Patient Registration

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Mailing Address: _____ City _____

State: _____ Zip: _____ Email Address: _____

Social Security #: _____ Preferred Language: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino Marital Status: ☐ M ☐ S ☐ D ☐ W Gender: ☐ Male ☐ Female

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other

Primary Phone: _____ Secondary Phone: _____

Occupation: _____ Employer: _____

Employer's Address: _____

Primary Care Physician (if different): _____ Phone #: _____

Emergency Contact: Name: _____ Relationship: _____

Phone #: _____ How did you hear about us: _____

Primary Insurance Company

Policy Holder: _____ Relationship To Patient: _____

SSN# of Policy Holder: _____ Date of Birth: _____

Name of Primary Insurance Company: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Policy Id #: _____ Group #: _____

Secondary / Supplemental Insurance Company

Policy Holder: _____ Relationship To Patient: _____

SSN# of Policy Holder: _____ Date of Birth: _____

Name of Secondary Insurance Company: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Policy Id #: _____ Group #: _____

Vienna
Woodbridge

Ashburn
Haymarket

Manassas
Stafford

Warrenton
Annandale

Visit us online at
www.carient.com
phone: 1.877.415.4116
fax: 703.335.9531

Carient
Heart & Vascular

I, _____ give my permission to any of the doctors or staff of Carient to speak to the following people regarding my medical care:

1) _____

2) _____

I give the staff at Carient permission to leave a message regarding satisfactory test results.

☐ YES ☐ NO **Initials**_____

Signature: _____

Notice of Cancellation Policies

Carient will implement the policies outlined below.

OFFICE VISIT: 24 hours notice is required to cancel an office visit appointment. The following fees will be charged for no show appointments and cancellations with less than 24 hours notice:

New Patient Visit	**$150.00**
Established Patient Visit	**$75.00**
Nursing Visit	**$25.00**

DIAGNOSTIC TESTS: 48 hours notice is required to cancel a procedure appointment. The following tests will be charged $150 for all no show appointments and cancellations with less than 48 hours notice.

Stress Test	Echocardiogram
Stress Echo	Thallium Stress
Carotid Doppler	Lower Extremity
Sleep Tests	

DIAGNOSTIC DEVICES: There will be a $50 charge per day for Holter Monitors that are not returned on time. The following fees will be charged for lost or damaged monitors:

Holter Monitor	**$795**
Pouch Set	**$35**
Compact Flash Card	**$40**
Lead Wire Set	**$35**

PLEASE READ AND SIGN THE FOLLOWING STATEMENT

I hereby authorize direct payment of medical/surgical benefits to Carient for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance. I hereby authorize Carient to release any medical or incidental information that may be necessary for either medical care or financial benefits. I request that payment of authorized benefits be made on my behalf. I understand that I am responsible for any collection fees associated with balances on my account. I agree that I am fully responsible for payment for all services rendered to me. If my account is referred for collection I will pay, in addition to the original amount owed, all costs of collection including attorney's fees equal to 1/3 of the debt owed. I understand that if I fail to comply with these polices, I may be subject to the charges outlined above. I also understand that missed appointment charges must be paid before subsequent appointments can be honored.

Patient or Responsible Party: _____ Date: _____

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.

This notice was published and becomes effective on/or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with administration in person or by phone at 703/335-8750.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____

Signature: _____ Date:_____

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Office Locations

Vienna, VA | 415 Church Street NE, Suite 101

Woodbridge, VA | 14904 Jefferson Davis Hwy, Suite 406

Ashburn, VA | 44790 Maynard Square, Suite 320

Haymarket, VA | 15195 Heathcote Blvd, Suite 310

Manassas, VA | 8100 Ashton Avenue, Suite 200

Stafford, VA | 422 Garrisonville Rd, Suite 110

Warrenton, VA | 559 Frost Ave, Suite 102

Annandale, VA | 7617 Little River Turnpike, Suite 710