Associates
Virginia Vascular Imaging, LLC
Attn: Office Manager
1201B Sam Perry Blvd., Suite 265
Fredericksburg, VA 22401

I understand that the revocation will take effect on the date that it is received by the Office Manager.

I understand that once my PHI is disclosed pursuant to this authorization, the federal privacy protections will no longer apply to the disclosed PHI, and thus, my family member(s) and others to whom my PHI is disclosed may re-disclose that PHI.

NAME (print):________________________ DATE: ________________________

SIGNATURE OF PATIENT: ____