THE VIRGINIA INSTITUTE
FOR SURGICAL ARTS
25055 Riding Plaza
Suite #140
Chantilly, Virginia 20152
(703) 327-8200
www.thevirginiainstitute.com

PATIENT MEDICAL INFORMATION FORM

Welcome to our practice! The Virginia Institute for Surgical Arts provides comprehensive medical and surgical care for adult and pediatric patients with diseases and disorders that affect the ears, nose, and throat, the respiratory and upper alimentary systems, and related structures of the head and neck. Our compassionate approach ensures expert diagnosing and managing of medical issues. Combining the latest in precision technology with the highest standards of surgical craftsmanship, we indulge our patients with bespoke premium care and exalted experiences.

Dr. Trang Vo-Nguyen is an otolaryngologist head and neck surgeon dedicating her practice to alleviating the ills and needs of her patients. She is honored as a Certified Diplomate of the American Board of Otolaryngology – Head and Neck Surgery. As a conductor for the collaboration of treatments, Dr. Trang Vo-Nguyen focuses her dedicated expertise to provide thorough diagnosis, expert strategems, and efficacious courses of action to resolve afflicting conditions. Dr. Trang Vo-Nguyen remains vigilant in her oath to oblige the needs of her patients through compassionate understanding of unique concerns and to communicate complex information in resolving anxiety at occasions of stress.

We are privileged for the opportunity to serve your medical needs.

Patient Name: _____ Preferred Language: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Cell Carrier: _____

DOB & Age: _____ Race: _____

SSN: _____ Gender: _____ Email Address: _____

Employer Name: _____ Address: _____

Occupation: _____ Work Phone: _____

How did you hear about our clinic?

☐ Yahoo
☐ Bing
☐ Google
☐ Other: _____

☐ Patient Referral: _____
☐ Friend: _____
☐ Dr. Referral: _____

What is the nature of your visit? _____

Patient Information

Requesting/Referring Physician		**Primary Care Physician**		
Patient Legal Name (First, MI, Last)		**Patient Social Security #**		**Patient Date of Birth**
Nickname	**☐ Mr. ☐ Ms. ☐ Mrs.**	**☐ Female ☐ Male**	**☐ Single ☐ Married**	**☐ Divorced ☐ Widowed**
Address		**Home Phone #**		**Work Phone #**
City, State, Zip		**Cell #**		**Pager #**
Religious Preference	**Email Address**			
Employer	**Occupation**	**Employer Phone #**		
Employer Address				

Insured/Subscriber Information

Legal Name (First, MI, Last)	**Relationship**	**Date of Birth**
Address (if different from above)	**Home Phone #**	**Social Security #**
City, State, Zip	**Work #**	**Phone #**
Employer Name & Occupation	**Employer Address**	

Emergency Contact Information: Relative/Friend not living with you (in case we are unable to contact you or need to contact someone regarding your case in an emergency).

Contact Name	**Phone #**	**Relationship to Patient**
Address	**City**	**State, Zip**

Insurance Information

***Call Insurance if you DO NOT know your Specialist Copay ***	Primary Insurance	Secondary Insurance
Insurance Name		
Mailing address for claims		
Insurance Phone #		
Policyholder Name		
Policyholder Date of Birth		
Policyholder Relationship to Patient	**☐ Self ☐ Child ☐ Spouse ☐ Other**	**☐ Self ☐ Child ☐ Spouse ☐ Other**
Policyholder Employer		
Group #		
Subscriber / Member ID #		
Deductible and/or Copay		

I understand that I am responsible for all charges. I will furnish this office with all information necessary to bill my insurance. Any balance after insurance has been paid or denied is due by me. I agree that if it becomes necessary to forward my account to a collection agency, I will also be responsible for the reasonable cost of collection, to include attorney fees. I understand that my insurance benefits and referral requirements are my responsibility and that all copayments are due at the time of service.

I authorize payment of medical benefits to physician for these services and all future claims and I authorize of any medical information necessary to process this claim and all future claims.

Signature (Must be a parent or guardian for children 17 and under) Date

I acknowledge that I am in receipt of/offered the Financial Policy/HIPAA.

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. Please fill out every item. It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcomed to a copy of the report if you wish. There is room to explain your answers more completely on the back of the second page.

NAME: _____ Date of Birth: _____

How did you hear about us? _____

PURPOSE FOR VISIT:

_____

_____

MEDICATIONS

Please list any medications including aspirin, vitamins, over-the-counter or herbal medication?		
Medication Name	**Dose**	**How often taken**

ALLERGIES

Medication Name	**Type of Reaction**
Do you have environmental Allergies? □ Yes □ No Please list:	
Do you have food Allergies? □ Yes □ No Please list:	
Do you have a known allergy to Latex? □ Yes □ No Please list:	

PAST MEDICAL HISTORY: Have you ever been DIAGNOSED with any of the following problems?

	Yes No	**Year**	**Comment**
CANCER (Please list type):	□ □		
Cardiovascular			
Do you have a pacemaker?	□ □		
High/Elevated cholesterol?	□ □		
Other Heart Problems?	□ □		
Respiratory			
Asthma	□ □		
COPD	□ □		
Tuberculosis	□ □		

NAME: _____ Date of Birth: _____

PAST MEDICAL HISTORY Continued:

	Yes	No	Year	Comment
Gastrointestinal				
Hepatitis	□	□		
Reflux	□	□		
Stomach ulcers	□	□		
Kidney				
Renal failure	□	□		
Mental and Emotional				
Depression (requiring treatment	□	□		
Anxiety (requiring treatment)	□	□		
Hematologic / Immunity				
Anemia	□	□		
HIV / AIDS	□	□		
Bleeding after surgery	□	□		
Blood transfusion	□	□		
Blood Clots/Pulmonary Embolus	□	□		
Other Not Listed Above				
Diabetes	□	□		
Problem	□	□		

PAST HOSPITALIZATIONS

Have you ever been hospitalized for a medical problem before: □ Yes □ No If "Yes" please list below:			
Year	**Reason for Admission**	**Date**	**Physician**

PAST SURGICAL HISTORY

Year	Procedure	Date	Surgeon

FAMILY HISTORY Please mark all that applies:

					Maternal		Paternal	
	Mother	**Father**	**Brother**	**Sister**	**Grandma**	**Grandpa**	**Grandma**	**Grandpa**
Specific Anesthesia problem	□	□	□	□	□	□	□	□
CANCER (please list type under check mark)	□	□	□	□	□	□	□	□
Cardiovascular:								
High Blood Pressure	□	□	□	□	□	□	□	□
Heart Problems	□	□	□	□	□	□	□	□
Respiratory:								
Asthma	□	□	□	□	□	□	□	□
Lung Cancer	□	□	□	□	□	□	□	□
Neurologic:								
Stroke	□	□	□	□	□	□	□	□
Hematologic								
Bleeding / Clotting problem	□	□	□	□	□	□	□	□

NAME: _____ Date of Birth: _____

SOCIAL HISTORY

Have you ever smoked? **Do you smoke now?**	**□ Yes □ No** **□ Yes □ No**	**Comments (indicate amount per day):**
Do you drink alcohol?	**□ Yes □ No**	**Comments (indicate amount per week):**
Do you use any recreational drugs?	**□ Yes □ No**	**Comments (indicate frequency):**

REVIEW OF SYSTEMS – Have you RECENTLY had any of the following problems?

	Yes	No	Comment
General Health Problems:			What is your current height: _____ Weight: _____
Fever or Chills	□	□	
Night Sweats	□	□	
Weight Loss/Gain > 10 lbs / 1 month	□	□	
Head / Neck Problems:			
New Headache	□	□	
Vision / Eye problems	□	□	
Ear ache, loss of hearing	□	□	
Chronic sinus infections	□	□	
Cardiovascular Problems:			
Fainting / Blacking out	□	□	
Chest pain	□	□	
Irregular heartbeat / palpitations	□	□	
Swelling of ankles	□	□	
Respiratory Problems:			
Frequent cough	□	□	
Shortness of breath	□	□	
Wheezing	□	□	
Gastrointestinal Problems:			
Difficulty swallowing / food sticking in throat	□	□	
Abdominal pain	□	□	
Constipation	□	□	
Diarrhea	□	□	
Heartburn	□	□	
Nausea / Vomiting	□	□	
Neurologic Problems:			
Numbness or Tingling	□	□	
Seizures	□	□	
Urologic Problems:			
Blood in urine	□	□	
Difficulty starting urine system	□	□	
Burning	□	□	
Leaking of urine	□	□	
Mental and Emotional Problems:			
Depression (requiring treatment)	□	□	
Anxiety (requiring treatment)	□	□	
Endocrine Problems:			
Diabetes	□	□	
Thyroid disorder	□	□	
Other	□	□	
Hematologic Problems:			
Swollen Lymph Nodes	□	□	
Bruising easily	□	□	
Bleeding into joints	□	□	
Skin Problems:			
Itching	□	□	
Rash	□	□	

Signature: _____ Date: _____

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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, represent to the physicians and staff that I am at least 18 (eighteen) years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by my doctor and such assistant or staff as may be assigned by him/her.

I, _____, hereby consent to the use or disclosure of my protected health information by the practice of Trang Vo-Nguyen, M.D., hereinafter referred to as ("Practice") for the purpose of diagnosing or providing treatment to me, obtaining payment for health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by Dr. Vo-Nguyen may be conditioned upon my consent as evidenced by my signature on this document.

I also understand that I have the right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The practice is not required to agree to these restrictions, which I may request. However, if the practice agrees to the restrictions that I request, the restriction is binding on the practice and Dr. Vo-Nguyen.

I have the right to revoke this consent, at any time, in writing, except to the extent that Dr. Vo-Nguyen or the practice has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by Dr. Vo-Nguyen, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

I understand I have a right to review the practice's Notice of Privacy Practices, which is available to me by request at any time, prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operation. This Notice of Privacy Practices also describes my rights and practice's duties with respect to my protected health information. The Notice of Privacy Practices for the practice is also provided at 25055 Riding Plaza, Suite 140, Chantilly, VA 20152.

As provided in our notice, the terms of our notice may change. If changes are made, I may obtain a revised Notice of Privacy Practices by calling your office and requesting a revised copy be sent in the mail or by requesting one at the time of my next appointment.

"To the best of my knowledge, the information I have provided regarding my medical history, allergies and smoking history is accurate, complete and honest. I understand failure to completely disclose this information may be detrimental to my condition and treatment and I accept full responsibility for any omissions."

I understand that photography is a necessary part of planning and evaluating any surgery. I authorize the taking of photographs at the direction of Dr. Vo-Nguyen and under such conditions as may be approved by Dr. Vo-Nguyen. These photographs will be used solely for documentation and educational purposes and will be kept confidential.

A copy of this authorization shall be considered as valid as the original.

Patient Signature: _____ Date: _____

Parent/Guardian:
Signature: _____ Date: _____

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CONSENT TO COMMUNICATE

Patient Name: _____

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Send Email			☐	-
☐ Email Appointment Reminders				
☐ Email Medical Information				
☐ Email Office Specials				
☐ Send Regular Mail			☐	-
Mail to which Address: ☐ Home ☐ Other (please list):				
☐ Send Text Message - if ok, please list cell carrier (e.g., AT&T):			☐	-
☐ Text Appointment Reminders				
☐ Text Office Specials				

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

If it's ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	

Signature: _____ Date: _____

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HIPAA INFORMATION AND CONSENT FORM

Patient Name: _____ DOB: _____

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the
patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I,_____ , do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____

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PAYMENT POLICY

We are committed to providing you with the best possible care. This information is designed to guide you through the rapidly changing world of medical insurance plans**. Please read carefully and sign at the bottom of the page indicating your understanding and acceptance of our policies and procedures**.

If you have medical insurance, we can provide you with a receipt for you to submit or as a courtesy submit your claim for you. Our receipt is suitable for your insurance company. We will have you pay for any **deductibles and co-pays** required at the time of service.

PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS PAYMENT ARRANGEMENTS HAVE BEEN MADE AND APPROVED IN ADVANCE.

YOU MUST REALIZE THAT:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not included in your contract.
2. Not all services are covered by all insurance policies. Some companies select certain services that they will not cover.
3. The "Usual and Customary Charges" that may be quoted by your insurance company are charges that have been determined and set by your insurance company. They do not necessarily reflect our fees.

We must emphasize that as physicians, **our relationship is with you**, not your insurance company. While filing your insurance claims for our patients is a courtesy that was extended, **ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICE IS RENDERED.** We do realize that there are times that a temporary financial problem may affect your payment of your account. In that case, PLEASE, contact our financial advisor for assistance so that we may be able to set up payment options for you.

In order to respect the time and availability of all our patients and staff, please contact the office at least 24 hours in advance of your appointment if you have a need to cancel your appointment. If you fail to cancel at least 24 hours in advance of your scheduled appointment, you will be charged an administrative No-Show fee of fifty dollars ($50).

If you have any questions, feel free to contact us. We will be glad to help.

REGARDLESS OF ANY INSURANCE COVERAGE THAT I MAY HAVE, I AGREE THAT IT IS MY RESPONSIBILITY TO PAY MY BALANCE AND WILL PAY ANY BALANCE DUE.

Printed Name: _____

Signature: _____ Date: _____

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Suite #140
Chantilly, Virginia 20152

PATIENT NAME: _____ DOB: _____

NASAL ENDOSCOPY INFORMATION AND CONSENT

Otorhinolaryngology is the medical specialty focusing upon the diseases of the ear, nose, and throat. Having undergone extensive training and garnered substantial experiences, Dr. Trang Vo-Nguyen is certified by the American Board of Otorhinolaryngology – Head and Neck Surgery.

In the diagnoses for the diseases of the Ear, Nose, and Throat, Dr. Trang Vo-Nguyen utilizes all necessary equipment and technology available to her to best discover, understand, and treat the medical conditions presented.

Please be advised there are times when Dr. Vo-Nguyen needs to perform an in-office procedure: Nasal Endoscopy, to correctly diagnose and treat problems of the ear, nose, and throat. This is accomplished with the use of a Nasal Endoscope, either Rigid or Fiber-Optic. It is a specialized camera tool used to help diagnose or detect problems such as nasal polyps, nasal blockage, recurrent sinusitis and other diseases of the nose or throat. Endoscopic examination allows Dr. Vo-Nguyen or her assistants to see areas not normally visible without use of the endoscope including:

- evaluate and diagnosis medical conditions of the nose and throat
- evaluate previous surgery, scar, openings, masses, polyps, causes of blockage
- evaluate healing or complications of surgery
- obtain drainage for culture, specimens / biopsy for pathology evaluation
- remove old blood, foreign material, packing, scabs/scar/blockage
- educate you and others

Nasal Endoscopy is an effective in-office procedure to diagnose ailments of the ear, nose, and throat. After spraying your nasal passages with a combination of Afrin (to shrink the tissue) and Lidocaine (to numb) to anesthetize the lining and shrink tissue, a thin tube or endoscope, whether rigid or flexible fiber-optic, is inserted into the nasal passage to visualize the internal anatomy of the nose, sinuses and / or throat. Possible side effects of the procedure are sneezing, coughing, and minor nasal bleeding. The throat will feel numb for approximately half-hour. The procedure is generally well-tolerated with minimal discomfort.

Please remember that Dr. Vo-Nguyen is a specialist. She is able to deliver specialized expert quality of care through the use of highly effective and highly specialized diagnosis tools such as a nasal endoscope. If you have any questions please do not hesitate to ask our front desk staff or Dr. Vo-Nguyen for more information.

Insurance companies may consider nasal endoscopy a surgical procedure. We do not have control over how endoscopies are processed by insurance companies. This form is to notify you in advance so you are not surprised when you receive your explanation of benefits that states a Surgical Service was provided.

Your insurance company may reimburse a surgical service at a different rate then an office visit. The nasal endoscopy procedure is often applied toward your deductible and co-insurance. To find out what your financial responsibility for this procedure may be, contact your insurance carrier and request coverage information for CPT codes: 31231, 31575.

YOUR CONSENT

The procedure and description of this procedure, the more common risks associated with it and the potential complications have been described to me. This includes: a small amount of pain/pressure, a mild amount of bleeding, and a reaction to the nasal spray.

I have had an opportunity to ask questions.

I am satisfied with my understanding and the responses that I have received.

I hereby authorize The Virginia Institute for Surgical Arts physician and personnel to perform the procedure of Nasal Endoscopy.

I hereby authorize the doctor or her associates, to provide such additional services as he or they may consider to be medically advisable, including but not limited to suctioning, culturing the drainage, biopsies and packing if needed.

I understand this procedure and its benefits and risks, and I consent to this procedure.

I have read the above information and understand my insurance company may reimburse a nasal endoscopy as a surgical service with the deductible and co-insurance guidelines applied.

I further acknowledge and agree to the financial responsibility established by my insurance carrier according to my individual policy.

If I have medical insurance, I may be provided with a receipt for to submit, or as a courtesy, the practice may submit my claim for me.

I agree that all charges are my responsibility from the date service is rendered.

Regardless of any insurance coverage that I may have, I agree that it is my responsibility to pay my balance and will pay any balance due, including co-payments and deductibles.

By signing this consent, I allow Dr. Vo-Nguyen or her assistants to perform an endoscopy procedure today and at all times in the future. This consent may be revoked in writing at any time.

Patient Name _____ Date _____

Patient Signature _____ Date _____

Guardian Name _____ Date _____

Guardian Signature _____ Date _____