Polaris Heart & Vascular Clinic

New Patient Registration Form

Please fill out this form completely. The following information will help us in providing you with the best medical care and treatment possible. If you have any questions, please contact the office.
Thank you and we look forward to seeing you!

PATIENT INFORMATION

First Name* | Last Name* | Middle Initial

Date of Birth* | SSN * | Gender | Your Pronouns

Cell Phone * | Home Phone | Other: | Email Address:

Address* | City, State* | Zip Code*

ADDITIONAL INFORMATION

Race *

- ☐ Native American
- ☐ Asian
- ☐ African American
- ☐ Hispanic
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other _____
- ☐ Decline

Ethnicity *

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Other _____
- ☐ Decline

Preferred Language

- ☐ English
- ☐ Spanish
- ☐ Other _____

EMERGENCY CONTACT INFORMATION

First Name* | Last Name* | Relation

Cell Phone * | Alternate Phone | Other Phone/Email:

Your Primary Care Provider (PCP) * _____ Phone: _____

Preferred Pharmacy _____ Phone: _____

Tel: (571) 398-2341
Fax: (571) 398-6388

2022 Opitz Blvd, Suite A & B,
Woodbridge, VA 22191

Scan for Direction

New Patient Registration Form

RESPONSIBLE PARTY (required if the patient is under 18, or has a Guardian or Guarantor)

First Name* | Last Name* | Relation

Cell Phone * | Alternate Phone | Other Phone/Email:

PRIMARY INSURANCE

Insurance Name* | Policy ID * | Group ID*

Policy Holder's Name (First, Last) * | Policy Holder's Date of Birth* | Policy Holder's SSN*

Patient Relationship to Policy Holder …. …:

SECONDARY INSURANCE

Insurance Name* | Policy ID * | Group ID*

Policy Holder's Name (First, Last) * | Policy Holder's Date of Birth * | Policy Holder's SSN*

Patient Relationship to Policy Holder …. …:

Tel: (571) 398-2341
Fax: (571) 398-6388

2022 Opitz Blvd, Suite A & B,
Woodbridge, VA 22191

Scan for Direction

New Patient Registration Form

MEDICAL HISTORY

Date today:

Please check all that apply*

- ☐ AIDS/HIV
- ☐ Asthma
- ☐ CAD
- ☐ CABG
- ☐ Carotid Disease
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ DVT
- ☐ Gout
- ☐ Heart Murmur
- ☐ Hepatitis A, B, or C
- ☐ Hiatal Hernia/Reflux
- ☐ Hypothyroidism
- ☐ Kidney/Urinary Problems
- ☐ Liver Disease
- ☐ Mental
- ☐ Mitral Valve Prolapse
- ☐ Palpitations/Irregular Heart Beats
- ☐ Peripheral Vascular Disease
- ☐ Pulmonary Embolism
- ☐ Pulmonary Hypertension
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Thyroid Disorder
- ☐ Ulcers
- ☐ Valvular Heart Disease
- ☐ Varicose Veins
- ☐ None

☐ Heart Attack	Please Specify When (if Applicable)	
☐ Stroke	Please Specify When (if Applicable)	
☐ High Blood Pressure	Please Specify How it is treated (if Applicable)	
☐ High Cholesterol or Triglycerides	Please Specify How it is treated (if Applicable)	
☐ Cancer	Please Specify the type (if Applicable)	

Pacemaker ☐No ☐Yes Brand: Referring Provider?

On Coumadin (Warfarin/Blood Thinners)? ☐No ☐Yes Followed by?

☐ Other Please Specify (if Applicable)

Do you experience any of the following?

- ☐ Bruise or Bleed Easily
- ☐ Cough
- ☐ Chest Pain/Pressure/Discomfort
- ☐ Dizziness
- ☐ Fatigue
- ☐ Edema (Swollen legs/ankles/feet
- ☐ Heartburn
- ☐ Sleep Disorder
- ☐ Palpitations/Irregular Heart Beats
- ☐ Nausea/Vomiting/ Abdominal Discomfort
- ☐ Leg Pain when walking
- ☐ Shortness of Breath while resting
- ☐ Shortness of Breath on exertion

New Patient Registration Form

MEDICAL HISTORY

Please list any Allergies *

Medication	Reaction

Please list all Medications you are currently taking * Include Over-The-Counter, Vitamins & Supplements

Medication	Dose	Times Per Day	Medication	Dose	Times Per Day

SURGICAL HISTORY

Please check all that apply*

- ☐ Appendix
- ☐ Tonsils/Adenoids
- ☐ Hysterectomy
- ☐ C-Sections
- ☐ Gallbladder
- ☐ Heart
- ☐ Angioplasty/Stent
- ☐ Pacemaker/ICD
- ☐ Other

Please Specify, if Applicable

New Patient Registration Form

SOCIAL HISTORY

Do you **smoke**? *

☐ No ☐ Occasionally ☐ Yes

How many cigarettes per day?
(If Applicable)

Any other forms of tobacco?
Please List, if Applicable

Do you **drink**?*

☐ No ☐ Occasionally ☐ Yes

How Often?
(If Applicable)

Do you use any illicit drugs?*

☐ No ☐ Occasionally ☐ Yes

Please List,
(If Applicable)

Do you **exercise**?

☐ No ☐ Occasionally ☐ Yes

If yes, how often and what type

FAMILY MEDICAL HISTORY

Does anyone in your family (living or deceased) have the following:

Please check all that apply*

☐ High Blood Pressure
☐ High Cholesterol
☐ Cancer
☐ Stroke
☐ Heart Disease
☐ Diabetes
☐ Depression
☐ Mental Illness
☐ Hypothyroidism

☐ Other
Please Specify, if Applicable

ACKNOWLEDGEMENT, the above information is true to the best of my knowledge.

Signature: **Date:** _____

Tel: (571) 398-2341
Fax: (571) 398-6388

2022 Opitz Blvd, Suite A & B,
Woodbridge, VA 22191

Scan for Direction

Patient Registration Form
Appendix A

IMPORTANT FINANCIAL POLICY & PATIENT RESPONSIBILITY NOTICE

Patient's First Name* | Patient's Last Name*

Insurance co-payments, co-insurance, deductibles, and non-covered services are expected to be paid at the time of service.

INSURANCE: We participate in multiple insurance plans, including Medicare. However, there are several commercial insurance plans that we do not participate with. If you are insured with a plan we are not contracted with, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. It is advised that you call and confirm with your insurance carrier that we are contracted with your insurance plan.

COPAYMENTS, COINSURANCE, AND DEDUCTIBLES: All co-payments, co-insurance, and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. When we do not collect copayments, coinsurance, and deductibles from patients at the time of service, it can be considered fraud. Please help us in upholding the law by paying your contracted fees at each visit.

PROOF OF INSURANCE: All patients must complete our patient information forms before seeing a provider. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

CLAIMS SUBMISSION: We will submit your claims for the insurance companies that we are contracted with and assist you in any way we reasonably can to help get your claim paid. Your insurance may need you to supply certain information directly. It is your responsibility to comply with their request in a timely manner. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefits are a contract between you and your insurance company.

NONPAYMENT: If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. In the event of finding it necessary to turn your unpaid balance over to a collection agency, all collection fees and/or legal fees will be owed in addition to the remaining balance. If this occurs, you will be notified by regular or certified mail.

Additional Practice-Related and Policies

$50.00 Fee - "No Shows" (failure to provide cancellation notice prior to your scheduled appointment), not paid by insurance. All appointments must be canceled **at least 36 hours** before the scheduled appointment.

$350.00 Fee - "No Shows" (failure to provide cancellation notice prior to your scheduled appointment), not paid by insurance. All PROCEDURE/TEST appointments must be canceled **at least 36 hours** before the scheduled appointment. You may be charged an additional fee for the Drug or Material which is prepared for your procedure/test.

$20.00 Fee - For MEDICAL RECORD requests, plus .50¢ per page, plus $5.00 postage for the mail. (You may also pick it up at once with NO additional $5.00 fee)

Patient Registration Form
Appendix A

$20.00 Fee - For all forms that need to be filled out by the providers.

$50.00 Fee - For returned checks for non-sufficient funds, which is charged back processing fee to the patient. We will be unable to accept any personal checks until the account balance and associated service fees are paid in full. If this is a repeated occurrence, we will only be able to accept cash or credit card as a method of payment.

ASSIGNMENT AND RELEASE: By signing below, I hereby authorize payment to Polaris Heart & Vascular Clinic for any benefits payable to me for the healthcare services provided to the client/patient at Polaris Heart & Vascular Clinic, to be paid directly to the practice. I understand that if the health insurance information is provided, this in no way relieves me of my financial responsibility for services rendered now or in the future at this practice. I understand that I am ultimately financially responsible for all amounts payable with regard to fees for healthcare services rendered now or in the future by this practice. I am responsible for paying the difference between the invoiced amount and the amount my insurance provider chooses to pay. In the event of non-payment by me of any amount due to the practice after 90 days, I agree to pay the original amount due, any collection fees of 33% of the amount due, court costs, and reasonable attorney's fees incurred by this practice in the process of collecting my debt owed.

By signing below, I acknowledge and understand the Financial Policy of Polaris Heart & Vascular Clinic and accept all payment terms under this Policy as well as my responsibility as a patient to know and understand my health insurance benefits for services provided.

Patient/Guardian's Signature _____ Date _____

HIPAA NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been presented with a copy of the HIPAA Notice of Privacy Practices for Polaris Heart & Vascular Clinic.

Patient/Guardian's Signature _____

Patient Registration Form
Appendix B

CONSENT FOR TEXT & EMAIL

Patient's First Name* | Patient's Last Name*

Polaris Heart & Vascular Clinic can provide our patients with certain types of information via email and text messaging, such as appointment reminders. If you wish to have the opportunity to receive notification of this type, please choose from the items below. The first option is your permission to receive texts and emails.

- ☐ Yes, please sign me up to receive email and text message confirmations.
- ☐ I do not wish to be contacted by either text messaging or email.

Polaris Heart & Vascular Clinic believes strongly in protecting the privacy of our patients. When you provide this information to us, it is only used to communicate with you. Confidential or personal information will not be sent from Polaris Heart & Vascular Clinic via email or text messaging to protect your privacy. Polaris Heart & Vascular Clinic does not share the names, email addresses, and telephone numbers of patients with any other company.

Patient/Guardian's Signature