Name: ______________________________
Chart: ______________________________
Date: ______________________________

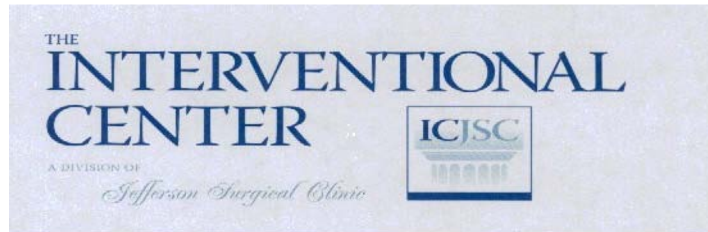
1. **<u>Consent to Treatment:</u>** I, the undersigned, do consent to the physicians of Jefferson Surgical Clinic, Inc. to administer any and all treatments deemed necessary for diagnostic or treatment purposes while in their care. This consent is given for a period of one year, ending one year from the date signed below.
2. **<u>Consent to HIV Testing:</u>** In case a health care worker of this Clinic, during your care, is punctured by a needle or is directly exposed to fluids that may transmit the HIV virus, in accordance with Section 32.1-45.1 of the Virginia Code, you will be deemed to have consented to the Clinic's right to draw blood for testing for the HIV virus and the release of such test results to the Clinic and the worker who suffered the exposure. All positive test results will be disclosed to the Department of Health. Other persons to whim the results may be disclosed include health care providers involved in your care or treatment, emergency medical services personnel, others who have access to the record for quality assurance, your parent(s) if you are a minor, or your spouse.
3. **<u>Consent for Virginia Jurisdiction:</u>** The relationship between the undersigned Patient and Jefferson Surgical Clinic shall be in accordance with and governed by the laws of the Commonwealth of Virginia in effect as of the date of this Registration. The Patient hereby consents to the personal jurisdiction of any state of federal courts located within the Commonwealth of Virginia.
4. **<u>Authorization of Benefits:</u>** I authorize the release of any medical information necessary to process my insurance claims for services rendered by Jefferson Surgical Clinic, and request payment to be made directly to Jefferson Surgical Clinic. I accept responsibility for all charges incurred at Jefferson Surgical Clinic.
5. **<u>Consent to Medical Photography:</u>** I consent for medical photographs to be made of me or my child (or person for whom I am legally responsible). By consenting to these medical photographs I understand that I will not receive payment from any party for them. I understand the photograph(s) may be used in my medical record and for purposes of medical teaching.
6. **<u>Authorization to Release PHI for participation in Electronic Prescription Database:</u>** I authorize the use or disclosure of my individual Protected Health Information (PHI) as described below with the understanding that this authorization is voluntary and may be revoked at any time by notifying JSC, in writing, except to the extent it has already taken action in reliance of this Authorization. This authorization covers individual prescription (present and future) PHI and prescription history disclosed by the physicians and other employees of Jefferson Surgical Clinic, P.C. (JSC) as well as to employees and agents of Sure Script and SRS soft. The purpose of this disclosure of PHI is to permit JSC to provide prescription and prescription history information to a national electronic clearing house of such information to facilitate accessibility to and exchange of such information among my various health care providers and third party pharmacy program payors for purposes of my treatment, reimbursement for prescriptions, and for any related purpose. If the organization authorized to receive the PHI is not a health plan, healthcare clearing house or healthcare provider covered by federal privacy regulations, the released PHI may no longer be protected from further use or disclosure by federal privacy regulations and may be subject to redisclosure by the recipient(s). I understand that I may see and receive a copy of the information described above if I request it in writing, I have the right to a copy of this consent, I have a right to refuse to sign this consent, and acknowledge that this consent will expire on termination of my status as a patient of Jefferson Surgical Clinic, P.C.

I have read and understand the consent information above. I understand any changes to the above consentsmust be made in person or in writing.

Patient Name (please print): ____________________________________

Patient Signature: ____ **Date:** __________________________

As the patient's ___Parent ___Legal Guardian or ___Power of Attorney, I am authorized to sign on behalf of the above named patient.
Authorized Signature: ____ **Date:** ________________________



Patient Instructions for Dialysis Graft/Fistulagram

PATIENT NAME: ________________________ CHART: ___________

Appointment __________at __________am/pm. Please arrive 30 minutes earlier.
Date Time

1. Have a light breakfast the morning of your procedure, then,

2. Only clear liquids the morning of your procedure until (stop clear liquids 4 hours prior to procedure) __________ am/pm and then nothing to eat or drink.

3. You will need a driver to drive you home.

If you have any questions please call The Interventional Center at:

(540) 283-3881

The Interventional Center
Suite A
4437 Starkey Road
Roanoke, VA 24018

Jefferson Surgical Clinic, Inc.
1234 Franklin Road
Roanoke, VA 24016
(540) 283-6000

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE/CONSENT

I have been presented with a copy of this practice's NOTICE OF PRIVACY POLICIES, detailing how my information may be used and disclosed as permitted under federal and state law.

I hereby authorize Jefferson Surgical Clinic, Inc. to release any and all information pertaining to my health care, test results, procedures, billing and/or accounting, appointment needs or any other information contained in my records to the following person(s) or agencies:

[ ] Spouse – Name ____

[ ] Parents – Name ____

[ ] Other – (Please Specify) __________________________________

[ ] No One

I further authorize any Jefferson Surgical Clinic, Inc. representative to contact me in one or more of the following ways:

By phone: [ ] At home [ ] At work

By leaving a message on an answering machine or voice mail: [ ] At home [ ] At work

By sending a postcard through the mail [ ]

I understand that Jefferson Surgical Clinic, Inc. may release any information to those persons whom I have designated. They may receive this information without a separate consent or prior notification. I also understand that this related to ALL the above-mentioned information. IF I WISH TO MAKE ANY CHANGES TO THE STATUS OF THIS FORM, I MUST DO SO IN WRITING.

Signed ______________________________________ Date ____________________

If not signed by the patient, please indicate relationship to the patient (e.g. spouse)

Relationship __________________________________

Witness _____________________________________

Jefferson Surgical CLINIC
HALF A CENTURY OF SERVICE

Name: ____________________ Date of Birth: ____________________

Allergies to:	Type of Reaction:	Allergies to:	Type of Reaction:

Current Medications:

Drug Name	Date Started	Strength	Dose	Frequency	Prescribing Doctor	Reason for Medication	Nurse Use Only

Jefferson Surgical Clinic

Physician ____________________

Patient Information

PLEASE PRINT AND COMPLETE ALL INFORMATION

PATIENT NAME: ____
(Last) (First) (Middle) (Maiden)

Address:____
Street or P.O. City State Zip

Home Phone: __________________ Work Phone: ________________ Cellular Phone:_______________

SSN: _________________ DOB ___________ Age _______ Sex: M F Marital Status: S M D W

Race: ________________ Ethnicity: _________________Preferred Language: _____________

Emergency Contact Name: ____________________________ Telephone: ________________________

EMPLOYER: ____RETIRED: Yes □ No □

Address: ____Telephone: ____________________

SPOUSE or PARENT/GUARDIAN (if minor)

NAME: __________________________________ DOB: ___________ SS# _____________________

Employer: ____

Employer Address: _______________________________________ Telephone: ____________________

PRIMARY INSURANCE COMPANY:____

Subscriber or Insured Name: _______________________________ DOB: ________________________

Policy # ____________________________ Group# ________________ Effective Date: ___________

Relationship to Patient __________________________________ SS# ___________________________

SECONDARY INSURANCE COMPANY: ____

Subscriber or Insured Name: ________________________________ DOB: _______________________

Policy # ____________________________ Group# ________________ Effective Date: ___________

Relationship to Patient __________________________________ SS#:____________________________

FAMILY PHYSICIAN ________________________________ ALLERGIES ______________________

REFERRED BY____ ______________________

THE INTERVENTIONAL CENTER

EPIDURAL STEROID INJECTION, VERTEBROPLASTY AND PORT PLACEMENT MEDICATION HOLD LIST

MEDICATIONS MUST BE HELD FOR 5 DAY SPRIOR TO PROCEDURE

ACTRON
ADVIL
ALEVE
AMIGESIC
ANAFLEX 750
ANAPROX
ANACIN
ANSAID
ARTHRITAB
ARTHROPAN
ASCRIPTIN
ASPIRIN or anything w/aspirin

BAYER
BC POWDER
BEXTRA
BUFFERIN
BUFFETS

CATAFLAM
CELECOXIB
CELEBREX
CHOLINE SALICYLATE
CHOLINE MAGNESIUM TRICALICAYLATE
COTYLBUTAZONE
COUMADIN
CRAMP END

DAYPRO
DICLOFENAC
DIFLUNISAL
DISALCID
DOAN'S PILLS
DOLGESIC
DOLOBID

EC-NAPROSYN
ECOTRIN
ETODOLAC
EXCEDRIN
EXCEDRIN IB

FELDENE
FENOPROFEN
FLURBIPROFEN

GENPRIL
GENPRIL CAPLETS
GOODY'S POWDER

HALTRA

IBIFON
IBREN
IBU any number
IBUPRIN
IBUPROFEN
INDOCIN
INDOMETHACIN

KETOPROFEN
KETOROLAC

LODINE
LOVENOK stop 12 hours prior

MAGNESIUM SALICYLATE
MAGAN
MARTTHRITIC
MECLOMEN
MECLOFENAMATE SULFATE
MEDIPREN
MEFENAMIC
MELOXICAM
MIDOL
MOBAN
MOBIC
MOBIDIN
MOBOGESIC
MONO-GESIC
MOTRIN

NABUMETONE
NALFON
NAPRELAN
NAPRAPAC
NAPRELAN
NAPROXEN
NAPROSYN
NUPRIN

ORIDIS
ORUDIS KT
OVRVAIL
OXAPROZIN

PAMPRIN
PIROXICAN
PLAVIX
PONSTEL

Q-PROFEN

RELAFEN
ROFECOXIB
RUFEN

SALFLEX
SALSALATE
SALSITAB
SINE-AID
SODIUM SALICYLATE
SULINDAC

TICLID
TRICOSAL
TRILISATE
TOLECTIN
TOLMETIN SODIUM
TRENDAR
TRILSATE

VALDECOXIB
VICOPROFEN
VIOXX
VITAMIN E-400 IU
VOLATAREN
VOLATERN XR

WARFARIN

REVISED 10/06/08

NOTICE OF PRIVACY POLICY

This notice, effective April 1, 2003, describes how information about you may be used and disclosed and how you can get access to this information. The physicians and staff of Jefferson Surgical Clinic are committed to treating and using your protected health information responsibly. This Notice of Privacy Policy describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice of Privacy Practices Covers all Departments within our practice, and any physicians, providers, and staff who treat you at any of our locations.

Each time you visit the physician, a record of your visit is made. These records contain personal information and medical information and are used for your direct care and treatment. It's also used to produce an accurate bill for the services you receive, helps improve the care we give and strengthens the operations of our organization.

Your Health Information Rights
Although your medical record is the physical property of Jefferson Surgical Clinic, the information in it belongs to you. You have the following rights with respect to your health information:

You can inspect and get a copy of your health information- that may be used to make decisions about your care, subject to a few limited exceptions. You may request copies of your health information, in writing, from medical records personnel at Jefferson Surgical Clinic. We may charge a fee for the costs of copying, mailing or other supplies associated with your request.

If you feel the health information is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, our practice. Your request must be made in writing and include the reason for your request. We may deny your request if you ask us to amend information that was not created by us. We may also deny your request to amend information if we believe the information to be accurate and complete.

You may request a restriction or limitation on the health information we use or disclose about you for treatment, payment or our operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. We are not required to agree to your request. In your request, you must tell us:

- What information you want to limit.
- Whether you want to limit our use, disclosure or both.
- Who you want to receive your medical information.

You can request an accounting of your health information disclosures, except for those needed to carry out treatment, payment or our operations. Other exceptions include, but are not limited to:

- For national security and intelligence.
- Use by law enforcement officials or correctional institutions.

Your request must state a time period that may not be longer than six years and may not include dates before April 14. 2003.

The first list you request within a 12- month period will be free.

You can request communications of your health information by alternative means, at alternative locations or in a confidential manner. For example, you can ask that we contact you only at work or by mail. We will accommodate all reasonable requests.

You can revoke your authorization to use or disclose health information, unless disclosure has already occurred.

You can request a paper copy of this notice even if you have agreed to receive the notice electronically.

Our Responsibilities
Jefferson Surgical Clinic is required by law and is committed to:

- Maintain the privacy of your health information.
- Provide you with this notice of our legal duties and privacy practices with respect to health information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction and, in most cases, allow you to request a review of our decision.

We reserve the right to change our privacy practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will amend this notice and post a copy of the revised notice.

This notice will contain on the first page the effective date. In addition, the first time you register at our practice for healthcare services as patient, we will offer you a copy of the current notice in effect.

For More Information or to Report a Problem
If you have questions and would like additional information, you may contact Karen Tuttle, Jefferson Surgical Clinic's Privacy Officer, at 540-345-1561. If you believe your privacy rights have been violated, you can file a complaint with Jefferson Surgical Clinic's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201

Jefferson Surgical Clinic — Half a Century of Service

NOTICE OF PRIVACY POLICY

Permitted Uses and Disclosures Which do not Require Your Written Consent or Authorization

We will use your health information for treatment, which means the provision, coordination or management of the healthcare services we provide. For example, information obtained by a nurse, physician or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his/her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will use your health information for payment, an activity necessary for us to receive reimbursement for the services we provide to you. For example: a bill may be sent to you, an insurance company or other payer. The information on, or accompanying, the bill may include information that identities you as well as your diagnosis, procedures and supplies used.

We will use your health information for regular healthcare operations, such as quality assessments, evaluating practitioner performance, cost management and general administrative activities. For example: members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and services we provide, and provide training to our staff.

Some services are provided in our practice through contracts with business associates, We may disclose your health information to our business associates so they can perform the job we've asked them to do. Our contracts require business associates to appropriately protect the privacy and security of your health information.

We may disclose health information relevant to your care or payment for your care to a family member, other relatives, a close personal friend or any other person you identify.

During the initial visit, we may ask you to identify those who you would like to receive information about you.

We may use or disclose health information to notify or assist in notifying a family member, personal representative, or another person responsible for your care about your location and general condition.

We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the practice. In leaving a message on an answering machine, we will only leave our name, and the appointment's time and date.

We may use sign-in sheets in certain locations to check you into the practice. We also may call your name in the waiting area. If you do not wish to sign the sign-in sheet or have your name called, please tell the receptionist and we will make adjustments to meet your request.

We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may also disclose health information as permitted or required by law, such as in the following circumstances:

- to the extent required by workers compensation or other similar programs.
- to a health oversight agency for audits, investigations and inspections.
- to public health or legal authorities charged with maintaining health records and preventing or controlling disease, injury or disability.
- to the FDA relative to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs or replacement.
- to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. We will always ask for your specific authorization if the researcher will have access to your name, address or other information that reveals who you are or will be involved in your care at one of our facilities.
- to research, public health and healthcare operations in a limited, non-identifiable, data set.
- to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant. Organs will only be procured with written authorization.
- to a coroner or medical examiner and to funeral directors as necessary to carry out their duties.
- to a law enforcement official or in response to a court order, subpoena, warrant, summons or similar process.
- to authorized federal officials for intelligence, counterintelligence and other national security activities.
- if you are a member of the armed forces, as required by military command authorities.
- to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct investigations.
- If you are an inmate of a correctional institution, to the institution or agents for your health and the health and safety of other individuals.
- A Group Health Plan may disclose protected health information to a plan sponsor.

Other uses and disclosures of medical information not covered by this notice, required for emergency treatment or permitted by the laws that apply to us will be made only with your written authorization. If you authorize disclosure, you may revoke that, in writing, at any time.

If you revoke your authorization, we will not use or disclose your medical information for the reasons covered by your prior written authorization. Please understand we are unable to take back disclosures we already made with your prior authorization, and that we are required to retain our records of the care that we provide to you.

DATE: ______________

PATIENT INFORMATION

NAME: ____ DATE OF BIRTH: _______________AGE: _______

REFERRING PHYSICIAN NAME & PHONE: ____

PRIMARY PHYSICIAN NAME & PHONE: ____

Please help us obtain accurate information for your medical records by completing this form:

List ALL allergies from medications, foods, etc. Please include reaction.

____

____

____

____

LIST ALL OPERATIONS:

Type of surgery:	Date:	Surgeon:

CONTINUED ON NEXT PAGE

Name: ________________________________

DOB: ________________________

PATIENT INFORMATION (continued)

Medical Illnesses (check either yes or no):

ILLNESS	YES	NO
Diabetes	_____	_____
Heart Disease	_____	_____
High Blood Pressure	_____	_____
High Cholesterol	_____	_____
Heart Murmur	_____	_____
Angina / Chest Pain	_____	_____
Heart Attack	_____	_____
Stroke	_____	_____
Atrial Fibrillation	_____	_____
Liver Disease	_____	_____
Epilepsy	_____	_____
Asthma	_____	_____
Glaucoma	_____	_____

Other: ________________________________

Family History (mark yes or no & type of relationship)

ILLNESS	YES	NO	Relationship
Diabetes	_____	_____	______________
High Blood Pressure	_____	_____	______________
Heart Disease/Attack	_____	_____	______________
Stroke	_____	_____	______________
Thyroid Disease	_____	_____	______________
Sudden Death	_____	_____	______________
Breast Cancer	_____	_____	______________
Testicular Cancer	_____	_____	______________
Uterine Cancer	_____	_____	______________
Ovarian Cancer	_____	_____	______________
Colon Cancer	_____	_____	______________
Kidney Cancer	_____	_____	______________
Prostate Cancer	_____	_____	______________
Bladder Cancer	_____	_____	______________
Kidney Stones	_____	_____	______________
Genitourinary malignancy	_____	_____	______________
Renal stone disease	_____	_____	______________
Genitourinary Illness	_____	_____	______________
Renal Failure	_____	_____	______________

Other: ____

	Yes	No
Do you smoke?	____	____
How much per day? ___________		
How long have you smoked? ______________		
Do you use alcohol?	____	____
How much per day? ___________		
How long have you used alcohol? ___________		
Have you ever had a problem with anesthesia?	____	____
Has anyone related to you ever had a problem with anesthesia?	____	____
Have you ever had a heart catheterization?	____	____
Have you had cardiac stents?	____	____
Do you have a cold now?	____	____
If female, could you be pregnant?	____	____

Number of children? ___________

Ages of children? ____________

COMMENTS

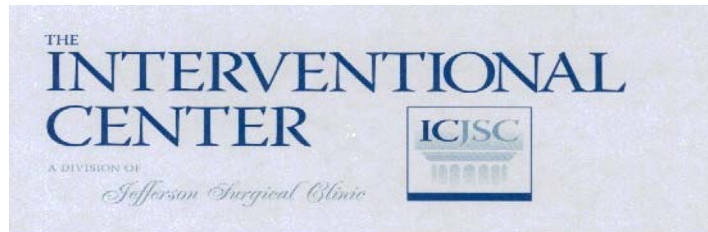
____

____

____

____

IF YOU NEED MORE ROOM PLEASE USE THE BACK OF THE SHEET



PHONE 540-283-3881
FAX 540-777-4949

PATIENT INSTRUCTIONS FOR VASCULAR PROCEDURES

Arteriograms, Angioplasty, Vascular Stents Placement

1- Coumadin must be stopped 5 days prior to the procedure but only after consultation with your referring physician.

2- Do not drink or eat anything after midnight on the day of your procedure. You may take your medications (with the exception of Coumadin and your diabetic pills) with a little sip of water. If you take insulin, please let your physician know, it may have to be adjusted.

3- Please bring the medications that you are currently taking with you on the day of your procedure.

4- You must have someone to drive you home and stay with you until the next morning. You will not be able to drive, leave by yourself, or take a cab home without a companion.

5- If your procedure requires sedation, please understand that you should not drive, operate hazardous equipment, or drink alcoholic beverages for 24 hours after sedation/analgesia

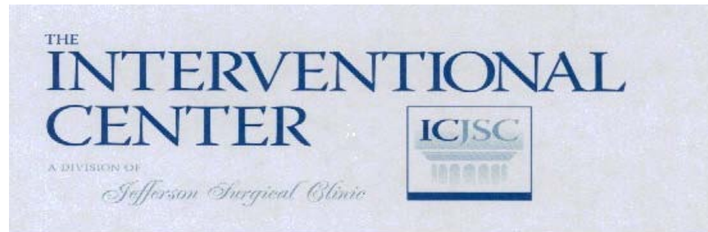
6- If you have any questions, please call The Interventional Center at 540-283-3881.

7- Please notify the staff if you have any allergies to the x-ray dye that will be used in this procedure.

Your Arteriogram is scheduled for________________ at _____________am/pm at
Date Time

Patient Name ____Chart # ________________

The Interventional Center
4437 Starkey Road, Suite A
Roanoke, VA 24018



PATIENT INSTRUCTIONS FOR ESI (EPIDRUAL STEROID INJECTION)

PATIENT NAME____

Your ESI is scheduled for________________ at _____________am/pm at
Date Time

The Interventional Center
4437 Starkey Road, Suite A
Roanoke, VA 24018

1. Discontinue all blood thinning medications and non steroidal anti-inflammatory medication **5** day prior to your procedure. These include among others, Coumadin, Plavix, Aspirin, Aleve, Ibuprofen, Ticlid, Voltaren, Advil, Aggrenox.
2. Please come to the Interventional Center registration desk at ___________am/pm.
3. Please arrange to have someone drive you home from the Center when you are discharged.
4. Please bring a list of all medications you are taking (this includes over-the-counter and herbal medications).
5. Please bring any films or images that your Doctor has recommended that you bring to your appointment.
6. If you have any questions, please call 540-283-3881.

The Interventional Center of
Jefferson Surgical Clinic
4437 Starkey Road SW, Suite A
Roanoke, VA 24018
540-283-3881

From I-81:

- Merge onto I-581 South/US 220 South via Exit 143 toward Airport/Roanoke
- Continue on I-581
- Take the VA-419N/US220 BUS/Franklin Road exit toward Salem
- Keep right at the fork, follow signs for VA-419 None. and merge onto VA-419N/Electric Road
- Turn right onto Starkey Road
- 4437 Starkey Road in on the left

From US 220 North/I-581 North:

- Take the VA-419 N/US-220 BUS/Franklin Road exit toward Salem
- Keep left at the fork, follow signs for VA-419 N and continue onto Franklin Road
- Turn right onto Starkey Road
- 4437 Starkey Road in on the left