PLEASE RETAIN FOR YOUR RECORDS

Vascular Specialists of Delaware, P.A.

One Centurian Drive
Suite 307
Newark, DE 19713

D. Bhaskar Rao, M.D., F.R.C.S.
Karen M. Smith, MSN, APRN, BC

Phone: (302) 543-8100
Fax: (302) 543-8905

Please complete the attached paperwork and either mail to our office or bring in on the date of your visit. Please also have the following highlighted items with you:

- **Insurance Card or Cards**
- **Photo Identification***
- Arteriogram Films and Report
- Ultrasound Report
- CT Films and Report
- MRI/MRA Films and Report
- Blood Work Reports
- Any Arm or Leg Circulation Test Reports
- Prescription for vascular test ordered by your doctor

***Accepted forms of identification are as followed:** photo identification issued by a local, state or federal government agency i.e. drivers license, State ID or other government/military issued photo ID.*
***If the patient is a minor:** photo identification of the patient's responsible party will be obtained.*
***If you do not have a valid photo ID:** Please bring **two forms** of non-photo ID, one of which is issued by a state or federal agency i.e. birth certificate, social security card, voters registration card, permanent residence card or "green card", etc.*

If an interpreter will be required for this visit, please notify our office at least 72 hours prior to your appointment.

If you are required by your insurance company to have a referral from your primary care physician, **it is your responsibility** to obtain this prior to your appointment. If you are unsure whether your insurance requires a referral, it is your responsibility to find out either from your insurance company or your primary care physician.

Please notify the office at least 24 hours prior to your appointment if you must cancel or reschedule for another day.

If you have any questions, please call our office at 302-543-8100 and we will be happy to assist you.

Thank You,

Vascular Specialists of Delaware, P.A.

Vascular Specialists of Delaware, P.A.

NAME _____ DATE _____

DATE OF BIRTH _____ AGE _____ SS#_____RACE _____ LANGUAGE _____

(PLEASE CHECK) ❑ LATINO* ❑ NON-LATINO* *Federal law requires that we obtain this information

(PLEASE CHECK) ❑ MALE ❑ FEMALE

(PLEASE CHECK) ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOW

ADDRESS_____ APT#_____

CITY _____ STATE _____ ZIP _____-_____

HOME NO. _____CELL NO. _____ WORK NO. _____

PATIENT E-MAIL ADDRESS: _____

REFERRING DR___ _____ FAMILY DR _____CARDIOLOGIST _____

INSURANCE INFORMATION:

Please note that all copays and deductibles are expected and will be collected at the time of service.

If you are a patient without insurance or you are a patient with insurance that requires you to see a physician within your network, and our office is not within this network, payment in full is required prior to services being rendered.

PRIMARY INSURANCE CO. _____IS A REFERRAL NEEDED? ❑ YES ❑ NO

COPAY _____ ID # _____ GROUP / ACCOUNT # _____

SECONDARY INSURANCE CO. _____IS A REFERRAL NEEDED? ❑ YES ❑ NO

ID # _____ GROUP / ACCOUNT # _____

****IF POLICY HOLDER IS ANYONE OTHER THAN THE PATIENT, PLEASE PROVIDE THE FOLLOWING:**

POLICY HOLDER NAME _____ DATE OF BIRTH _____

RELATIONSHIP TO PATIENT_____ SS# _____

IS YOUR CONDITION RELATED TO: **(LEAVE BLANK IF DOES NOT APPLY)**

❑ EMPLOYMENT/WORKMEN'S COMPENSATION ❑ AUTO INJURY

WILL AN INTERPRETER BE REQUIRED FOR THIS VISIT? ❑ YES ❑ NO

IF YES, WILL YOU BE BRINGING SOMEONE WITH YOU TO PROVIDE INTERPRETATION? ❑ YES ❑ NO

IN CASE OF EMERGENCY OR ANY APPOINTMENT CHANGES AND WE CANNOT REACH YOU; WE MUST HAVE A NAME AND NUMBER OF AN EMERGENCY CONTACT.

NAME _____ RELATIONSHIP _____

DAYTIME NO. _____ ALTERNATE NO. _____

Vascular Specialists of Delaware, P.A.

Name: _____ Date: _____

DESCRIBE YOUR PROBLEM AND HOW IT BEGAN:

_____

_____

_____

_____

HOW HAVE THE SYMPTOMS CHANGED OR PROGRESSED?

_____

_____

HAVE YOU HAD ANY TREATMENT OR HAVE YOU SEEN ANOTHER PHYSICAN FOR THIS PROBLEM?

_____

_____

PLEASE CHECK ALL THAT APPLY: (LEAVE BLANK IF 'NO')

PREVIOUS ILLNESS:

❑ HEART ❑ LUNGS ❑ LIVER ❑ GALLBLADDER

❑ STOMACH ❑ BOWELS ❑ BRAIN ❑ EYES

ARE YOU ON DIALYSIS? ❑ YES ❑ NO

IF YES, WHERE _____

PHONE NO. _____

WHEN? **M, W, F** OR **T, TH, SA** START TIME? _____

DO YOU HAVE A PACEMAKER? ❑ YES ❑ NO

SMOKING HISTORY: ❑ CURRENT ❑ FORMER ❑ NEVER
If history of smoking: How much _____ How long _____ Quit? _____

ALCOHOL HISTORY: ❑ CURRENT ❑ FORMER ❑ NEVER
If history of alcohol: How much _____ How long _____ Quit? _____

CAFFEINE HISTORY: ❑ CURRENT ❑ FORMER ❑ NEVER
If history of caffeine: How much _____ How long _____ Quit? _____

OFFICE USE ONLY

Vascular Specialists of Delaware, P.A.

NAME _____ DATE _____

HAVE YOU OR ANYONE IN YOUR FAMILY EVER HAD ANY OF THE FOLLOWING?

PLEASE CHECK THE APPROPRIATE BOX(ES)

Condition	Self	Mother	Father	Sister	Brother	Grandmother	Grandfather
HEART ATTACK	❒	❒	❒	❒	❒	❒ Maternal ❒ Paternal	❒ Maternal ❒ Paternal
STROKE	❒	❒	❒	❒	❒	❒ Maternal ❒ Paternal	❒ Maternal ❒ Paternal
DIABETES	❒	❒	❒	❒	❒	❒ Maternal ❒ Paternal	❒ Maternal ❒ Paternal
HIGH BLOOD PRESSURE	❒	❒	❒	❒	❒	❒ Maternal ❒ Paternal	❒ Maternal ❒ Paternal
CANCER (please specify type)	❒	❒	❒	❒	❒	❒ Maternal ❒ Paternal	❒ Maternal ❒ Paternal
ANEURYSM (please specify type)	❒	❒	❒	❒	❒	❒ Maternal ❒ Paternal	❒ Maternal ❒ Paternal
HIGH CHOLESTEROL	❒						
CORONARY ARTERY DISEASE	❒						
DVT (Blood Clot)	❒						
PULMONARY EMBOLISM	❒						
PERIPHERAL ARTERIAL DISEASE	❒						
VARICOSE VEINS	❒						
VENOUS INSUFFICIENCY	❒						
ASTHMA	❒						
LUPUS	❒						
RENAL FAILURE	❒						
COPD	❒						
DEPRESSION	❒						
THYROID (please specify type)	❒						
BLOOD DISORDER (please specify type)	❒						

PLEASE LIST ANY PREVIOUS OPERATIONS AND THEIR APPROXIMATE DATES:

1. _____

2. _____

3. _____

4. _____

Vascular Specialists of Delaware, P.A.

Name: _____ Date: _____

ARE YOU ALLERGIC TO IODINE OR SHELLFISH? ❑ YES ❑ NO

MEDICATION ALLERGIES ❑ **CHECK HERE IF NO MEDICATION ALLERGIES**

NAME OF MEDICATION_____ REACTION _____

NAME OF MEDICATION_____ REACTION _____

NAME OF MEDICATION_____ REACTION _____

PHARMACY NAME & PHONE _____

MEDICATION HISTORY CONSENT:
I give consent for Vascular Specialists of Delaware, P.A. to electronically access my medication history, via Surescripts network, stored in the databases of community pharmacies and pharmacy benefit managers. ❑ YES ❑ NO

LIST YOUR CURRENT MEDICATIONS

MEDICATION NAME:	**DOSE (ex: 20 mg)**	**FREQUENCY (ex: once daily)**	**Reason for taking Medication**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

THANK YOU FOR YOUR PATIENCE AND COOPERATION IN FILLING OUT THIS FORM.

I VERIFY THAT ALL OF THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. SHOULD ANY OF THE ABOVE INFORMATION CHANGE I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO NOTIFY THE PRACTICE.

PATIENT/POA SIGNATURE: _____ DATE: _____

PHYSICIAN SIGNATURE: _____ DATE: _____

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FOR ALL PATIENTS
AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT

I, _____, authorize any holder of medical or other information about me to release this information to my insurance company, its intermediaries or carriers, to my attorney or another healthcare provider, including information concerning HIV and/or mental health status and/or drug or alcohol problems. I hereby authorize direct payment of medical and/or surgical benefits to include major medical benefits to which I am entitled. Medicare, Private Insurance, and any other health plan to Vascular Specialists of Delaware, P.A. I also permit a copy of this authorization to be used in the place of its original. This assignment will remain in effect until revoked by me in writing. I understand that, as the services were performed for me or my legal dependent, I am financially responsible for all charges whether or not paid by insurance.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

FOR MEDICARE PATIENTS
PLEASE ALSO ANSWER THE FOLLOWING QUESTIONS

I request that payment of authorized Medicare/Medigap benefits to be made to me or on my behalf to Vascular Specialists of Delaware, P.A. for any services furnished my by Vascular Specialists of Delaware, P.A. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

In compliance with Medicare regulation, we are required to ask the following questions:

Currently, do you or your spouse work for a company that provides you health insurance? ____YES ____NO

Are you entitled to Medicare because of disability or End Stage Renal Disease? ____YES ____NO

Is the illness or injury the result of an automobile accident or other injury? ____YES ____NO

Has your treatment for the accident or illness been authorized by the Veterans Administration? ____YES ____NO

Are you entitled to any benefits under the Federal Black Lung Program? ____YES ____NO

I certify that this information is true and complete to the best of my knowledge.

Signature: _____ Date: _____

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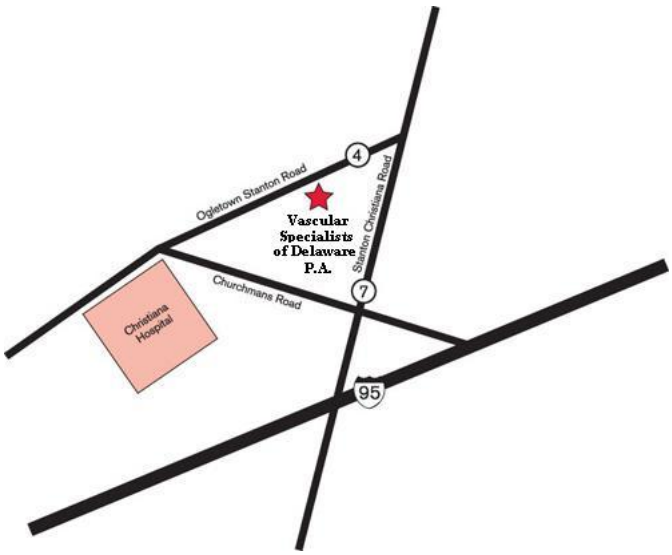

From Wilmington and north locations:

1) Take I-95 South towards Newark/Delaware Memorial Bridge.
2) Take the SR-58 exit (4B) toward SR-7N/Stanton/Metroform.
3) Turn right onto Stanton Christiana Road/DE-7 N. At the second light, make a left onto DE-4 W.
4) Abby Medical Center will be on the left side of Route 4 across from the First State Surgery Center.

From Newark, Maryland, and south locations:

1) Take I-95 North toward Delaware exit 4B (Route 7 North).
2) Stay on Route 7 North past exit for 58 and Christiana Care.
3) Make a left at the second light onto DE-4 West (Route 4).
4) Abby Medical is on the left across from the First State Surgery Center.

OR

1) Take DE-4 East (Route 4) towards Newark/Christiana Hospital
2) Stay on Route 4 as you pass Christiana Hospital on your right; Delaware Park will be on your left
3) Abby Medical Center will be on the right side of Route 4 across from the First State Surgery Center

From Dover & South of the C & D Canal:

1) Take DE Route 1 North over the new St. George's Bridge.
2) Stay on Route 1 North past Christiana Mall, it then becomes Route 7 North.
3) Stay on Route 7 North until you reach DE-4 West (Route 4) then make a left onto Route 4.
4) Abby Medical is on the left side across from the First State Surgery Center.

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PATIENT CONFIDENTIALITY FORM

PATIENT NAME: _____ DATE OF BIRTH: _____

DATE: _____

To our patients,

Please complete this form. This is for your protection and will allow us to forward information regarding your disease and care to the designated persons.

Physicians that you would like information passed on to (please list physicians' full name):

Referring Physician: _____

Primary Care Physician: _____
(if different than referring physician)

Cardiologist: _____

Other: _____

_____

Family Members who you would like us to contact if we need to speak with someone:

Primary Person _____ Phone _____

Secondary Person(s) _____ Phone _____

_____ Phone _____

Is there anyone that you DO NOT want us to discuss your care with? If so, please list:

_____

_____

Thank you for completing this form.

Patient Signature _____

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Patient Name: _____ DOB: _____ DATE:_____

TO OUR NEW PATIENTS: In order to assist you in your care, please check any of the following conditions that apply to you.

TO OUR RETURNING PATIENTS: Please check any conditions which may have changed since your last visit.

❒ CHECK HERE IF NONE APPLY OR THERE HAVE BEEN NO CHANGES SINCE YOUR LAST VISIT

Constitutional
__ Recent weight change
__ Fatigue
__ Fever
__ Rash

Neurologic
__ Headaches
__ Loss of vision
__ Slurred speech
__ Motor symptoms
__ Sensory symptoms

Eyes
__ Loss of vision
__ Glaucoma
__ Cataracts

ENT
__ Dizziness/Vertigo
__ Nosebleeds
__ Bleeding gums

Cardiovascular
__ High blood pressure
__ Heart trouble
__ Heart murmur
__ Palpitations
__ Shortness of breath
__ DVT/Blood clots
__ Pain when walking/stops with rest
__ Leg swelling/pain

Respiratory
__ Asthma
__ Emphysema
__ Tuberculosis
__ Cough
__ Coughing up blood

Gastrointestinal
__ Trouble swallowing
__ Nausea
__ Vomiting
__ Bloody stools
__ Diarrhea
__ Abdominal pain
__ Liver trouble
__ Gallbladder trouble

Genitourinary
__ Excessive/Frequent urination
__ Burning on urination
__ Pain on urination
__ Blood in urine
__ Kidney stones

Musculoskeletal
__ Extremity pain
__ Muscle pain
__ Joint pain
__ Arthritis
__ Gout

Skin
__ Rash
__ Lumps
__Open wound
__ Skin discoloration

Psychiatric
__ Anxiety
__ Depression
__ Post-Traumatic Stress Disorder
__ Bipolar Disorder
__ Schizophrenia
__ Multiple Personality Disorder

Endocrine
__ Excessive thirst/hunger
__ Heat or Cold intolerance
__ Diabetes

Hematologic
__ Anemia
__ Past transfusions
__ Easy bruising
__ Easy bleeding

Allergic/Immunologic
__ Allergies
__ Autoimmune disease

Patient Signature _____ Date _____

OFFICE USE ONLY: ❒ Entered in Chartmaker Initials _____

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*H*ealth *I*nsurance *P*ortability and *A*ccountability *A*ct
Notice of Privacy Practices

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to sue or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other healthcare providers who are participating in your treatment, to pharmacists who are filing your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will sue and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures
We may use of disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:
Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and administrative proceedings: We may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate for exercising these rights.
Notice of Breach: You have the right to receive notification if your Protected Health Information (PHI) has been breached.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions. You also have the right to request restrictions on information sent to your health plan(s) regarding services that you have paid for in full at the time of service.
Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.
Electronic Copies: You have the right to receive electronic copies of your PHI and to request in writing to have PHI transmitted to a third party of your choice.
Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this notice about our legal duties and privacy practice regarding protected health information, and to abide by the terms of the notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our notice and post the new notice in the waiting area and each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the >S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:

Vascular Specialists of Delaware, P.A.
One Centurian Drive, Suite 307
Newark, DE 19713

Effective Date: June 5, 2012

I _____
Hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____
Date: _____

If not signed, reason why acknowledgement was not obtained: _____

Staff Witness seeking acknowledgment
_____ Date_____