Cardiothoracic &
Vascular Surgeons, Ltd.

CARDIOTHORACIC & VASCULAR SURGEONS, LTD
DR. HERMAN PANG

PATIENT INFORMATION

PATIENT'S NAME: ______________________________ DATE OF BIRTH: ______________________

ADDRESS: ____

CITY: __________________________ STATE: _______________ ZIP CODE: _____________________

HOME PHONE: ____________________________ CELL PHONE: _______________________________

WORK PHONE: ________________________ SOCIAL SECURITY #: __________________________

EMAIL ADDRESS: ____

WOULD YOU LIKE TO RECEIVE EMAILS REGARDING MONTHLY SPECIALS? _____ YES _____ NO

MARITAL STATUS: S M D W IF MARRIED SPOUSE'S NAME: ______________________

EMERGENCY CONTACT:

NAME: ____ PHONE: ______________________________

DOES THIS PERSON SCHEDULE APPOINTMENTS FOR YOU? YES NO

PATIENTS EMPLOYER: ____

ADDRESS: ____

CITY: __________________________ STATE: __________________ ZIP CODE: _________________

PRIMARY CARE PHYSICAN: _______________________________ PHONE: ___________________

REFERRING PHYSICAN: __________________________________ PHONE: ____________________

PRIMARY INSURANCE: ____

ID #__________________________________ GROUP: _______________________________________

SECONDARY INSURANCE: ____

ID #__________________________________ GROUP: _______________________________________

I, the undersigned certify that I have insurance coverage as stated above and assign payment to be made directly to Cardiothoracic & Vascular Surgeons, LTD / Dr. Pang. I understand that I am financially responsible for any co-insurance or co-payments that may occur and I authorize this office to release any information necessary to secure payment of benefits. I authorize the use of my signature on all insurance submissions. I authorize the use of my signature on all insurance submissions. I authorize Dr. Pang to request any medical records or information that may be necessary for my medical care.

PATIENT'S SIGNATURE: __________________________________ DATE: ______________________

CARDIOTHORACIC & VASCULAR SURGEONS, LTD
DR. HERMAN PANG
Venous History Questionnaire

Name_____________________________________ Age________ Date of Birth_________________

Ethnicity_________________ City ______________________ Occupation _____________________

Problem/Progression/Complications:____

____

____

How long have your legs bothered you? ____

Have you ever worn compression stockings? YES NO

Does one leg bother you more than the other? RIGHT LEFT EQUALLY

Have you or any of your family members traveled outside of the US recently? Yes No
Have you recently been sick with the flu or have had flu like symptoms? Yes No
If yes, what symptoms? Fever Headache Vomiting Diarrhea Sore Throat
Other: ____

Below are some questions about your legs. This information will help keep track of how you feel and how well you are able to do your usual activities.

1. During the past 4 weeks, how often have you had any of the following leg problems?

(check one box on each line)	Every Day	Several times a week	About once a week	Less than once a week	Never
Heavy/Full legs					
Aching/Throbbing legs					
Swelling					
Night cramps					
Heat or burning sensation					
Restless legs					
Itching					
Tingling sensation (e.g. pins and needles)					
Muscle fatigue					
Pain					
Bleeding					
Pelvic symptoms					
Easily bruise					

2. At what time of day are your leg symptoms the most intense? (circle one)

1. On waking
2. At mid-day
3. At the end of the day
4. During the night
5. At any time of the day
6. Never

3. Compared to one year ago, how would you rate your **leg problem** in general now? (circle one)

1. Much better than one year ago
2. Somewhat better than one year ago
3. About the same as one year ago
4. Somewhat worse than one year ago
5. Much worse than one year ago
6. I did not have any leg problems last year

4. The following items are about activities that you might do in a typical day. Does your leg problem now limit you in these activities? If so, how much?

(check one box on each line)	Not applicable	YES, limited a lot	YES, limited a little	NO, not limited at all
Daily activities at work				
Daily activities at home (e.g. housework, ironing, doing odd jobs/repairs, gardening, etc.)				
Social or leisure activities in which you are standing for long periods (e.g. parties, weddings, shopping, etc.)				
Social or leisure activities in which you are sitting for long periods (e.g. going to the cinema, theatre, travelling, etc.)				

5. During the past 4 weeks have you had any of the following problems with your work or regular daily activities **as a result of your leg problem**?

(check one box on each line)	YES	NO
Cut down the amount of time you spent on work and other activities		
Accomplished less than you would like		
Were limited in the kind of work or other activities		
Had difficulty performing the work or other activities (for example, it took extra effort)		

6. During the past 4 weeks, to what extent has your leg problem interfered with your normal social activities with family, friends, neighbors, or groups? (circle one)

1. Not at all
2. Slightly
3. Moderately
4. Quite a bit
5. Extremely

7. How much leg pain have you had in the past 4 weeks? (circle one)

1. None
2. Very mild
3. Mild
4. Moderate
5. Severe
6. Very severe

8. These questions are about how you feel and how things have been with you during the past 4 weeks **as a result of your leg problem**. For each question, please give the answer that comes the closest to the way you have been feeling. How much time during the past 4 week-

(check one box on each line)	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
Have you felt concerned about the appearance of your legs?						
Have you felt irritable?						
Have you felt like a burden to your family or friends?						
Have you been worried about bumping into things?						
Has the appearance of your leg(s) influenced your choice of clothing?						

Preferred Pharmacy:______________________Phone:_________________Address:______________

Patient Signature: ____Date: ___________________

INTER OFFICE USE ONLY:

Ht:__________ Wt:_________ T:________ P:________ R:_________ BP:_________

Compression Stocking Measurement: Ankle: ________ Calf: ________ Thigh: ________

Reflux Seen: RIGHT LEFT BILATERAL NOT SEEN

Comments:____

____

____

____

Provider:____ Witness:__________________

Health History Questionnaire

Name: ____ Date of Birth: ___________________

Current Prescription Medications: Dosage How Often

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Medication Allergies:

____
____
____

Previous Vein Treatment:

Surgery: [] stripping - Right leg [] stripping - Left leg Date: ________________
[] ligation - Right leg [] ligation - Left leg Date: ________________

Injections: [] right leg [] left leg Date: ___________________________
Laser: [] right leg [] left leg Date: ___________________________

Comments: ____

Name: ______________________________ Date of Birth: ______________

Medical History:

Do you have or have you ever been treated in the past for:

Migraines or other headaches? Yes No
Stroke/TIA? Yes No
Carotid Artery Disease (blockages in the neck arteries)? Yes No

COPD/Emphezema? Yes No
Asthma? Yes No
Other Respiratory/Lung Conditions?______________________________

High Blood Pressure? Yes No
High Cholesterol? Yes No
Coronary Artery Disease? Yes No
Heart Attack? (If yes, when?) ______________________________ Yes No
Other Heart Conditions? ______________________________

Thyroid Problems? Yes No
Diabetes? Yes No
GERD? Yes No
Kidney Disease/Kidney Failure/Kidney Transplant? Yes No
Gout? Yes No
Arthritis? Yes No
PVD/PAD?(If yes, treatment)______________________________
Cancer? (If yes, type and treatment)______________________________

Other Medical/Health Conditions not listed above?

____
____
____
____

What surgeries have you ever undergone in your lifetime?

____
____
____
____

Name: ____ Date of Birth: _________________

In the **past year** have you had any of the following? (If yes, please explain)

Unexplained 10 lb. weight gain or loss? Yes________________________________
Vertigo? Yes________________________________
Visual disturbances? Yes________________________________
Hearing loss? Yes________________________________
Sinusitis? Yes________________________________
Shortness of breath? Yes________________________________
Wheezing? Yes________________________________
Unexplained cough? Yes________________________________
Chest pain? Yes________________________________
Palpitations? Yes________________________________

Abdominal pain? Yes________________________________
Unexplained nausea or vomiting? Yes________________________________
Blood in sputum, urine, or stool? Yes________________________________
Unexplained diarrhea or constipation? Yes________________________________

Syncope? Yes________________________________
Seizures? Yes________________________________
Tremors? Yes________________________________
Changes in mentation or memory? Yes________________________________
Joint swelling, tenderness or stiffness? Yes________________________________

Abnormal skin pigmentation, rashes, or itching? Yes______________________
Abnormal bleeding, easy bruising? Yes______________________
Blood disorder? Yes______________________

Family History:

Did any of your blood relatives (parents or siblings) ever have a heart attack? Yes No
If yes, at what age: ______________________________________

Social History:

Do you or have you ever smoked? Yes No
When was the last time you had a cigarette? _________________
How old were you when you had your first cigarette? __________
Most number packs a day you ever smoked? ________________

Do you drink alcohol? Yes No
If yes, how much? ______________________________________
What types? ____

Do you use recreational drugs? Yes No
If yes, what types? ____________________________________

CARDIOTHORACIC & VASCULAR SURGEONS, LTD
DR. HERMAN PANG

INSURANCE/BILLING/COLLECTIONS POLICIES (as of 6/16/04)

We must emphasize that as medical care providers, our relationship is with you, our patient, and not with your insurance company. As a courtesy to you, we will bill your insurance. We charge what is usual and customary for our area. The patient is responsible for any remaining, unpaid charges, as determined by the insurance company. **There will be a $25.00 per month billing fee added to any unpaid, patient-responsible balances over 60 days old**. If you need to arrange a payment plan, please contact the office.

You are responsible for knowing what your insurance benefits are, with regards to what insurance will and will not pay for. If in doubt, contact your insurance carrier. This office assumes no responsibility for your lack of knowledge regarding your insurance benefits. Please understand that payment of your bill is considered part of your treatment.

We accept cash and personal checks drawn on American funds. We require all co-pays to be paid at time services are rendered, as indicated in our contract with insurances. If you are unable to pay your co-pay at this time, you will be given a return envelope to mail back within 5 days. **Any co-pays not received within 5 days from date of service will be subject to an additional $5.00 billing charge**.

We are able to offer payment plans that are both reasonable and equitable to both you and to this office. Please keep in touch with us regarding any changes in your ability to pay any bills. **Any accounts sent to collections will be assessed a collection fee of $100.00.**

RETURNED CHECKS

Any returned checks are subject to a $25.00 service fee. Any returned check must be resolved prior to any future appointments. Only cash and money orders will be accepted after the second occurrence. Post-dated checks dated 1 week in advance are accepted.

We thank you for understanding our financial policies. This has become necessary in order to continue to accept insurance plans without having our patients pay the balance upfront and then wait themselves for reimbursement for their insurance company. Our goal is to make your visit with us pleasant and professional. If you have any questions, please feel free to ask or call for assistance. Thank you again for choosing us for your care.

I have been given a copy of the financial policies and agree to be bound by its terms. I also understand that such terms may be amended from time to time by the practice at which time the practice will give me verbal/written notification of such amendments.

______________________________	____________________
Signature of Patient	**Date**

CARDIOTHORACIC & VASCULAR SURGEONS, LTD
DR. HERMAN PANG

NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about our patients may be used and disclosed. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996. (HIPAA). This notice is effective as of 4/14/03 and will remain in effect until we replace it.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to prevent the threat.
5. If you are a member of US or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or a law enforcement official.
8. For Workers Compensation and similar programs.
9. To remind you of needed appointments in the near future by way of a mailed postcard.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in the patient’s care, such as family members or friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, please ask the front desk receptionist.
4. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable laws.

If you have any questions regarding this notice please ***let us know!!!***

I hereby acknowledge that I have been presented with a copy of the Notice of Privacy Practices for Cardiothoracic & Vascular Surgeons, LTD.

Signature of Patient ______________________________________

Name of Patient____ Date_____________________________

CARDIOTHORACIC & VASCULAR SURGEONS, LTD
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Patient Record of Disclosures

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

[ ] Home Telephone ________________________
[ ] Ok to leave message with detailed information
[ ] Leave message with call back number only

[ ] Written Communication
[ ] Ok to mail to my home address
[ ] Ok to mail to my work/office address
[ ] Ok to fax to this number

[ ] Work Telephone________________________
[ ] Ok to leave message with detailed information
[ ] Leave message with call back number only

[ ] Other ____________________________

_______________________________________ Patient Signature

_______________________ Date

_______________________________________ Print Name

_______________________ Birthdate

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests the PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to who Address or Fax number		By whom Disclosed		

Cardiothoracic and Vascular Surgeons, LTD

8415 N Pima Rd Suite 100 13090 N 94th Dr Suite 202
Scottsdale, Arizona 85258 Peoria, Arizona 85381
480-661-4761

E-PRESCRIBING CONSENT FORM

ePrescribing is defined by a Physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program.

These include:

- **Formulary and benefit transactions** Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

By signing this consent form, you are agreeing that Cardiothoracic and Vascular Surgeons can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Cardiothoracic and Vascular Surgeons to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

This consent will remain enforce until revoked or changed.

Name of Patient (Printed):_________________________________ **Date:** ______________

Signature of Patient: ____

Pharmacy (Name & Location): ____