Chesapeake
Vein Center and MedSpa

Surya N Challa MD PC, 300 Medical Parkway, # 208, Chesapeake, VA. 7578197633|f 7578197655|cvcmedspa.com

PATIENT INFORMATION

Last Name:_____First Name:_____M.I._____

Home Address: _____

SS#:_____Home Phone:_____

Cell Phone: _____Work Phone:_____

Email Address: _____

DOB:_____ Age: _____ Sex: ____M _____F

Marital Status: _____Married _____Single _____Divorced/Sep._____Widowed

Referring Physician: _____

How did you hear about our practice? _____

Emergency Contact Information: (Person to contact in case of an emergency)

Last Name:_____First Name:_____
Relationship to Patient: _____

Home Address: (if different from patient)_____

Home Phone: (if different from patient)_____

Employer Information (If applicable)

Company Name: _____ Phone: _____

Company Address: _____

Responsible Party Information (Please complete if responsible party is other than patient)

Last Name:_____First Name:_____
SS#:_____Home Phone:_____

Company Name: _____ Phone: _____

Name of Primary Insurance Carrier: _____

Subscriber's Name:_____ Relationship to Patient: _____

ID Number: _____Group Number: _____

Name of Secondary Insurance Carrier: _____

Subscriber's Name:_____ Relationship to Patient: _____

ID Number: _____Group Number: _____

I certify that I am the above named patient or the above named patient's responsible party. I certify that to the best of my knowledge the above information is true and correct, and I will update the office of any changes in the future. I further certify that I have read and understand the Patient Consent Form on the reverse side of this form.

_____

Patient/Responsible Party (Print) Patient/Responsible Party Signature Date

_____

Witness Signature Date

SC reviewed 5/31/2017

FINANCIAL POLICY

Dr. Challa and staff thank you for choosing our practice. We will do our best to make your visit a pleasant experience. Please review our financial policy below. You can contact our office manager if you have any questions or concerns.

1. We ask that you present your **insurance card** at each visit. It is your responsibility to provide us with the correct information so that we may bill your insurance. Please notify us if this changes.
2. If you have a **change of address**, telephone number, or employer, please notify our front desk.
3. We will collect your **co-pay, deductible and any balance** remaining after your insurance has paid, or **charge for non-covered services** at the time of your visit. We accept cash, checks, and most major credit cards.
4. If we do not **participate** with your insurance company or if you are a self-pay patient, you will be expected to make payment in full at the time the service is rendered. It is **your responsibility** to check with your insurance company whether we are participating in your insurance plan.
5. If your insurance denies our charges or does not pay us in a timely manner, or if your account becomes delinquent we reserve the **right to refer** your account to a collection agency.
6. **Forms** – We will charge a $20.00 fee for the completion of any of your forms for disability, employer, time off work, etc. Please complete your portion before leaving them at the office. We can fax those forms to your employer if you so request.
7. **Returned checks** – We will charge a $30.00 fee if your check is returned to us for insufficient funds. Our Office Manager will be happy to assist you with arrangements to clear up this matter as soon as possible.
8. **No-show or missed appointment** – it is important that you notify us as soon as possible if you know you will not be able to make your appointment. This will allow us time to fill that appointment slot and to schedule more efficiently. We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel an appointment by you. Failing above, we reserve the right to charge you an appropriate **no show fee**.
9. **Surgery changes or cancellations** – we try to schedule all surgeries in a time frame convenient for you and according to physician instructions. Please remember that once a surgery has been coordinated with the physician, hospital/office and your insurance company, it is difficult to make changes. If a change is necessary, you will have to take whatever time is available in the operating room and on the physician schedule.
When you schedule a procedure at a time slot in the office, the practice incurs substantial **expenses specific to that slot** related to physician time, payments to contracted staff & technologists, supplies ordered/opened for your procedure, etc. Please understand that <u>when you make late changes or cancellations</u> most of the expenses listed <u>still have to be borne</u> by the practice. For this reason, we reserve the right to charge you an appropriate **late cancellation or no show fee**.
10. **Your insurance** is a contract between you, your employer, and the insurance company. We are not a party to that contract. We cannot guarantee payment of all claims by your insurance. If your insurance company pays only a portion of the bill or rejects your claim, any contact or explanation should be made to you, their policy holder. Reduction or rejection of your claim for services rendered does not relieve you of your financial responsibility towards payment of the same.

I have reviewed and will abide by the financial policy of Dr. Surya N. Challa, M.D. P.C.

Signature: _____

Date: _____

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PATIENT CONSENT

Consent for Treatment

I, the undersigned, as the patient or on behalf of the above named patient hereof, do hereby consent to and authorize all diagnostic and therapeutic treatment considered necessary or advisable in the judgment of Dr. Surya N. Challa.

No Guarantee of Results

I understand that no guarantee or assurance has been made as to the results which may be obtained from the exam, testing, treatment, or surgery.

Release of Medical Information

I hereby authorize the release of any medical records to any company insuring the patient named above and assign all benefits from said insurance to Dr. Surya N. Challa. In the case of a work related injury or illness, I hereby authorize Dr. Surya N. Challa to release any information obtained by him to any employer or prospective employer when the medical exam, testing, treatment, or surgery is in accordance with the provisions of and under the conditions prescribed by the Workers' Compensation Act, any state or federal mandated exams, or company policy which requires a medical exam.

Blood borne Pathogen Exposure

As established in Virginia Law (Virginia Code Section 32.1-45.1), I acknowledge that if a caregiver is exposed to my blood or body fluids in the course of my treatment, my blood will be tested for the Human Immunodeficiency Virus (HIV) antibody and the results released to the exposed caregiver. If I am exposed to the blood or body fluids of the caregiver in the course of treatment, the caregiver's blood will be tested for the HIV antibody and the results will be release to me.

Payment

I understand that payment is due when services are rendered unless other arrangements have been made in advance. I understand that my medical insurance carrier will be billed as a courtesy, if requested. I understand and agree that I am responsible for all co-pays (if applicable) and all balance due. I understand and agree to pay all reasonable attorney fees and collection fees, as well as any court cost incurred by the practice in the collection of any monies due by myself and/or dependents.

In case of a work related injury or illness, employer requested medical services are usually paid by the employer or their insurance company. I understand, however, that I will be responsible for services provided by Dr. Surya N. Challa, if arrangements have not been made, or arrangements have been negated for any reason.

Patient/Responsible Party (Print) Patient/Responsible Party Signature Date

Witness Date

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ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

_____I hereby acknowledge that I have received a copy of the Notice of Privacy.

_____ I want no one to receive my Personal Health Information except myself.

_____ I request the following person(s) be allowed to access my Personal Health Information:

_____

_____

_____

_____ I specifically request the following person(s) **do not receive** any of my Personal Health Information:

_____

_____

I give permission for my physician's office to leave a message at my personal Residence _____Yes ____No

A message regarding my appointment only may be left on my answering machine _____Yes ____No

I would like to avail of the Chesapeake Vein Center online portal feature

email communications ___Yes ____No
text messages_____Yes _____No

_____

Patient Name (Print) Patient Signature Date

SC reviewed 5/31/2017

Cancellation Policy/No Show Policy
For Office Appointments and Surgery

1. Cancellation/No Show Policy for Office Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, if you do not call us to cancel your appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance or you are a no show, you will be charged a fifty-dollar ($50) cancellation fee; this will not be covered by your insurance company.

2. Cancellation/No Show Policy for Hospital Surgery

We understand that there are times when you must miss a surgery due to emergencies or obligations for work or family. When we schedule your hospital surgery, multiple parties are involved (hospital, physician, preop testing, radiology etc.). We schedule into a limited number of slots for surgeries. We reserve a block of physician and hospital time for your surgery. Hence, cancellations without adequate notice are severely disruptive and add significant expenses for the office. When you give us adequate notice, we schedule another patient into your slot.

If surgery is not cancelled at least 3 days in advance or you are a no show, you will be charged a two hundred-dollar ($200) fee; this will not be covered by your insurance company. If you have to cancel for a medical reason, we will need proof of medical documentation to avoid charging you a fee.

3. Office Rescheduling Policy in case of physician emergencies

We will do our best to communicate any schedule changes to you ASAP. As a surgeon, your physician may occasionally be called on to respond to medical emergencies. We will give you immediate notice if such changes occur and will do our best to reschedule you.

I _____HAVE REVIEWED ABOVE POLICY. I UNDERSTAND AND AGREE WITH THE TERMS SET FORTH.

_____	_____	____/_____/_____
Print Name Patient	**Signature Patient/Guardian**	**Date**

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Surya Challa MD, FACS, RPhS, Dipl ABVLM, Asst Prof Surgery EVMS
Surya Challa started the practice in 2006. We use a state of the art EMR with a patient portal, online scheduling and communication. Surya is on staff at Chesapeake Regional Medical Center, where he also serves as the Chief Medical Information Officer. He is Board Certified in General Surgery, Board certified in Clinical Informatics, is a Diplomate of the American Board of Venous and Lymphatic Medicine and is a Registered Phlebology Specialist certified in venous ultrasound. His other interests include personal development, physical fitness and travel. He lives in Chesapeake with his family.

Office Staff:
We utilize a full complement of office staff, including specialized resources for the surgical, venous and aesthetic areas. We utilize Athena EHR suite of medical records.

Our GENERAL SURGERY Practice
Some of our common services are:

- Hernia Surgery: ROBOTIC and Laparoscopic TEP and TAPP approaches are offered, utilizing the latest in lightweight meshes and absorbable tacks. Open hernia repairs are offered when appropriate. Extensive repairs are also approached laparoscopically or robotic.
- Gallbladder Surgery: SINGLE SITE ROBOTIC AND Laparoscopic approach is offered. Dr Challa performs Da Vinci Robotic Surgery.
- Colon Surgery: For diverticulitis and colon cancers, a state of the art, laparoscopic OR ROBOTIC approach is utilized with postoperative pain busters to reduce patient discomfort.
- Acid Reflux Surgery: A ROBOTIC OR laparoscopic approach is utilized for complex hiatal hernia repair and antireflux surgery; More than 200 surgeries performed.
- Spleen Surgery: A ROBOTIC OR Laparoscopic approach utilizing vessel sealers allows typically for overnight stay prior to discharge
- Hemorrhoids: Ultrasonic Shears minimizes anesthesia time while allowing for targeted removal with minimal blood loss. We also perform other anal procedures.
- Breast Surgery: We offer genetic testing; ultrasound guided biopsies, cutting edge surgical solutions, radiation catheter placements, extensive support and dedicated network resources. We liaison with the dedicated breast center and tumor board at CRMC. Dr Challa performs lumpectomies with cosmetic closures and mastectomies (this potentially can include immediate reconstruction with a nipple sparing technique, radiotracer and dye based sentinel lymph node biopsies, pain buster placements and consultations)
- Colonoscopy and EGD: We offer these preventative and/or diagnostic services as requested by our patients. An advantage of having a surgeon perform these low risk procedures is the ability to perform more aggressive procedures if required, typically not attempted by gastroenterologists.

Our VENOUS practice: (chesapeakeveincenter.com)
Typical complaints of venous disease include Leg aches, pain, heaviness, tiredness and itching, burning, numbness, Leg Cramps, Restless Legs, ankle swelling, skin changes, varicose or spider veins.

We have treated more than 2000 patients and performed more than 3000 procedures on patients with venous disease. Our Quality of Life improvements are significantly higher than national average. We offer personalized service and treatments tailored to patient needs.
We have a dedicated Venous Duplex Ultrasound Lab (ICVAL accredited)to objectively analyze and map leg veins. Based on this information and using objective criteria customized patient plans are developed.
Office based procedures which typically last less than an hour and covered by insurance for venous disease include:

- Radio Frequency ablation (heating and collapsing diseased veins)
- MOCA: Mechanico-Chemical Occlusion (a 'rotorooter' type mechanical device is combined with medication to collapse diseased veins)
- Microphlebectomy (physically removing unsightly veins with microscopic incisions)
- Sclerotherapy (spider vein injections- not covered by insurance and may cost upto $350 a session) we use special vein lights and filters to do this accurately.
- Large vessel sclerotherapy – Injecting unsightly and larger vessels which are too tortuous to ablate.
- Glue to shut down veins (no need for stockings, > 1 vein treated at a time. Just starting to get approved by insurance)

Our AESTHETICS practice:
Our vein patients have asked for more comprehensive cosmetic solutions. Based on this feedback and as a natural extension of our venous practice, we have incorporated aesthetic s as a focus area of expansion office services. We offer the following aesthetics services:

- Coolsculpting (noninvasive office based body contouring) is for patients with persistent subcutaneous fat in problem areas (muffin top, bra roll etc)
- Injectables – Botox for wrinkles and Juvederm as a filler
- Laser & Light – Laser Hair Removal, BBL Photo Facial, Microlaser Peel , Halo and Halo Pro, Forever young BBL
- Dermapen, Dermaplaning, Chemical Peels
- Skincare products as an extension of above treatments and for preventative care