JAMES H. LEE, MD FACS
1177 E. WARNER AVE.
FRESNO, CA 93710
OFFICE PHONE: 559-702-1390
OFFICE FAX: 619-519-7073
JHLEEMD@VCIFRESNO.COM
INFO@VCIFRESNO.COM

NEW PATIENT REGISTRATION

PATIENT'S INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____/_____/ _____ Social Security # _____- _____-_____ Sex: □ Male □ Female

Address: _____ City: _____ Zip Code: _____

Mailing Address (If different): _____

Primary Language: □ English □ Spanish □Other: _____

Primary Phone: _____ Secondary Phone: _____

RACE: □ American Indiana/Native □ African American □ Asian □ Caucasian □ Other: _____

ETHNICITY: □ Hispanic or Latino □ Non-Hispanic/Latino

REFERRING PROVIDER

NAME: _____ OFFICE NUMBER: _____

PRIMARY CARE PROVIDER:

NAME: _____ OFFICE NUMBER: _____

CARDIOLOGIST (Heart Doctor/Specialist):

NAME: _____ OFFICE NUMBER: _____ LAST SEEN: _____

DIALYSIS PATIENTS ONLY

DaVita Center:	Circle: Monday, Tuesday, Wednesday, Thursday, Friday, Saturday
Fresenius Center:	
Other:	

PHARMACY INFORMATION

NAME: _____ PHARMACY NUMBER: _____

Address: (Main Cross streets and City, if unknown) _____

VASCULAR CENTER OF INTERVENTION

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PATIENTS HEALTH HISTORY FORM – PART 1 OF 2

(Please acknowledge each section; simply put N/A if it does not apply or leave blank)

ALLERGIES

☐ No Allergies

Medication		Reaction
Contrast Dye	☐Yes ☐No	
Shellfish/ Seafood allergy	☐Yes ☐No	
Tape Type: _____	☐Yes ☐No	
Other (Please List with Reaction):		

MEDICATION

☐ Not taking Medication

Please list ***all*** current medication you are taking, if you need additional room, please fill out medication on a sheet of paper.

Name of Medication	Dosage (mg, gm, tsp)	How many tablets per dose?	How often?

PAST MEDICAL HISTORY (Circle or Mark with X)

☐ Denies any Past Medical History

Abdominal Aortic Aneurysm (AAA)
Alzheimer's or Dementia
Asthma
Anemia
Blood Clots- Location:
Cancer
Cholesterol
Cirrhosis
Congestive Heart Failure
Chronic Obstructive Pulmonary Disease (COPD)
Diabetes-Type I or II
DVT (Deep Vein Thrombosis)
Epilepsy
Heart Attack
Hepatitis: (CIRCLE: A, B, C)
High Blood Pressure
HIV or AIDS
History of MRSA
Irregular Heartbeat
Kidney Problems
Parkinson Disease
Pneumonia
Seizures
Sleep Apnea
Stroke
Varicose Veins
Other:

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PATIENTS HEALTH HISTORY FORM – PART 2 OF 2

(Please acknowledge each section; simply put N/A if it does not apply or leave blank)

PAST SURGICAL HISTORY (Circle or Mark with X)

☐ No Surgical History

SURGERY TYPE	AREA	YEAR	SURGERY TYPE	AREA	YEAR
Above-Knee Amputation			Carotid Endarterectomy		
Below-Knee Amputation			Endovascular Repair Of AAA		
Angiogram Leg			Fistulagrams		
Angioplasty			Hip Replacement		
Aneurysm Repair			Knee Replacement		
Av Fistula			Pacemaker		
Av Graft			Spine Surgery (Type):		
Bypass (Specify):			Stent Placement		
Cardiac Catheterization			Other: _____		
CABG					

FAMILY HISTORY

☐Unknown ☐Adopted

	Father	Mother	Father's Parents	Mother's Parents
Aortic Aneurysm				
Blood Clots				
Cancer (Type)				
Cholesterol				
Diabetes				
Heart Problems				
High Blood Pressure				
Kidney Problems				
Seizures				
Stroke				
Vascular Disease				
Varicose Veins				

SOCIAL HISTORY

Do you smoke? ☐ Never ☐ Currently (___) cigarettes per day ☐ Formerly

Do you drink alcohol? ☐ No Alcohol ☐ Yes, consume alcohol (___) per day ☐ Previous Alcoholism

Drug overuse/abuse: ☐ Never ☐ Currently (Type): _____ ☐ In the Past (Type) _____

Do you exercise: ☐Sedentary (Sitting) ☐Moderate (Brisk Walk) ☐Vigorous (Jogging/Hiking)

***Marital Status*:** ☐Divorced ☐Domestic Partner ☐Married ☐Separated ☐Single ☐Widowed

***Children*:** How many? _____ *Total number of people currently living with you:* _____

Immunization History

Have you had your flu vaccine? ☐ No ☐ Yes _____ (MM)/_____ (YY) ☐Prefer not to answer

Do you receive it yearly? ☐ Yes ☐ No

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EMERGENCY CONTACT/NEXT OF KIN

The individual listed below is to **only** be contacted in the event of a life-or-death situation. We can only contact the person below in the certain cases such as: Surgeries, procedures, changes to our office hours and/ or the medical provider will not be in office.

Full Name: _____Relationship: _____Phone #: _____

INITIALS: _____I hereby give permission to Vascular Center of Intervention (VCI) to disclose any information related to my medical conditions to the following individual above.

IF YOU MARKED YES TO ANY OF THE QUESTIONS BELOW, PLEASE PROVIDE A COPY OF YOUR LEGAL DOCUMENT.

ADVANCED DIRECTIVE

Legal written statement of the patient's wishes regarding medical treatment if you're too ill to speak for yourself.

Do you have an advanced directive: □ Yes □ No

MEDICAL POWER OF ATTORNEY

Legal document granting someone you trust authority to make medical decisions if you are unconscious, mentally incompetent, or otherwise unable to make decisions on you own.

Have you established a medical power of attorney? □ YES □ NO

CONTACT NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER
		( )

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RELEASE OF MEDICAL RECORDS

(This form allows the office of Dr. James H. Lee at Vascular Center of Intervention (VCI) to request medical records from other providers or facilities caring for your health.)

Patient's Name: _____ Date of Birth: _____

I give my consent and authorize the release of my personal medical records including but not limited to records, reports, notes chart notes, letters, photographs, test report or results (including physical test results, pathology test results, laboratory test results, x-rays, MRI & CAT scans, EKG's, etc.), financial information (including insurance information and/ or billing statements), and referral letters, I also consent and authorize the discussion of medial records and information pretraining to me or my treatment, I understand I am authorizing the release of this information to the dialysis centers (including DaVita, Fresenius, Community Dialysis and/or other dialysis center not named).

Vascular Center of Intervention (VCI)

1177 E. Warner Avenue

Fresno, CA 93710

Phone: 559-702-1390 Fax: (619) 519 -7073

I understand that by singing this release, Vascular Center of Intervention and its affiliated doctors have my approval to receive my person medical records as noted above. I understand that this medical release will remain in effect until you are discharge from all medical services provided by Dr. James H. Lee and/or Vascular Center of Intervention (VCI) or unless revoked by me in writing.

SIGNATURE: _____ Date: _____

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Photography Consent Form

Patient's Name: _____ Date of Birth: _____

MEDICAL CHART PROFILE PHOTOGRAPH

I hereby grant Vascular Center of Intervention (VCI) permission to take a digital photo of me for my medical chart. I understand the chart. I information will only be used for identification purposes when I seek medical care at Vascular Center of Intervention (VCI) and will be stored permanently on my medical record and will also be stored securely to protect my privacy only the staff members and the medical provider will have access to view your photograph. The photograph will NOT be used outside of Vascular Center of Intervention (VC), unless I or my legal representative give my permission in writing. Once the photograph is stored in your medical record Vascular Center of Intervention (VCI) will own the photography, you may look at the photograph or ask for a copy if I or my legal representative sign a release form. Refusal to photograph will not affect my medical care. If I prefer NOT to be photographed my photo identification will be used to identify myself.

☐ Yes, I agree for a photograph to be taken of me for identification purposes ONLY.
☐ No, I prefer NOT to have a photograph taken of me for identification purposes.

INSURANCE PURPOSE AND DOCUMENTATION PHOTOGRAPH

During your visit(s) at Vascular center of Intervention (VCI) your healthcare provider may find it helpful in managing your care by photographing any wounds and/or ulcers, varicose veins and any injuries made during and/or after any treatment. Our staff members and medical providers will document the specific location and appearance of your condition or clinical findings. Th purpose of medical photography is to document findings, care and treatment progress. The images will be protected and handled in accordance with applicable HIPAA privacy regulations.

The medical photographs will not be used for any purpose other than your care and treatment without your express written consent. You may refuse to have photographs taken at any time; however, this may delay the course of my treatment due to the insurance and/or the provider needing digital documentation for approval of discussed treatments and/or procedures for my symptoms and diagnosis.

I have been provided the opportunity to ask questions concerning the information containing this consent.

☐ I agree to have medical photographs taken.
☐ I prefer NOT to have medical photographs taken.

By singing below, I understand and read the purpose of photographs requested by Dr. James H. Lee and/ or Vascular Center of Intervention (VCI).

SIGNATURE: _____Date: _____

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OFFICE POLICIES AND PRIVACY PRACTICE NOTICE

This is a ***summary only*** of Vascular Center of Intervention (VCI) office policies and privacy practice notice, if you would like to have a hard copy of entire office policies and privacy practice notice please ask one of the medical staff.

VASCULAR CENTER OF INTERVENTION (VCI) FINANCIAL POLICY

The following is a summarized statement of our Financial Policy, which we require you to read and sign prior to any treatment. All patients must complete our patient information and insurance information forms prior to seeing the physician(s)

Co-pays, deductibles, and non-covered services are due at time of service.
Your insurance policy is a contract between you and your insurance company.
Please be aware that some, and perhaps all of the services provided may be non-covered services, which you will be liable for if unpaid.
PAYMENT GUARANTEE: The undersigned severally agree, whether signing as a patient or guarantor, to guarantee payment of the account in accordance with the standard rates and terms.
I further understand that any balance remaining after insurance approves or denies payment is my responsibility to pay, including any amount not paid by a secondary or supplemental insurance policy.
All balances over 180 days past due will be subject to be turned over to collections.
In the event the charges incurred are not paid in full when due and collection activity is instituted, whether by a collection agency or an attorney, you agree to be responsible for and pay, in addition to the charges incurred, all costs associated with such collection activity including, but not limited to, reasonable collection fees, attorney fees, court costs, and contingent fees to collection agencies of not less than thirty-five percent.
The provider of service has the right to terminate services based on noncompliance of all or any office agreements and policies.
In the event that a patient is considered "Out of Network" all payments paid directly to the patient must be authorized and checks/payment delivered to VCI. Failure to assign the payments to VCI will result in the above-mentioned collections process.

CANCELLATION POLICY

Please note that once you have scheduled an appointment with us it means that we have reserved time in our schedule exclusively for you. If you cancel your appointment less than 24 hours before it is scheduled to take place, you will be subject to a **no-show fee of *$20* for all clinic and ultrasound visits. There will be also be a charge of *$40.00-$60.00* for all surgeries and/or procedures that are not cancelled within a 24 hours' notice.**

To avoid a cancellation fee, please provide cancellation notice at least 24 hours prior to your appointment. ***You can cancel or reschedule an appointment by calling our office at 559-702-1390, texting 559-797-0000, or simply leaving a detailed voicemail.***

PATIENT RIGHTS, RESPONSIBILITIES AND NOTICE OF PRIVACY PRACTICES

PATIENT RIGHTS: Knowledge of the name of the physician who has primary responsibility for coordinating your care and the names and professional relationships of other physicians who will see you.
Receive information from your physician about your illness, your course of treatments and your prospects for recovery in terms that you can understand.
Receive as much information about proposed treatment or procedure as you may need in order to give informed consent or to refuse this course of treatment.
Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate courses of treatment or non-treatment and the risks involved in each, and to know the name of the person who will carry out this procedure.
To extent permitted by law, this includes the right to refuse treatment.
Case discussion, consultation examination and treatment are confidential and should be conducted discreetly.
Confidential treatment of all communication and records pertaining to your care and visit to VCI. Your written permission shall be obtained before your medical records can be made available to anyone not directly concerned with your care.
Reasonably continuity of care and to know in advance the time and location of appointment as well as the physician providing care.
Be advised if VCI/physician proposed to engaged in or perform human experimentation affecting your care or treatment.
Have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
PATIENT RESPONSIBILITIES: The care a patient receives depends partially on the patient him/herself.
The patient is responsible for making it known whether he/she clearly comprehends the course of his/her medical treatment and what is expected of him/her.
The patient is responsible for following the treatment plan established by his/her physicians, including the instruction of nurses and other health professional as they carry out the physician's orders.
The patient is responsible for his/her actions should he/she refuse treatment or not follow orders.
The patient is responsible for assuring that the financial obligations of his/her care are fulfilled as promptly as possible.
The patient is responsible for being considerate of the rights of other patients and facility personnel.
The patient is responsible for being respectful of his/her personal property and other persons in the lab.

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Notice of Privacy Practices

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information. Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information: How we may use and disclose your PHI: Your privacy rights in your PHI, our obligations concerning the use and disclosure of your PHI. The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We may use and disclose your PHI in the following ways: The following categories describe the different ways in which we may use and disclose your PHI. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice - including, but not limited to, our doctors and nurses - may use or disclose your PHI in order to treat you or to assist others in your treatment. We may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. We may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts. Our practice may use and disclose your PHI to operate our business. *As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.*

We may disclose your PHI to other health care providers and entities to assist in their health care operations. Our practice may use and disclose your PHI to contact you and remind you of an appointment. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We may release PHI if asked to do so by a law enforcement official: Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement, Concerning a death we believe has resulted from criminal conduct, Regarding criminal conduct at our offices, In response to a warrant, summons, court order, subpoena or similar legal process, To identify/locate a suspect, material witness, fugitive or missing person, In an emergency, to report a crime of the crime, or the description, identity or location of the perpetrator).Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. Our practice may use and disclose your PHI 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. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces and if required by the appropriate authorities. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Our practice may release your PHI for workers' compensation and similar programs.

Your rights regarding your PHI: You have the following rights regarding the PHI that we maintain about you: You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. You have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to VCI Office Manager at the address and number listed above. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to VCI Office Manager at the address and number listed above in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. We may deny your request if you ask us to amend information that is in our opinion: accurate and complete; not part of the PHI kept by or for the practice; not part of the PHI which you would be permitted to inspect and copy; or not created by our practice, unless the individual or entity that created the information is not available to amend the information. All of our patients have the right to request an "Accounting of disclosures." An "Accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented - for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization.

By signing below, I have read and agree by Vascular Center of Intervention (VCI) office policies, my rights and responsibilities as a patient and Notice of Privacy Practices, I have been provided the opportunity to ask questions concerning the information containing this consent and wish to continue care.

SIGNATURE: _____ Date: _____