Complete
CARDIAC AND VASCULAR CARE
Viral Lathia, MD

PATIENT INFORMATION

Date_____ Patient Name_____Medical Record#: _____
SS#/SIN_____ ❒ Male ❒ Female Birthdate_____ Home Phone_____
Adress_____ City_____ State/Prov ._____ Zip/P.C ._____
E-Mail_____ Cell Phone _____
Check Appropriate Box: ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated
Patient's or Parent/Guardian's Employer_____ Work Phone_____
Business Address_____ City_____ State/Prov._____ Zip/P.C._____
Spouse or Parent/Guardian's Name_____ Employer_____ Work Phone_____
If patient is a student, name of school/college _____ City _____ State/Prov. _____
Whom may we thank for referring you? _____
Person to Contact in case of emergency _____ Phone _____

X_____ _____
Patient or Guardian Signature Date

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____
Address _____ Home Phone _____
E-Mail _____ Cell Phone _____
Driver's License # _____ Birthdate _____ Financial Institution _____
Employer _____ Work Phone _____
Is this person currently a patient at out office? ❒ Yes ❒ No

Insurance Information

Name of insured _____ Relationship to patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group # _____ Union or Local # _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C.
_____
How much is your Deductible? _____ How much have you used? _____ Max. annual Benefit?_____

Do you have any additional insurance? ❒ Yes ❒ No If yes, Complete the Following:

Name of Insured_____ Relationship to patient _____
Birthdate_____ SS#/SIN _____ Date Employed _____
Name of Employer_____ Work Phone _____
Insurance Company _____ Group # _____ Union or Local # _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C.
_____
How much is your Deductible? _____ How much have you used? _____ Max. annual Benefit?_____

I authorize the release of information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X_____ _____
Patient Guardian Signature Date

Complete
CARDIAC AND VASCULAR CARE
Viral Lathia, MD

Protected Health Information (PHI) Communication Consent Form

At Complete Cardiac and Vascular Care, we would like to understand your preferred method(s) of communication and obtain your consent for releasing medical information to family members and other individuals of your choice. You give us permission to relay your medical information such as lab results, prescription requests, appointment reminders, and referrals via phone, fax, post mail, or other specified methods as selected below. You also give us permission to release medical information to your family members, caregivers, or other selected individuals according to your preferences below. By signing this form, you understand that you have the right to revoke this authorization in writing at any time. Revocation will not cover information released prior to that date. This form is optional and does not expire. Your request will be in effect until you notify our practice of any changes.

Name: _____ DOB: _____ Medical Record #: _____

Methods of Communication (check all that apply):

Home Telephone: _____

- ○ Leave a voice message
- ○ Do not leave a voice message

Work Telephone: _____

- ○ Leave a voice message
- ○ Do not leave a voice message

Cell Phone: _____

- ○ Leave a voice message
- ○ Do not leave a voice message
- ☐ Text message

Written Communication:

- ○ Send to home address
- ○ Send to work address
- ☐ Fax to this number: _____

Secured e-messaging through Online Patient Portal (must be 18 years of age or older)
Email to access patient portal: _____

- ☐ Messaging via Healow & ECW

Others: _____

Permission(s) (check all that apply):

- ○ I do not want my medical information to be communicated to my family members or caregivers
- ○ I give this practice the permission to verbally communicate my medical information to family members, caregivers, or other individuals listed below:

  Name: _____ Phone: _____

  Relation: _____

  Name: _____ Phone: _____

  Relation: _____

Information to be released/accessed (check all that apply):

- ☐ Appointment Information
- ☐ Prescription Drug Information
- ☐ Referral Information
- ☐ Lab Results
- ☐ Medical Instructions/Advice
- ☐ Billing, Insurance, & Payment Information

X _____ _____
Patient/Guardian Signature — Date

_____ _____
Print Name — DOB

Complete
CARDIAC AND VASCULAR CARE
Viral Lathia, MD

Patient Agreement in Office Policies

Name: _____ DOB: _____ Medical Record #: _____

Our financial policy has been established to give a clear understanding and prevent any misunderstanding.

I hereby agree to assign payments over to the office of Dr. Viral Lathia. if my insurance carrier does not cover services due to co-payments, deductibles, etc.

I realize that I am responsible for payment(s) of any or of any treatments that my insurance carrier may not pay.

I am responsible for my $ _____ deductible and co-payment which has been determined by my insurance. My co-payment and deductible will be paid at the time of the service, unless other arrangements have been made with the office. If insurance information is incorrect, I will be responsible for the entire payment.

I understand that a $20.00 fee will be charge for all returned/bad checks and will terminate my privilege to pay by check on future visits.

I understand and agree that in the event of any outstanding balance has to be referred to a collection agency or attorney for recover, I will be responsible for all collection and attorney's fees.

Because your time is valuable, we will make every effort to begin promptly. However, our time is equally as important, and we expect that you be on time for scheduled appointments and give us a 24-hour notice of any cancellation(s).

By signing this form, I agree that I have read and fully understand the policy.

X _____ _____

Patient/Guardian Signature Date

Viral Lathia, MD

FINANCIAL POLICY

Patient: _____ SSN: _____ Date: _____

Thank you for choosing **Complete Cardiac & Vascular Care** as your healthcare provider. This office is committed to your health and successful treatment. Please understand that payment of your services is considered part of your treatment. We ask that you please read the following FINANCIAL POLICY and sign this form prior to any treatment.

ALL COPAYS AND DEDUCTIBLES ARE DUE AT THE TIME THE SERVICE IS RENDERED. IF OTHER ARRANGEMENTS NEED TO BE MADE PLEASE SPEAK WITH THE RECEPTIONIST PRIOR TO YOUR VISIT.

WE ACCEPT CASH, CHECK, VISA,
And MASTERCARD.

INSURANCE

We do accept assignment on MOST insurance plan (We do NOT accept assignment on MVA claims). We must have your insurance information to do any insurance billing. In the event that your insurance company does not pay within 45 days, we reserve the right to transfer balances to your responsibility. We will be happy to assist you by providing you with claim forms and an explanation of benefits from your primary insurance after your balance with us is satisfied.

Please be aware that some of the services provided may not be considered reasonable and necessary under your health plan and will be considered self-pay.

All copays and deductibles are due at the time of treatment unless prior billing arrangements have been made. If your insurance requires a referral, we request that you bring it with you at the time of your visit.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans. This assignment will remain in effect until revoked by me in writing. A copy of the Assignment is to be considered as valid as an original.

I understand that I am financially responsible for all charges. I hereby authorize **Complete Cardiac & Vascular Care** to release all information necessary to secure payment.

Signature Patient/Legal Guardian: _____

Patient: _____ SSN: _____ Date: _____

Financial policy continued on next page.

Complete
CARDIAC & VASCULAR CARE

Viral Lathia, MD

MEDICARE GUIDELINES

I authorized any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare claims. I permit a copy of this request for payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature Patient/Legal Guardian: _____

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

ADULT AND MINOR PATIENTS

Adult patients are responsible for payment at the time of service. Minor patients must be accompanied by a parent or legal guardian who is responsible for the minor. Payment for services provided to minors is due at the time of service.

MISSED APPOINTMENTS

Due to our practice philosophy and intensive time requirements for each of our patients it has been necessary to implement a missed appointment policy.

Unless canceled, **at least 48 hours** in advance, our policy is to charge for missed appointments at the below rate which is not covered by insurance;

Office visit - $50.00
ECHO appointment - $75.00
Stress Test - $200

This must be paid in full prior to rescheduling a future appointment. If you miss 2 (two) appointments without 48 hour notification, you will be responsible for any missed appointment charges and any future appointments will need to be paid in full prior to scheduling.

We understand that circumstances arise in which schedule appointments are missed. However, please note that if you miss 3 (three) appointments without notifying the office **48 hours** in advance, you will be discharged from care.

Thank you for understanding our FINANCIAL POLICY. Please let us know if you have any questions or concerns.

I have read the FINANCIAL POLICY. I understand and agree to this policy.

Signature Patient/Legal Guardian: _____

COMPLETE CARDIAC AND VASCULAR CARE
NOTICE OF PRIVACY PRACTICES

REVISION DATE: 09/15/2022 **Medical Record #: _____**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. **Receive a copy of this Notice of Privacy Practices** from us upon enrollment or upon request.
2. **Request restrictions on our uses and disclosures of your protected health information** for treatment, payment and health care operations. This includes your right to request that we not disclose your health information to a health plan for payment or health care operations if you have paid in full and out of pocket for the services provided. We reserve the right not to agree to a given requested restriction.
3. **Request to receive communications of protected health information in confidence.**
4. **Inspect and obtain a copy of the protected health information** contained in your medical and billing records and in any other Practice records used by us to make decisions about you. If we maintain or use electronic health records, you will also have the right to obtain a copy or forward a copy of your electronic health record to a third party. A reasonable copying/labor charge may apply.
5. **Request an amendment to your protected health information**. However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request:
    - was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
    - is not part of your medical or billing records;
    - is not available for inspection as set forth above; or
    - is accurate and complete.

    In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.
6. **Receive an accounting of disclosures of protected health information** made by us to individuals or entities other than to you, except for disclosures:
    - to carry out treatment, payment and health care operations as provided above;
    - to persons involved in your care or for other notification purposes as provided by law;
    - to correctional institutions or law enforcement officials as provided by law;
    - for national security or intelligence purposes;
    - that occurred prior to the date of compliance with privacy standards (April 14, 2003);
    - incidental to other permissible uses or disclosures;
    - that are part of a limited data set (does not contain protected health information that directly identifies individuals);
    - made to patient or their personal representatives;
    - for which a written authorization form from the patient has been received
7. **Revoke your authorization to use or disclose health information** except to the extent that we have already been taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.
8. **Receive notification if affected by a breach of unsecured PHI**

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

This organization may use and/or disclose your medical information for the following purposes:

Treatment: We may use and disclose protected health information in the provision, coordination, or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another.

Payment: We may use and disclose protected health information to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities.

Regular Healthcare Operations: We may use and disclose protected health information to support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities.

Appointment Reminders: We may use and disclose protected health information to contact you to provide appointment reminders.

Treatment Alternatives: We may use and disclose protected health information to tell you about or recommend possible treatment alternatives or other health related benefits and services that may be of interest to you

Health-Related Benefits and Services: We may use and disclose protected health information to tell you about health-related benefits, services, or medical education classes that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location, general condition or death.

Business Associates: There may be some services provided in our organization through contracts with Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Worker's Compensation: We may release protected health information about you for programs that provide benefits for work related injuries or illness.

Communicable Diseases: We may disclose protected health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Health Oversight Activities: We may disclose protected health information to federal or state agencies that oversee our activities.

Law Enforcement: We may disclose protected health information as required by law or in response to a valid judge ordered subpoena. For example in cases of victims of abuse or domestic violence; to identify or locate a suspect, fugitive, material witness, or missing person; related to judicial or administrative proceedings; or related to other law enforcement purposes.

Military and Veterans: If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.

Lawsuits and Disputes: We may disclose protected health information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.

Abuse or Neglect: We may disclose protected health information to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Fund raising: Unless you notify us you object, we may contact you as part of a fund raising effort for our practice. You may opt out of receiving fund raising materials by notifying the practice's privacy officer at any time at the telephone number or the address at the end of this document. This will also be documented and described in any fund raising material you receive.

Coroners, Medical Examiners, and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release protected health information about patients to funeral directors as necessary to carry out their duties.

Public Health Risks: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose such as controlling disease, injury or disability.

Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Food and Drug Administration (FDA): As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Research (inpatient): We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a Web site that provides information about our patient/customer services or benefits, the new notice will be posted on that Web site.

Your health information will not be used or disclosed without your written authorization, except as described in this notice. The following uses and disclosures will be made only with explicit authorization from you: (i) uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; (ii) disclosures that constitute a sale of your health information; and (iii) other uses and disclosures not described in the notice. Except as noted above, you may revoke your authorization in writing at any time.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our Privacy Officer, Mrs. Lathia at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer at Elite Cardiovascular Group or with the Secretary of the Department of Health and Human Services. The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. We will take no retaliatory action against you if you make such complaints.

The contact information for both is included below.

Complete Cardiac & Vascular Care
Mrs. Lathia
Privacy Officer
309 Regency Parkway, Suite 201
Mansfield, TX -76063
P: 682-499-1777
F: 682-499-1779
admin@completecvcare.com

U.S. Department of Health and Human Services
Office of the Secretary
200 Independence Avenue, S.W.
Washington, D.C. 20201
Tel: (202) 619-0257
Toll Free: 1-877-696-6775
http://www.hhs.gov/contacts

NOTICE OF PRIVACY PRACTICES AVAILABILITY

This notice will be prominently posted in the office where registration occurs. You will be provided a hard copy, at the time we first deliver services to you. Thereafter, you may obtain a copy upon request, and the notice will be maintained on the organization's Web site (if applicable Web site exists) for downloading.

Complete
CARDIAC AND VASCULAR CARE
Viral Lathia, MD

Acknowledgement of Receipt of Notice of Privacy Practices

Date of revision: 09/15/2022

Name: _____ **Medical Record #:** _____

I hereby acknowledge that I have received a copy of Complete Cardiac and Vascular Care Notice of Privacy Practices.
I understand that I have the right to refuse to sign this acknowledgement if I so choose.

_____
Signature of Patient or Legal Representative

_____
Date

_____
Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)
- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

_____ but acknowledgment could not be obtained because:

- ☐ Patient/representative refused to sign
- ☐ An emergency prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
- ☐ Communication barriers prohibited obtaining acknowledgement (Explain)

_____

_____

_____

_____

_____

- ☐ Other (Specify)

_____

_____

_____

_____

_____

Complete
CARDIAC AND VASCULAR CARE
Viral Lathia, MD

List of Medications

Name: _____ DOB: _____ Medical Record #: _____

Pharmacy Name: _____ Address: _____

Phone #: _____

Please include all prescription medications, over-the-counter medications, vitamins, and herbal supplements. Please update and bring in this form to every office visit.

	Name of Medication	Dosage	How many times per day?
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			

Review of Systems

Please check the symptom(s) you are **currently** experiencing

General

- ☐ Fever
- ☐ Chills
- ☐ Loss of appetite
- ☐ Generalized weakness
- ☐ Fatigue
- ☐ Weight gain
- ☐ Weight loss
- ☐ Night sweats
- ☐ Difficulty sleeping

Other: _____

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Poor appetite
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Abdominal pain
- ☐ Bloating
- ☐ Loose stools (diarrhea)
- ☐ No stools (constipation)
- ☐ Yellow colored eyes or skin
- ☐ Changes in bowel habits
- ☐ Bright red blood in stools
- ☐ Dark colored or black stools
- ☐ Hemorrhoids

Other: _____

Eyes

- ☐ Blurry vision
- ☐ Double vision
- ☐ Wear glasses

Other: _____

Ear/Nose/Throat

- ☐ Difficulty hearing
- ☐ Ringing in ear(s)
- ☐ Loss of hearing
- ☐ Sore throat

Other: _____

Cardiovascular

- ☐ Chest pain or discomfort
- ☐ Heart racing/pounding Irregular/funny heartbeat
- ☐ Dizziness/feeling lightheaded
- ☐ Fainting
- ☐ Shortness of breath on rest
- ☐ Shortness of breath with activity
- ☐ Shortness of breath when lying flat
- ☐ Waking up at night from shortness of breath
- ☐ Blue discoloration of skin
- ☐ Pain in leg(s) when walking
- ☐ Swelling of leg(s)

Other: _____

Neurological

- ☐ General body weakness
- ☐ Weakness in a specific area
- ☐ Numbness
- ☐ Changes in sensations (ex: tingling)
- ☐ Shaky hands
- ☐ Difficulty concentrating
- ☐ Difficulty with coordination
- ☐ Daytime sleepiness
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Feeling lightheaded
- ☐ Seizures

Other: _____

Genitourinary

- ☐ Pain/burning during urination
- ☐ Hesitancy during urination
- ☐ Urgency to urinate
- ☐ Blood in urine
- ☐ Frequent urination at night
- ☐ Urine dribbling
- ☐ Decreased libido
- ☐ Enlarged Prostate
- ☐ Changes in breast(s)

Other: _____

Respiratory

- ☐ Long standing cough
- ☐ Wheezing shortness of breath on rest
- ☐ Shortness of breath with activity
- ☐ Snoring
- ☐ Gasping for air during sleep
- ☐ C-Pap use
- ☐ Oxygen use
- ☐ Coughing up blood

Other: _____

Psychiatric

- ☐ Feeling jittery/ nervous
- ☐ Difficulty remembering
- ☐ Changes in mood
- ☐ Racing thoughts

Other: _____

Musculoskeletal

- ☐ Joint pain
- ☐ Joint swelling
- ☐ Back or neck pain
- ☐ Morning stiffness
- ☐ Muscle cramping/ tightening
- ☐ Limitation of motion

Other: _____

Endocrine

- ☐ Feeling hotter than usual
- ☐ Feeling colder than usual
- ☐ Excessive thirst
- ☐ Excessive sweating
- ☐ Excessive urination

Other: _____

Hematologic/Lymphatic

- ☐ Bleeding easily
- ☐ Bruising easily
- ☐ Lumps/bumps/masses

Other: _____

Complete
CARDIAC AND VASCULAR CARE
Viral Lathia, MD

Peripheral Arterial Disease (PAD) Questionnaire

Name: _____ DOB: _____ Medical Record #: _____

Peripheral Arterial Disease (PAD) is a condition in which the arteries that carry blood to the muscles of the legs become narrowed and hardened due to the build up of plaque. It can result in leg pain or "fatigue," which can limit your physical activity. PAD can also increase your risk of having a heart attack or stroke if left untreated.

Please take a moment to answer the questions below so that we may briefly screen you for PAD. If you have any questions or concerns regarding PAD and your risk or would just like more information, please do not hesitate to ask.

1) Do you have any discomfort in the muscles of your legs when you walk that is relieved by rest?
   ◯ Yes ◯ No
2) Do your legs ever feel fatigued or heavy when walking or active? ◯ Yes ◯ No
3) Do you ever need to stop and rest when walking or have difficulty keeping up with others?
   ◯ Yes ◯ No
4) Do your feet and toes bother you at night? ◯ Yes ◯ No
5) Would you have difficulty doing any of the following because of leg fatigue, weakness, or discomfort? ◯ Yes ◯ No

Select the appropriate answer:

	Difficulty	Some Difficulty	Unable
Walking one block?	1 ◯	2 ◯	3 ◯
Climbing one flight of stairs?	1 ◯	2 ◯	3 ◯
Walking at an increased pace?	1 ◯	2 ◯	3 ◯

X _____ _____

Patient/Guardian Signature Date

Complete
CARDIAC AND VASCULAR CARE
Viral Lathia, MD

Venous Insufficiency Screening

Name: _____ DOB: _____ Medical Record #: _____

Patient Signature **X** _____ Date: _____

Have you ever been diagnosed with or do you have any of the following? Please circle your answer.

Varicose Veins	Yes	No	Right Leg	Left Leg
Leg or Ankle Ulcers	Yes	No	Right Leg	Left Leg
Spider Veins	Yes	No	Right Leg	Left Leg
Aching/Pain	Yes	No	Right Leg	Left Leg
Heaviness	Yes	No	Right Leg	Left Leg
Tiredness/Fatigue	Yes	No	Right Leg	Left Leg
Itching/Burning	Yes	No	Right Leg	Left Leg
Swelling	Yes	No	Right Leg	Left Leg
Cramps	Yes	No	Right Leg	Left Leg
Restless Legs	Yes	No	Right Leg	Left Leg
Throbbing	Yes	No	Right Leg	Left Leg
Skin or Ulcer Problems	Yes	No	Right Leg	Left Leg

Do you do any of the following to improve the discomfort in your leg(s)?

Take medication for pain? Yes No; If yes, which medication _____

Elevate your leg? Yes No; If yes, for how long _____

Wear support hose? Yes No; If yes, which type _____

How does your leg condition affect your daily activities? _____

Personal & Family History:

Does anyone in your family have Varicose Veins? Yes No; If yes, whom _____

FEMALES – Have you ever been pregnant? Yes No; If yes, how many times _____

Do you sit or stand for long periods of time? Yes No; If yes, how often _____

Doctor's Signature **X** _____ Date: _____

Viral Lathia, MD

Interventional Cardiologist

309 Regency Pkwy, Ste. 201
Mansfield, TX 76063
Phone: (682) 499-1777
Fax: (682) 499-1779

Medical Release Form

Patient Name _____ Date of Birth _____/_____/_____
SSN _____ Address _____ City _____
State _____ Zip Code _____Phone (____) _____ Email _____

Information Requested From

Name _____
Address _____ City _____ State _____
Zip Code _____ Phone _____ Fax _____

Send Information To

Name Viral Lathia, MD Send By ☐ Mail ☒Fax ☐Secure Email
Address 309 Regency Parkway, Ste-201 City Mansfield State TX
Zip Code 76063 **Phone**: (682) 499-1777 **Fax:** (682) 499-1779

I, _____(Name), herby grant permission for you to release confidential health information about me, by releasing a copy of my medical record, or a summary or narrative of my protected health information, to the physician/person/facility/entity.

_____ _____
Signature of Patient or Authorized Individual Date

_____ _____
Relationship if Signed by Other Than Patient Date of Birth