Heart Vein & Vascular LLC
Babak Alex Vakili M.D, F.A.C.C, F.S.C.A.I
Integrative Cardiovascular Clinic
2170 W State Road 434, Suite 190
Longwood, FL 32779
Phone: 407-990-1921 Fax: 855-537-4411
E-Mail: Support@heartveinvascular.com
Web: www.heartveinvascular.com

PATIENT REGISTRATION

Directions: Please complete all sections, initial where necessary, and sign at the bottom. Write/check N/A if applicable.

Last Name:		First Name:		MI	Date:
Sex: M ☐ F ☐	DOB:	Age:	SSN:	Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed	
Home phone:		Cell:		Email:	
How do you prefer to be contacted? ☐ Home Phone ☐ Cell Phone ☐ Email					
Address:		City:		State:	Zip:
Employment Status:		Employer Name:		☐ N/A	Work phone:

How did you hear about us: ☐ family/friend ☐ doctor ☐ insurance company ☐ internet ☐ other			
Primary Care doctor:	Phone Number:	Fax Number:	
Referring Doctor Name:	Phone Number:	Fax Number:	
Pharmacy Name:	Location:	Phone Number:	

Do you have Health Insurance: ☐ Yes (a copy will be placed in your chart) ☐ No/Self Pay

EMERGENCY CONTACT INFORMATION

Name:		Relation:	Phone:
HVV has permission to discuss my medical care with myself and the following people:			

CONSENT TO TREATMENT & INSURANCE AGREEMENT

I authorize Heart Vein and Vascular LLC to examine me and order/perform any reasonable and necessary testing, to diagnose and treat my case. I acknowledge that I am voluntary seeking medical care without coercion.

Reimbursement of services rendered by HVV is described more fully in the Heart Vein and Vascular LLC written Notice of Privacy Practices as posted in office and available on request. I further acknowledge that I am responsible for paying any balances which remain after insurance payments have been made.

Signature of Patient or Patient Representative: _____ **Date:** _____

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MEDICAL HISTORY

- ☐ No known Medical History
- ☐ Angina
- ☐ Palpitations
- ☐ Cardiomyopathy
- ☐ Carotid Stenosis
- ☐ Congestive Heart Failure
- ☐ Arrhythmia
- ☐ CVA (stroke)
- ☐ Valve Disease
- ☐ Hypertension
- ☐ Ischemia
- ☐ Postural orthostatic tachycardia syndrome
- ☐ Chronic Vein Insufficiency
- ☐ Pedal Edema
- ☐ Atrial Fibrillation
- ☐ Coronary Artery Disease
- ☐ Renal Disease
- ☐ Peripheral Arterial Disease
- ☐ Fatigue
- ☐ Syncope (fainting)
- ☐ shortness of breathe
- ☐ Anemia
- ☐ Cancer
- ☐ COPD
- ☐ Alzheimer's/Dementia
- ☐ Sleep Apnea
- ☐ Thyroid Disease
- ☐ Hyperlipidemia
- ☐ Seizures
- ☐ Diabetes

Allergies

☐ No Known Allergies

Please list all known allergies: _____

Medications

☐ **No Medications Taken** ☐ **See Attached Med List:**

MEDICATION NAME	DOSAGE	FREQUENCY

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Dear Patient,

Thank you for choosing Heart Vein & Vascular, LLC for your healthcare needs. We are pleased to welcome you to our practice. We'd like to familiarize you with our policies to keep you informed and avoid any potential misunderstandings.

APPOINTMENTS: In the event you are unable to attend your scheduled appointment, please provide a minimum of 24 hr. notice to avoid a no show/cancellation fee of $25.00 to your account. Diagnostic testing and procedures require a minimum of 48 hr. notice and a higher no-show fee will be applied to your account. This allows us to schedule other patients in the vacant appointment slot.

CO-PAYMENTS AND DEDUCTIBLE: By law, we are required to collect your insurance designated co pay at time of service. Any diagnostic testing or procedures performed may require a separate co pay, deductible and/or co-insurance.

FMLA/DISABILITY FORM COMPLETION: Please have FMLA and/or disability paperwork completed by your PCP wherever possible. If you may need FMLA and/or disability paperwork completed by our office, a $30 charge will apply. Please allow a minimum on 7 business days for completion of these forms.

MEDICAL RECORDS REQUESTS: We will provide you with a copy of your medical records upon request. **A charge of $1.00 per page will be assessed for the first 25 pages and $.25 per page thereafter.** There will be no charge if you would like them faxed. HVV is only permitted to release records from our facility.

REFILL REQUESTS: Medication refills will be sent electronically to your pharmacy on file. Refills are generally processed at your scheduled appointment. However, please call our office during business hours if refills are needed prior to your scheduled appointment date and we will process your request with in 72 hrs.

By initialing here, I am agreeing that I have read the information above. _____

MEDICARE AND MEDICAID PATIENTS: I certify that the Information given by me in applying for payment under Title XVIII of the Social Security Act is correct, I authorize any holder of medical or other information about me to be released to the Social Security Administration or its Intermediaries or carriers any Information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

INITIAL_____

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PATIENT NOTIFICATION RESPONSIBILITY: If my follow up appointment for results is cancelled or rescheduled by myself or HVV, I understand it is my responsibility to contact the office within 7-10 business days after the test or procedure has been completed to make an appointment to verify results.

Initial_____

PAYMENT/GUARANTOR: I agree to assist in communicating with my insurance should there be a delay in payment on claims over 30 days. If after 45 days the claim remains unpaid, I understand that I may be responsible for the balance. Initial_____

Advanced Directives: (for compliance with the patient self-determination act)

Have you executed an advanced directive? ☐ Yes ☐ No

If YES, is the directive in the form of: ☐ Living Will ☐ Durable Power of Attorney

☐ Health Care Surrogate

PATIENT CONSENT/NOTICE OF PRIVACY PRACTICES ACKNOWLEGEMENT FORM

I understand that under the HIPPA of 1996, I have certain privacy rights related to my protected health information. I understand that this information can be used to:

1. Conduct, plan, and direct my treatment and follow up among multiple healthcare providers who may be involved in such treatment directly and indirectly.
2. Obtain payment from third party vendors.
3. To conduct normal healthcare operations such as quality assurance and physician certifications.

I have been informed by Heart Vein & Vascular LLC's Notice of Privacy Practices which provides a more complete description of how my PHI may be used or disclosed. I understand that I have the right to review this Notice before signing this form. I understand that this organization at any time at their address to obtain a current copy of the notice.

By signing this form, I consent to the HVV's use and disclosure of my protected health information to carry out treatment and healthcare operations and/or determine a claim for payment as described in their Notice. By signing below, I also agree to all the information stated and understand my rights and responsibilities as a patient at HVV.

_____ _____

Printed Name of Patient or Patient Representative **Date**

_____ _____

Signature of Patient or Patient Representative **Relationship to Patient**

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HVV Authorization of Medical Records Form

I _____ hereby authorize Heart Vein & Vascular to obtain/release my Personal Health information from/to the following person(s) and/or organization(s).

Doctor/Health Provider or Plan Name:	Phone Number:	Fax Number:	Purpose of records request: ☐Release to HVV ☐Obtain from HVV
Doctor/Health Provider or Plan Name:	Phone Number:	Fax Number:	Purpose of records request: ☐Release to HVV ☐Obtain from HVV
Doctor/Health Provider or Plan Name:	Phone Number:	Fax Number:	Purpose of records request: ☐Release to HVV ☐Obtain from HVV
Doctor/Health Provider or Plan Name:	Phone Number:	Fax Number:	Purpose of records request: ☐Release to HVV ☐Obtain from HVV

The information disclosed may include matters regarding mental health, development disability, alcohol and drug abuse and neglect, sexual assault, adult disabilities, and infectious diseases including HIV. Refusal of information will result in such confidential records not being released. If you do not wish for such information to be released, state information to be excluded: _____.

This authorization is valid for records from _____ to _____/ ☐ Current Care.

_____ I understand that I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the office manager of HVV. I am aware to use and/or disclose my Protected Health Information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that HVV may not condition treatment on whether I sign this authorization. I further understand that the person(s) or organization(s) authorized to receive information may be re-disclosed and would no longer be protected by federal privacy regulations.

_____ I agree that a copy of this release or fax of this release should be valid as the original release. If I authorize HVV to fax information, I realize there are inherit risks in faxing Protected Health Information.

I understand that I will get a copy of this form after I assign upon request.

_____ _____ _____

Printed Name of Patient or Patient Representative **DOB** **Todays Date**

_____ _____

Signature of Patient or Patient Representative **Relationship to Patient**