Nova Cardiovascular Care

422 Garrisonville Road #104 Stafford, VA. 22554
Ph: 540-628-2173 Fax: 540-628-2197

1990 Old Bridge Road # 201 Woodbridge, Virginia 22191
Ph: 703-492-6822 Fax: 703-492-6826

At NoVa Cardiovascular Care, we strive to provide culturally-sensitive patient care. Per our policy, we support our patient's right to utilize chaperones when requested or necessary during examinations or procedures.

Patient Name: _____

Patient DOB: _____

____ I wish to have a chaperone in the room during my test.

____ I do not wish to have a chaperone in the room during my test.

Patient Signature: _____

NOVA Cardiovascular Care, Inc.
Patient History Questionnaire

Name:_____ Date of birth: ___/___/_____ Age: ____

Referring Provider: _____ Today's Date: ___/___/_____

Reason for today's visit: _____

If you **HAVE HAD** or **CURRENTLY HAVE** any of the following,

please indicate with a check next to the condition:

CARDIOVASCULAR

- Angina/chest pain/chest discomfort
- Arrhythmia/palpitations
- Irregular heart rate
- Dizziness
- Fainting/near fainting
- Enlarged heart
- Heart attack
- Congestive Heart Failure
- Heart murmur
- High blood pressure
- Low blood pressure
- High cholesterol
- Rheumatic fever
- Leg swelling/edema
- Leg cramps with activity
- Erectile dysfunction
- Vascular Disease
  - Abdominal Aortic Aneurysm
  - Peripheral Vascular Disease
  - Carotid Arter Disease

RESPIRATORY

- Asthma
- COPD/Bronchitis
- Pneumonia
- Persistent cough
- Shortness of breath
- Sleep Apnea
  - CPAP? ___

HEMATOLOGY/ONCOLOGY

- Anemia
- Bleeding disorder
- Thrombophilia/Clotting disorder
- Blood clots in legs or lungs
- Cancer:

  _____

RHEUMATOLOGY

- Gout
- Arthritis/joint swelling
- Muscle aches
- Connective tissue disorder

INFECTIOUS DISEASE

- Hepatitis
- HIV/AIDS

ENDOCRINE

- Diabetes
- Thyroid Disease
- Weight gain/loss
- Night sweats

GASTROINTESTINAL

- Gastrointestinal bleeding
- Blood in stool
- Gall stones
- Hiatal Hernia
- Acid reflux/heartburn
- Stomach ulcers
- Liver Disease
- Nausea/vomiting

RENAL/UROLOGICAL

- Kidney Disease
- Dialysis
- Blood in urine
- Kidney stones
- Painful urination
- Enlarged prostate

NEUROLOGICAL

- Neuropathy
- Vision change / Loss of vision
- Stroke / TIA
- Seizures

PSYCHOLOGICAL

- Anxiety / Panic attacks
- Depression
- Insomnia
- Other psychiatric concern:
  - _____

PRIOR TESTING

- EKG
- Stress test
- Echocardiogram
- Heart catheterization
- Coronary angioplasty/stent
- Coronary bypass surgery (CABG)
- Valve repair/replacement
- Pacemaker or defibrillator
- TEE / Cardioversion
- Cardiac CT / Calcium scoring

NOVA Cardiovascular Care, Inc.
Patient History Questionnaire

Social History

Occupation: _____ Marital Status: Single / Partner / Married / Divorced

Smoker: yes / no If so, how long? ____ years. Packs per day: ____ If you quit, when? _____

Alcohol: yes / no If so, how much? _____ drinks per day / week / month

Recreational drugs: yes / no If so, what kind? _____

Caffeine: yes / no If so, how much? ____ drinks per day.

Exercise: yes / no If so, how often? ____ days per week. Type of exercise: _____

Family History

Please indicate any family health problems such as Hypertension, Diabetes, Coronary Artery Disease, Stents, CABG, Valve replacement/repair, Hyperlipidemia, AAA, CHF, Cardiomyopathy, Arrhythmias, Congenital Heart Disease, Sudden/unexplained death. Include age and alive/deceased.

Father: _____

Mother: _____

Siblings: _____

Other: _____

Surgical History

Please indicate any surgical operations you have had, including date if known:

_____

_____

Allergies

Are you allergic to any medications or food? yes / no If so, please list: _____

_____

Are you allergic to IODINE or CONTRAST DYE? yes / no

Current Medications

Please list current medications and doses (if known):

_____ _____

_____ _____

_____ _____

_____ _____

NOVA Cardiovascular Care

Dr. K. Yazdani - Dr. M. Ghazvini - Dr. S. Boloruduro
Jaime Stephenson, DNP - Matin Taheri, NP – Samuel Dogbey, PA
1990 Old Bridge Road Suite 201 Woodbridge, VA 22192
422 Garrisonville Road Suite 104 Stafford, VA 22554

Acknowledgement of Receipt of Privacy Practices

I, _____, have received a copy of the "Notice of Privacy Practices" for NOVA Cardiovascular Care, Inc. As provided in the notice, terms of the notice may change. If we change our privacy practices, you may receive a revised copy. This notice is available in our office for review. I understand that I may access my medical records at any time and that I may copy or inspect my PHI to be used or disclosed in accordance with NOVA Cardiovascular Care, Inc.'s policy. ____ I understand that NOVA Cardiovascular Care, Inc. may charge me for copies of my medical records or completion of medical forms (including FMLA, Worker's Comp, etc.) and that a fee schedule will be provided to me. Electronic copies of my records can be emailed to me directly or faxed to other providers for free. ____ I understand that a request for a copy of my records must be submitted to NOVA Cardiovascular care in writing and may take up to **7 business days** to process. ____ I understand that NOVA Cardiovascular Care, Inc. has the right to deny me access to my records in certain circumstances that are in accordance with the law; however, in such an instance I will be provided with a denial in writing. ____

Authorization For Use & Disclosure of Personal Health Information

Our Notice of Privacy Practices provides information about we may use and disclose protected health information (PHI) about you. It has been explained to the patient that disclosures may be made to family and friends related to the patient's health with permission provided by the patient. It has also been explained that we will only disclose information relevant to current treatment. Our patient has agreed to only disclose PHI to the following:

Spouse: _____ In Person ___ By Phone___

Parent(s): _____ In Person ___ By Phone ___

Sibling(s): _____ In Person ___ By Phone ___

Other: _____ In Person ___ By Phone ___

Expiration date of authorization: __/___/20___ **OR** Until otherwise specified ____

I, _____, authorize the use or disclosure of my PHI as specified in the Notice of Privacy Practices for NOVA Cardiovascular Care, Inc. I understand the purpose of the authorized use and disclosure of PHI is for use within NOVA Cardiovascular Care, Inc. or for authorized disclosure to another entity subject to the privacy rules of NOVA Cardiovascular Care, Inc. for treatment, payment, or healthcare operation purposes. I also understand that is the organization authorized to receive my PHI is not a health place or health care providers, that organization may disclose my PHI and it may no longer be protected under federal privacy rules and regulations. I understand that this authorization is voluntary and may be revoked at any time. I understand that I may ask questions of NOVA Cardiovascular Care, Inc. if I do not understand any information contained in the Notice of Privacy Practices.

Printed Name: _____ Date: ___/___/_____

Signature: _____ Relationship: _____

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VA Exchange Policies Waiver

NOVA Cardiovascular Care, Inc. accepts all patients regardless of their insurance status. It is, however, the patient's responsibility to check with their insurance about network coverage. NOVA Cardiovascular Care may not be in the preferred network of certain insurance policies, including some VA Exchange Plans. These new plans have developed due to healthcare changes connected to the Federally Funded Healthcare Policies.

Due to the possibility of healthcare changes, I, _____, understand that it is my responsibility as the insured part to have verified that my visit with any physician at NOVA Cardiovascular Care, Inc. will be covered by my current insurance plan as either an in-network or out-of-network service.

NOVA Cardiovascular Care, Inc. will do its best to submit and collect charges to/from my insurance company according to standard practices, but as the patient I am ultimately responsible for any charges that are incurred if my insurance company does not participate with NOVA Cardiovascular Care.

I have read the above, understand, and agree to these terms and conditions as they pertain to this and all future services with NOVA Cardiovascular Care, Inc.

Printed Name: _____

Signature: _____ Date: _____

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Patient's Rights and Responsibilities

Awareness of patient's rights has been heightened with the rise in healthcare consumerism. Patients have active participation in decisions about their healthcare. The conventional model where the doctor "always knows best" no longer goes unchallenged. Relinquishing power to patients includes acknowledging a patient's rights.

Patient Rights

A patient and/or his/her legal representative has the right to:

- Receive informed consent regarding procedures, risks and alternatives, and receive answers to questions with respect to treatments
- Refuse treatment and accept the potential consequences of that choice after thorough explanation
- Have another person present during exams and/or treatments
- Expect all communications and records will be treated as confidential
- Receive complete, current information concerning diagnosis, treatment, and prognosis in terms reasonably understood
- Know the identity and professional status of the individual providing the service to them
- Expect reasonable continuity of care
- Be fully advised of and accept or refuse to participate in any research project
- Receive an explanation of charges for services rendered
- Receive considerate and respectful care
- Expect to not be denied treatment solely on the basis of race, color, religion, or sexual preference

Patient Responsibilities

A patient and/or his/her legal representative has the responsibility to:

- Be honest and forthright with the doctor and office staff by providing accurate and complete information about present complaints, past illnesses, accidents, hospitalizations, medications, and any other information related to his/her health
- Report to the doctor in a timely manner any new incident, trauma, or changes in health
- Acknowledge and consider instructions provided by the doctor/staff
- Request clarification, about any aspect of care not fully comprehended
- Keep scheduled appointments or give adequate notice of delay or cancelations
- Treat doctors and staff with respect and courtesy
- **Seek results of any and all tests ordered in a timely manner, understanding their significance and that failure to do so may have a negative impact on health**

Considering the above items, lack of cooperation may cause endangerment to the patient's health and /or impaired results of care. It is permissible for the doctor to discontinue treatment of a patient who fails to cooperate in an agreed upon plan of management.

I understand and accept these terms and conditions.

Printed Name: _____

Signature: _____ Date: _____

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Authorization for Release of Medical Records

Patient Name: _____ DOB: _____
Address: _____
Phone Number: _____ Physician(s): _____

Please include the following items:

Admission Notes ___ Progress Notes ___

Discharge Summary ___ Pathology Reports___

Operative Reports ___ Consultation Notes ___

EKG's ___ Studies/Test Results ___

X-Ray Reports ___ Other (_____) __

I hereby authorize NOVA Cardiovascular Care, Inc. to release any and all medical records requested by the above-named Physician(s).

Signature: _____ Date: _____

NOVA Cardiovascular Care, Inc.

Patient Insurance Information

Patient Name: _____
First Middle Last

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (Home) _____ (Cell) _____ (Work) _____

Email Address: _____

SS#: _____ Date of Birth: _____ Gender: _____

Marital Status: Single / Partner / Married / Divorced Referring Provider: _____

** This information is required, regardless of insurance status **

Primary Insurance: _____ Phone Number: _____

Policy Holder: _____ Date of Birth: _____

ID #: _____ Group #: _____ Expiration: _____

Relationship to Policy Holder: _____ Policy Holder SS#: _____

Secondary Insurance: _____ Phone Number: _____

Policy Holder: _____ Date of Birth: _____

ID #: _____ Group #: _____ Expiration: _____

Relationship to Policy Holder: _____ Policy Holder SS#: _____

Emergency Contact / Next of Kin: _____

Emergency Contact Phone Number: _____ Relationship: _____

I, the undersigned, have insurance coverage with the above-named insurance provider and assign directly to NOVA Cardiovascular Care all medical benefits for services rendered. I understand that I am financially responsible for all charges unpaid by insurance. I hereby authorize NOVA Cardiovascular to release all information necessary to secure payment of benefits. I authorize the use of this signature on all of my insurance submissions. I understand that any charges incurred are ultimately my responsibility. If my account becomes delinquent, any fees required to collect the debt will be added to my account balance. I understand that there will be a $35 charge for any returned checks or insufficient funds. I have read and agree to the above terms and conditions.

Patient Signature: _____ Date: _____