# Heart & Vascular Specialists
# Patient Registration & Consent Packet

**19465 Deerfield Ave, Suite 405, Leesburg, VA 20176**
**P: 571.252.8119 F: 800.735.1643**

## PATIENT INFORMATION

Patient Name: _____

Preferred Name: _____

DOB: _____/_____/_____ Sex: ___ SSN: _____

Address:

_____

City: _____ State: _____

Zip: _____

Home Phone: _____

Cell Phone: _____

Email Address:

_____

**Preferred Contact:**
□ Text Message □ Cell Phone □ Home Phone

**Marital Status:**
□ Single □ Married □ Widowed □ Separated □ Divorced

**Language:**
□ English □ Spanish □ Other: _____

**MEDICAL CONTACTS:** Please list the following

_____ _____
**Primary Care Provider** **Phone Number**

_____ _____
**Referring Provider** **Phone Number**

_____ _____
**Preferred Pharmacy** **Phone Number**

**EMPLOYMENT**
□ Full Time □ Part Time □ Self Employed □ Retired □ Student
□ Military □ Unemployed

Employer: _____

Occupation: _____

## ADDITIONAL INFORMATION

**Race:**
□ White □ Black/African American □ Asian
□ Hawaiian/Pacific Islander □ Other

**Ethnicity:**
□ Hispanic/Latino □ Non-Hispanic/Latino □ Other

**EMERGENCY CONTACT**

Name: _____

Relationship: _____

Phone: _____

**INSURANCE INFORMATION**

**Primary Insurance:** _____

**Member ID #:** _____

**Group #:** _____

**Relationship to Insured:**
□ Self □ Spouse □ Child □ Other

**Subscriber Name (if not self):**

_____

DOB: _____/_____/_____

**Secondary Insurance:** _____

**Member ID #:** _____

**Group #:** _____

**Relationship to Insured:**
□ Self □ Spouse □ Child □ Other

**Subscriber Name (if not self):**

_____

DOB: _____/_____/_____

**Heart & Vascular Specialists, PC**
**Privacy Practices Acknowledgment**
**Receipt of Notice of Privacy Practice**

_____
Patient's Name

I acknowledge that I have received a copy of Heart & Vascular Specialists' Notice of Privacy Practices. The Notice explains how my/the patients' protected health information may be used and disclosed and describes my privacy rights. I have been given an opportunity to ask questions about the Notice.

_____ _____
Patient/Representative Signature: Date:

_____
Relationship to Patient (if applicable):

**FOR OFFICE USE ONLY**

**If an acknowledgment could not be obtained, document the good-faith effort and reason below.**

Date: _____ Staff Initials: _____ ☐ Refused to Sign ☐ Other: _____

Reason/Notes: _____

## Heart & Vascular Specialists, PC
## Permission to Discuss Health Information
## Individuals Involved in my Care or Payment

I authorize Heart & Vascular Specialists to discuss relevant health information with the individual(s) listed below for purposes related to my care or payment, including appointments, test results, treatment plans, medications, and billing information, to the extent I have indicated.

| Name | Phone | Relationship | Information / Limits |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

I understand that I may revoke this permission in writing at any time, but the revocation will not affect information already disclosed in reliance on this permission. This form does not require the practice to disclose information when disclosure is not otherwise permitted by law.

My or my authorized patient representative's signature below confirms that this authorization accurately reflects my wishes.

_____ _____
Patient Name: Date Of Birth:

_____ _____
Patient Signature: Date:

**IF signed by patient representative:**

_____ _____
Representative Name: Relationship to Patient:

_____ _____
Representative Signature: Date:

**Patient Initials: _____** **GENERAL CONSENT**

I consent to medical evaluation and treatment provided by Heart & Vascular Specialists and its authorized clinicians and staff. I understand that no guarantee has been made regarding the outcome of care.

I understand that protected health information may be used and disclosed for treatment, payment, and health care operations as permitted by applicable law and the Notice of Privacy Practices.

---

**Patient Initials: _____** **NOTICE OF HIV / HEPATITIS B & C TESTING**

Virginia law requires healthcare providers to notify patients that if a healthcare professional or employee of **Heart &** Vascular Specialists, a Loudoun Medical Group Practice**,** is directly exposed to my blood or body fluids during my treatment, my blood may be tested for HIV and Hepatitis B and C as permitted by Virginia law. Test results may be released as required by law.

If I am directly exposed to the blood or body fluids of a healthcare professional or employee of Heart & Vascular Specialists, a Loudoun Medical Group Practice**,** I understand that the healthcare professional may also be tested as permitted by law.

---

**Patient Initials: _____** **MEDICATION HISTORY**

I authorize Heart & Vascular Specialists, a Loudoun Medical Group Practice, to electronically obtain medication history, pharmacy benefit information, prescription coverage, formulary information, and prescription information as permitted by law for purposes of medication safety and coordination of care.

---

**Patient Initials: _____** **HEALTH INFORMATION EXCHANGE**

Heart & Vascular Specialists participates in the Loudoun Medical Group Health Information Exchange to securely share clinical information with participating healthcare providers when necessary to coordinate your care.

**Please select one:**

☐ **OPT IN** – I authorize Heart & Vascular Specialists, a Loudoun Medical Group practice to securely send and receive my medical records through participating Health Information Exchange networks.

☐ **OPT OUT** – I do not authorize Heart & Vascular Specialists, a Loudoun Medical Group practice to exchange my medical records through participating Health Information Exchange networks.

---

**Patient Initials: _____** **TELEHEALTH CONSENT**

I consent to receive telehealth services from Heart & Vascular Specialists, a Loudoun Medical Group Practice, when clinically appropriate. I acknowledge that telehealth uses electronic communications and that technical difficulties or privacy risks may occur despite reasonable safeguards.

I agree to provide accurate medical information and participate from a safe and reasonably private location. I acknowledge that I may withdraw my consent at any time and that an in-person evaluation may be recommended when appropriate.

**Patient Initials: _____**

## FINANCIAL POLICY

I authorize Heart & Vascular Specialists, a Loudoun Medical Group Practice, to bill my insurance carrier for services provided to me and to receive payment of applicable insurance benefits. I acknowledge and agree that I am financially responsible for applicable copayments, deductibles, coinsurance, non-covered services, and other amounts determined to be my responsibility under my insurance plan and applicable law. I agree to provide current and accurate insurance information and to pay applicable patient-responsibility amounts when due.

I acknowledge and agree that **testing appointments must be cancelled or rescheduled at least 48 business hours in advance** and that **clinician/provider appointments must be cancelled or rescheduled at least 48 business hours in advance**.

I acknowledge and agree that late cancellations and missed appointments may be subject to the following fees:

- **$75** for vascular studies, echocardiograms, and regular stress tests.
- **$75** for all provider appointments, including consultations, follow-up visits, and other clinician appointments.
- **$200** for Nuclear Stress Tests.

I consent and agree to the applicable cancellation or missed appointment fee when the required advance notice is not provided or when I fail to attend my scheduled appointment. I acknowledge that repeated missed appointments or late cancellations may result in discharge from the practice in accordance with practice policy.

I acknowledge and agree that statements may be sent for unpaid balances and that overdue accounts may be referred to collections in accordance with applicable law and practice policy.

---

My or my authorized patient representative's signature below confirms that the information above has been read and understood.

_____ _____

Patient Name: Date Of Birth:

_____ _____

Patient Signature: Date:

**IF signed by patient representative:**

_____ _____

Representative Name: Relationship to Patient:

_____ _____

Representative Signature: Date: