

CENTER FOR VEIN RESTORATION

SANJIV LANKHANPAL M.D., JAIME MARQUEZ M.D., JERRILYN JUTTON M.D., LUIS DIBOS M.D., THOMAS MILITANO M.D.,
FRANK SBROCCO M.D., ARVIND NARASIMHAN M.D., KHANH NGUYEN D.O., EDDIE FERNANDEZ M.D., J. ANDREW SKIENDZIELEWSKI D.O.,
STEPHANE CORRIVEAU M.D., PAUL R. JOHNSON M.D., SEAN STEWART M.D., ROBERT KISER D.O.

CVR CLINICAL OFFICES:

Annapolis
108 Forbes Street
Annapolis, MD 21401

Bel Air
2225 Old Emmorton Rd Ste. 110
Bel Air, MD 21015

Easton
505 A Dutchman's Lane, Ste. A-2
Easton, MD 21601

Columbia
11085 Little Patuxent Parkway S
Suite 203, Columbia, MD 21044

Germantown
19785 Crystal Rock Dr Suite 310
Germantown, MD 20874

Greenbelt
7300 Hanover Drive, Ste. 104
Greenbelt, MD 20770

Glen Burnie
1600 Crain Hwy S, Ste. 408
Glen Burnie, MD 21061

Prince Frederick
301 Steeple Chase Dr, Ste. 401
Prince Frederick, MD 20678

Rockville
11119 Rockville Pike, Ste. 101
Rockville, MD 20852

Silver Spring
831 University Blvd E Ste. 25
Silver Spring, MD 20912

Towson
7300 York Rd Ste. LL
Towson, MD 21204

Waldorf
12107 Old Line Center
Waldorf, MD 20602

Washington, DC
106 Irving St. NW Ste. 2400
Washington, DC 20010

Alexandria, VA
1900 N. Beauregard St. Ste. 110
Alexandria, VA. 22311

Fairfax / Merrifield, VA
8316 Arlington Blvd. Suite 610B
Fairfax, VA 22031

Woodbridge, VA
2200 Opitz Boulevard, Suite 320
Woodbridge, VA 22191

Michigan
3810 West Centre Ave Ste. A
Portage, MI 49024

Welcome to the Center for Vein Restoration!

Thank you very much for choosing the Center for Vein Restoration as your partner in health. We feel you and your doctor have made the right choice to schedule an Initial Screening with us. Unfortunately many people continue to suffer from leg discomfort for far too long. We hope that at the conclusion of your therapy you will realize that the treatment was probably far quicker and easier than you imagined.

Here are a few of the reasons you are in good hands at our practice:

- Our exceptional doctors specialize in vein treatment, performing thousands of procedures each year. **Our physicians and vein centers have received numerous accolades from the Washingtonian, Bethesda Best of, and Baltimore Best of, Magazines. Also, What's up Annapolis and What's up Eastern Shore.**
- Treatment is performed on an outpatient basis in our offices, patients usually return to work the same day.
- We offer the full range of vein treatment options (radiofrequency, laser and sclerotherapy) so you will receive the best solution for your specific needs.
- Our office will collaborate with your health insurance plan to get your treatment(s) covered.

At the Initial Screening our Doctor will evaluate your needs and recommend a treatment plan. We look forward to helping you enjoy healthy and happy legs once again!

Sincerely,

Sanjiv Lakhnopal, MD

Sanjiv Lakhnopal, MD, FACS

President & CEO

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New Patient Instructions - Center for Vein Restoration (CVR)

This information is to assist you in preparing for your initial appointment with us at CVR.

Please complete the following documents prior to your visit and bring them with you. This will help expedite the registration process.

1. **Patient Information Form** – this includes your insurance information for us to register you with our practice.
2. **Allergies and Medication Form** – this form is to list any and all medications you may be taking at this time and any allergies that you may have.
3. A few questions regarding your **Referral Process** to us are part of the same **Allergies/Medication Form**, in the lower portion. This information is to assist us in communicating with your physician and to inform us of how you were referred.

Most importantly, when you come for your visit, please be sure to bring the following documents as we need copies of them for our records:

1. **A photo ID such as, Driver's License, State ID, Military ID, etc.**
2. **Your current insurance card**
3. **Your referral slip, from your Primary Care Physician, (if required by your insurance plan.)**

Note: Your initial consultation will take about two hours of your time, please plan accordingly. Please drink plenty of fluids, dress warmly, and bring loose fitting shorts (if possible) to facilitate your leg exams.

We at CVR, look forward to seeing you at our office soon. If you have any questions or need any assistance regarding the above information, please feel free to contact us at any time and we would be glad to assist you. (301) 860-0930.

Your appointment is on: _____ @ _____

At our CVR office in: _____

Have a good day and we look forward to serving you in the very near future.

Your CVR Team



PATIENT INFORMATION						
NAME (Last, First Middle)		MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS		SECONDARY/BILLING ADDRESS (if Applicable)				
CITY, STATE ZIP	HOME PHONE	CITY, STATE ZIP	HOME PHONE			
PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN	CONTACT NAME		CONTACT HOME PHONE		
ETHNICITY	RACE	EMAIL:				
PRIMARY EMPLOYER		SECONDARY EMPLOYER (if Applicable)				
ADDRESS		ADDRESS				
CITY, STATE ZIP		CITY, STATE ZIP				
WORK PHONE		WORK PHONE				

RESPONSIBLE PARTY INFORMATION (if Different than above)					
NAME (Last, First Middle)		SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS		SECONDARY/BILLING ADDRESS (if Applicable)			
CITY, STATE ZIP		CITY, STATE ZIP			
HOME PHONE		HOME PHONE			
RELATIONSHIP TO PATIENT					

PRIMARY INSURANCE		
NAME OF INSURANCE COMPANY		POLICY#
NAME OF INSURED		GROUP#
ADDRESS OF INSURANCE COMPANY		COPAY AMT \$
CITY, STATE ZIP		DEDUCTIBLE \$
RELATIONSHIP TO PATIENT		EFFECTIVE DATE EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)		
NAME OF INSURANCE COMPANY		POLICY#
NAME OF INSURED		GROUP#
ADDRESS OF INSURANCE COMPANY		COPAY AMT \$
CITY, STATE ZIP		DEDUCTIBLE \$
RELATIONSHIP TO PATIENT		EFFECTIVE DATE EXPIRATION DATE

I certify that the information above is correct. I agree that insurance benefits for The Medical Clinic provider charges payable to the insured are to be made payable to The Medical Clinic and that physician benefits otherwise payable to the insured are to be made payable to The Medical Clinic. Any payments received for services rendered to me by The Medical Clinic may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits. I acknowledge that I am fully responsible for all non-covered services, deductibles and co-payments. I further agree, in the event of default due to non-payment, to be responsible for collection fees, court costs, and/or legal fees, and there will be a \$35.00 fee for all returned checks.

SIGNATURE OF PATIENT/GUARDIAN _____

DATE _____



MEDICAL INFORMATION

Date _____

Patient Name _____ Birthdate _____ Age _____

Chief complaint/reason for visit _____

Date of first symptoms (required by insurance) _____

Symptoms: Describe _____

Family History of varicose veins: No Yes

Medications – include dosage

Allergies- include reaction

Latex No Yes

Over the counter meds/supplements _____

Aspirin daily no yes

Bleeding/Clotting History:

Plavix no yes

DVT/Blood clot _____ When _____

Coumadin no yes

frequent miscarriages _____

Do you smoke? No Yes Packs per day _____ Years _____ Date quit _____

Alcohol use? No Yes Occasionally Daily

Employed No Yes Retired Job _____ Yrs _____

Previous surgeries _____

Other hospitalizations: _____

CENTER FOR VEIN RESTORATION



Do you have NO YES Comment _____ NO YES Comment

Arthritis _____

Asthma _____

Cancer _____

Hypertension _____

Diabetes _____

Depression/Anxiety _____

Stroke _____

COPD _____

GERD _____

Other _____

HEART DISEASE: Atrial fibrillation

CAD Stents

History of MI/Heart attack when? _____ Other: _____

Pregnant? Children: _____ ages: _____

Height _____ Weight _____

How did you learn about Center for Vein Restoration? Please circle

Physician TV Ad Employee Magazine Self Friend Radio

Other: _____

Your Referring Physician:

Dr. Name Address Phone
Your Primary Physician:

Dr. Name Address Phone
Others:

Dr. Name Address Phone

Dr. Name Address Phone

Patient Signature _____

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Consent for Disclosure of Protected Health Information

Patient Name: _____ DOB: _____

We use information that you provide to us, including health information, to carry out treatment, payment and health care operations. Please refer to our "Notice of Privacy Practice" for a more complete description. You have the right to review the notice before signing the consent. The terms of our Notice of Privacy Practices may change. You may obtain a revised notice from our office by calling (301) 860-0930. You have the right to restrict the use of your health information to carry out treatment, payment or health care operations. We are not required to agree to the restriction. If we do agree to any restrictions, the agreement is binding to us. You have the right to revoke this consent at any time by notifying us in writing. Our address is as follows: 12200 Annapolis Rd, Ste 225, Glenn Dale, MD 20769. I hereby consent to *Center for Vein Restoration* contacting my physician's office to release pertinent information for future follow up care. I *hereby consent* to the use and disclosure of my individuality identifiable health information for treatment, payment and health care operations. I have been provided with a copy of the Notice of Privacy Practice.

Patient Name (Print): _____

Signature of Patient or Patient's representative

Date

No Show / Cancellation Policy

Welcome to the Center for Vein Restoration. We care about your time and strive to keep the flow in our office going in a timely manner. In order to strive for perfection we have implemented the following No Show / Cancellation policy for our office.

The goals of this policy are as follows:

- To reduce the number of lost or broken appointments due to patients not coming in for their scheduled time and/or not calling in advance to cancel their appointments.
- To make sure that those patients who want or need an appointment don't have to be displaced due to the inconvenience of those patients who don't co-operate with the office policy.

Our policy states:

- Any Missed / No Show appointments for surgery, studies to be done, consultations or sclerotherapy that are not canceled in 48 hrs prior to their appointment time, will be charged a place holding fee.

Our office scheduled your appointment and reserved a time slot for you in good faith. Please help us to keep our goal in offering our patients appointments and keep the flow in our office going in a timely manner.

Patient Signature

Date