AMBRAD-CHALELA
Tri-Cities Vein & Vascular Institute

761 Williams Blvd, Ste. 1, Richland, WA 99354
Phone: 509-946-9707 Fax: 509-946-8145

Dear Patient:

We would like to take this opportunity to welcome you to our practice. We look forward to meeting you and providing the highest quality Vein & Vascular care. In order to facilitate your appointment, we ask that you please take a few moments and complete the enclosed forms. **Please return the forms at least 1 week prior to your appointment**. By doing this prior to your office visit, we hope to make your visit as efficient as possible. Pages 1 and 2 of packet are yours to keep.

Appointment Dates
In House Ultrasound: _____ Time: _____

New Patient Appointment: _____ Time: _____

Our office will call and/or send text message to the number provided to confirm your appointment at least 1 day prior to your appointment. If you do not receive this call before your appointment, please call 509-946-9707.

We need you to bring the following to your appointment:
- Completed forms **(if not previously mailed)**
- Insurance cards
- Insurance co pay or prepayment estimate
- List of medications, allergies, surgeries and past medical history

Please arrive 10 minutes early with completed paperwork and additional information pertinent to your appointment. Arriving late to your appointment or not having required filled out paperwork may result in rescheduling.

If your insurance requires a referral or pre-authorization when seeing a specialist, please contact your primary care physician and confirm this has been completed.

If you are coming from Kennewick/Highway 395:
1. Merge onto WA-240 W (via ramp to Richland) Continue onto George Washington Way.
2. Turn Left onto Williams Blvd (which is right before the Denney's) go through one traffic light and start heading up the hill just slightly and we will be on the left hand side of the road. There is a sign along the road and the building is medium green stucco.

If you are coming from West Richland/Benton City:
1. Merge onto Interstate 82 E ramp to U.S. Highway 12 / Interstate 182 / Richland / Kennewick.
2. Merge onto I-182 E / U.S. Highway 12 E.
3. Take Exit 102 for US-12 E / I-182 E Toward Richland / Pasco.
4. Continue onto I-182 / US 12 E.
5. Take exit 5B to merge onto George Washington Way.
6. Turn Left onto Williams Blvd (which is right before the Denney's) go through one traffic light and start heading up the hill just slightly and we will be on the left hand side of the road. There is a sign along the road and the building is medium green stucco.

Patient Portal

We have recently transitioned to the Electronic Medical Records (EMR) program called **CARECLOUD**. Due to changes in Health Care Reform, we are required to meet certain objectives through our EMR. The **PATIENT PORTAL** is now required by our office for all patients. It is extremely important that you sign up to better help you and to meet your healthcare needs.

The **PATIENT PORTAL** will be helpful to you and will give you the ability to:

- REVIEW YOUR LABS, HEALTH HISTORY, MEDICATIONS AND VISIT SUMMARIES.
- DOWNLOAD EDUCATIONAL MATERIAL.
- VIEW FINANCIAL RESPONSIBILITY.
- SEND MESSAGES TO OUR OFFICE.

Two ways to join our patient portal

1. Visit our website www.ambradsurgery.com and click PATIENT PORTAL located in the top right portion of your screen. It will direct you to a secure site, then see directions below on connecting to the Patient Portal.

OR

2. Give us your email and we will save it into your secure personal file and send an invite directly to you. Follow the directions below to help you get connected!

You will receive an email from our office at the email address you provided. It will state it is from: Esteban Ambrad Chalela MD and subject will state: Connect with Esteban Ambrad Chalela MD through CareCloud Community!

How to connect to our PATIENT PORTAL:

1. OPEN EMAIL.
2. CLICK ON THE GREEN ACCEPT INVITATION. (IT WILL THEN REDIRCT YOU TO A SECURE SITE)
1. RE-ENTER EMAIL ADDRESS.
2. CREATE PASSWORD.
3. CONFIRM PASSWORD.
4. DATE OF BIRTH.
5. TO CHOOSE A SECURITY QUESTION-TRY USING SOMETHING EASY TO REMEMBER SINCE NO ONE WILL KNOW THE ANSWER BESIDES YOU.
6. ANSWER THE SECURITY QUESTION.
7. AGREE TO TERMS OF USE AND PRIVACY POLICY.

After completing the list above click CONTINUE and you are now connected.

(Once connected you will have the option to personalize your account.)

Please send us a secure email back to let us know you're connected by selecting message on the tool bar and following the prompts! Thank You in advance!

Our office will gladly assist in signing you up in our PORTAL.

Financial Policy

Thank you for choosing Tri-Cities Vein & Vascular Institute as your healthcare provider. We are committed to the success of your medical treatment and care. Our practice will work with you to help fulfill your payment responsibility. As the patient, you bear responsibility for any unpaid balance not contractually covered by your insurance, including: copays, non-covered services, deductibles and co-insurance.

Tri-Cities Vein & Vascular Institute requires payment at the time of service. Some insurance companies also require co-payments, deductibles or pay percentages (co-insurance).

You are responsible for the payment of these patient responsibility portions at the time of service.

Copay $ _____, Coinsurance _____%, Remaining deductible $_____.

Your estimated out-of-pocket payment due at ultrasound is $_____.

Your estimated out-of-pocket payment due at office visit is $_____.

Pre-collection amounts are estimates only; we are unable to determine all services performed prior to being seen. You will be billed for any remaining amount due or refunded should you overpay, after your bill is processed by your insurance company.

- Failure to make payment at time of service could result in a $25.00 co-pay billing fee. Statements are sent on a monthly basis for patient balances. If there is no response from the initial billing, a letter is generated that reminds the patient of their balance and our collection Policy.
- A $10.00 Late Fee will be added. If there is no response from the second statement, a final letter is sent allowing 10 days for payment in full and states that the account may be placed with an outside collection agency.
- A $40.00 Collection Transfer Fee will be added to any account that is turned over to an outside collection agency.

Each time you visit our office you will be required to sign a fee slip which is a consent for treatment that will include your estimate of out of pocket costs for that date of service.

Should you have any questions regarding your bill, or refund status, please contact our billing department 509-713-7104. If you have a problem paying a bill, or fall behind with payments, please call immediately so we may assist you in resolving the matter. We do not accept any random payments received as a negotiated agreement.

Release of Benefits and information: I consent for medical treatment. I have read and understand the office policy stated above. I authorize my insurance benefits be paid directly to the doctor and I agree to accept responsibility as described.

Patient or legal Representative Signature: _____ Date: _____

Non-Sufficient Funds Fee $35.00 * Forms Fee $25.00 * Records Fee based on number of pages

Cancellation & No-Show Policy

AMBRAD-CHALELA
Tri-Cities Vein & Vascular Institute

To Our Valued Patients:

As most of you know, there is a shortage of Vascular Surgeon Providers in the Tri-Cities. That makes our office very busy, often with long waits to obtain a routine appointment. That causes us to want to be as efficient as possible to help you, our valued patient, get into the clinic as timely as possible.

Understandably, it can be frustrating when a person doesn't show up for an appointment. This "no-show" problem should be frustrating to you, too, because those are un-used appointments that you or your loved ones could use for important medical help. People who make appointments and don't keep them cause everyone else's appointment to be delayed further in the future.

We require at least 24 HOURS' notice to cancel and/or reschedule your appointments, at least 1 WEEK notice for any in office procedure or hospital surgery to give our office time to fill that appointment slot, failure to do so results in a No Show.

- **First "No Show"** to an in-office ultrasound or exam- you will receive a No Show letter and fee of **$50.00** and will be able to reschedule once fee is paid.

- **Second "No Show"** to an office ultrasound or exam - you will receive a No Show letter and fee of **$100.00** and at that time we reserve the right to cancel our patient/physician relationship.

- **No Show to an in-office procedure or a hospital scheduled procedure** our office will charge you a **$1000.00** fee that will need to be paid in full prior to rescheduling.
  (Additional charges may be issued by the hospital)

Our office will call and/or send text message to the number provided to confirm your appointment at least 1 day prior to your appointment. **If you do not receive this call before your appointment, please call 509-946-9707.**

Please be patient with our office if we call and need to reschedule your appointment, we strive to give each and every patient the best possible care and sometimes it results in a change in our schedule. We apologize for any inconvenience this may cause.

Patient or legal Representative Signature: _____ Date: _____

PATIENT REGISTRATION FORM

Patient Name: _____ **DOB:** _____ **M / F**

Address: _____ **SSN:** _____

_____

_____

Primary Phone Number: _____

Secondary Phone Number: _____

Would you like to be signed up for the **PATIENT PORTAL**: Y N

If yes email: _____

(Please put a check mark in front of your answer.)

Preferred Language: ___English ___Spanish ___Russian ___French ___Creole ___Chinese ___Polish ___Hebrew ___Vietnamese ___Declined to Specify Other:_____

Primary Race: ___White ___Hispanic ___Black/African American ___Asian ___American Indian or Alaskan Native

___Native Hawaiian or Other Pacific Islander ___Declined to Specify

Marital Status: ___Single ___Married ___Widowed ___Divorced ___Legally Separated ___Domestic Partner

Ethnicity: ___Hispanic or Latino ___Not Hispanic or Latino ___Declined to Provide This Information

Employment Status: ___Employed ___Retired ___Not Employed ___Part Time ___Disabled ___Student

Emergency Contact:

Name:_____ Relation: _____ Phone: _____

Primary Care Provider: _____ Phone:_____

Referring Provider: _____ Phone:_____

Primary Insurance Coverage Name: _____

Secondary Insurance Coverage Name: _____

AMBRAD-CHALELA

Esteban Ambrad-Chalela, MD, PLLC

Tri-Cities Vein & Vascular Institute
761 Williams Blvd, Richland, WA 99354
Phone: 509-946-9707 Fax: 509-946-8145 Billing: 509-713-7145

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:_____ Date of Birth:_____

I request and authorize DR. AMBRAD-CHALELA @ TRI-CITIES VEIN & VASCULAR INSTITUTE to release **ALL** Healthcare Information of the patient named above to:

- ☐ Self
- ☐ **Emergency Contact you are ok with our office relaying a non-detailed message for you to call us :**

Name: _____ Relation: _____ Number: _____

- ☐ **Any person(s) you are ok with our office disclosing detailed information to: which may include verbal and/or written information regarding to; appointment/billing/medical history/diagnosis:**

Name: _____ Relation: _____ Number: _____

Name: _____ Relation: _____ Number: _____

- ☐ **Physician(s) you are ok with our office disclosing detailed information to: which may include verbal and/or written information regarding to; appointment/billing/medical history/diagnosis:**

Which we will automatically fax a copy of your results to:

- ☐ Physician:_____ Phone:_____
- ☐ Physician:_____ Phone:_____
- ☐ Physician:_____ Phone:_____
- ☐ Physician:_____ Phone:_____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes Herpes, Herpes Simplex, Human Papilloma Virus, Wart, Genital Wart, Condyloma, Chlamydia, Non-Specific Urethritis, Syphilis, VDRL, Cancroid, Lymphogranuloma Venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and Gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person (s) listed above. I understand that the person (s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person (s) listed above.

NOTICE OF PRIVACY PRACTICES: We keep a record of the health care services provided to you. You may ask to see a copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes us to do so. You may see your record or get more information about it by contacting **Tamara Winter, Practice Manager and Privacy Officer at (509) 946-9707.** Your signature below acknowledges that you have been given the opportunity to review our privacy practices.

Patient or legal Representative Signature: _____ Date: _____

NAME:_____ DOB: _____

HEALTH HISTORY

REASON FOR VISIT:

_____

_____

_____

PAST MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

(Put a check mark in front of your answer if applicable)

___Chronic Renal Failure ___Diabetes Mellitus Type:_____
___Pulmonary Disease ___Hypertension ___History of Cancer Type:_____
___Cerebrovascular Accident ___Congestive Heart Failure ___Heart Disease ___Acute Myocardial Infarction
___Arthritis ___Gout ___Convulsions ___Easy Bleeding ___Atherosclerosis ___Hyperlipidemia

SURGICAL HISTORY: Procedure Name/Date

_____

_____

_____

_____

_____

ALLERGIES NAME/REACTION:

_____

_____

MEDICATIONS:

_____

_____

_____

Name:_____ DOB:_____

Medications Continued:

_____

_____

_____

SOCIAL HISTORY:

Do You Use Tobacco? ___Yes ___No If Yes; __Everyday Smoker/Chewer ___Someday Smoker/Chewer

___Wishing to Quit If You Have Quit, How Long Ago:_____

Do You Use Alcohol? ___Yes ___No If Yes; ___Beer ___Wine ___Hard Liquor ___Social Drinker ___Moderate Drinker ___Heavy Drinker ___Alcohol use interfering with work/school ___Alcohol use disrupting home environment

___Wishing to Quit If You Quit, How Long Ago?_____

Do You Use Drugs? ___Yes ___No If Yes; ___Everyday User ___Someday User ___Social User

___Marijuana ___Cocaine ___Cocaine in an Alkaloid Form ___"Designer Drugs"
___Methylenedioxymethamphetamine (MDMA) commonly know as Ecstasy ___Methamphetamines

___Wishing To Quit If You Quit, How Long Ago?_____

Do You Have a Good Exercise Habits? ___Yes ___No Exercise Regularly? ___Yes ___No

Physical Activity Tolerance Recently Decreased? ___Yes ___No

FAMILY HISTORY: (Please put a check mark in front of your answer.)

Diabetes Mellitus: ___Grandparents ___Father ___Mother ___Siblings ___Aunts and Uncles ___Children
Family History of Early Deaths ___Yes ___No

Heart Conditions: Disease ___Yes ___No Congestive Heart Failure ___Yes ___No
If Yes, ___Grandparents ___Father ___Mother ___Siblings ___Aunts and Uncles ___Children

Stroke: Transient Ischemic Attack ___Yes ___No
If Yes, ___Grandparents ___Father ___Mother ___Siblings ___Aunts and Uncles ___Children

Aortic Aneurysm: ___Yes ___No
If Yes, ___Grandparents ___Father ___Mother ___Siblings ___Aunts and Uncles ___Children

Cancer: ___Yes ___No
If Yes; ___Grandparents Type:_____ ___Father Type:_____
___Mother Type:_____ ___Siblings Type:_____
___Aunts and Uncles Type:_____ ___Children Type:_____

Varicose Veins: ___Yes ___No
If Yes, ___Grandparents ___Father ___Mother ___Siblings ___Aunts and Uncles ___Children

Name:_____ DOB:_____

PATIENT GENERAL HEALTH:

How Are You Feeling? ___Fine ___Same ___Terrible
Recent Change in Weight? ___Gain ___Loss
___Fever ___Headache

Eye Symptoms: ___Worsening Vision ___Blurry Vision ___Currently Wearing Glasses or Contact Lenses
___Eye Disorder ___Glaucoma ___Other:_____

ENT Symptoms: ___Sinus Pain ___Sinus Pressure ___Eye Discharge ___Hearing Loss ___Earache ___Tinnitus
___Nasal Discharge ___Sore Throat

Cardiovascular Symptoms: ___Chest Pain ___Palpitations ___Leg Pain With Exercise ___Shortness of Breath

Pulmonary Symptoms: ___Difficulty Breathing ___Shortness of Breath ___Awakening At Night Shortness of Breath
___Orthopnea ___Cough ___Coughing up Sputum ___Coughing Up Blood ___Wheezing

GI Symptoms: ___Decreased Appetite ___Anorexia ___Heartburn ___Nausea ___Vomiting ___Abdominal Pain
___Change in Stool ___Diarrhea ___Constipation

GU Symptoms: ___Blood In The Urine ___Urine Odor is Abnormal ___Change in Urinary Frequency
___Urinary Stream Starts and Stops ___Urinary Incontinence ___Burning Sensation During Urination ___Flank Pain
___Kidney Disease ___Renal Disease

Vascular Symptoms: ___Leg Pain With Exercise ___Cold Hands or Feet ___Sudden Onset of Cold Hands or Feet
___Cold Intolerance ___Pain in Thigh ___Leg Pain ___Skin Ulcer ___Atherosclerosis of Extremities with Rest Pain
___Acute Ischemia ___Ischemic Foot ___Peripheral Vascular Disease ___Varicose Veins ___Transient Ischemic Attack

Endocrine Symptoms: ___Excessive Thirst and Fluid Intake ___Heath Intolerance ___Cold Intolerance
___Excessive Sweating ___Feeling of Weakness ___Inadequacy of Penile Erection ___Impotence ___Thyroid

Musculoskeletal Symptoms: ___Generalized Decrease in Strength ___Back Pain ___Muscle Aches ___Muscle Cramps
___Joint Pain ___Localized Joint Stiffness

Neurological Symptoms: ___Headache ___Dizziness ___Vertigo ___Fainting ___Confusion ___Memory Loss
___Speech Disturbance ___Limb Weakness ___Paralysis ___Involuntary Movements ___Abnormality of Walk
___Unsteady Gait ___Difficulty with Balance ___Tingling ___Numbness ___Tremor ___Head Injury

Skin Symptoms: ___Dry Skin ___Itching ___Peeling of Skin ___Skin Scaling ___Skin Ulcer ___Localized Skin
Discoloration ___Change in Skin Color ___Rash ___Symptoms Involving Nails

Hematological / Lymphatic: ___Adenopathy ___Phlebitis ___Anemia ___Transfusions

Anything Other Symptoms Dr. Ambrad Should Be Aware Of;_____

_____

_____

_____

Name:_____ DOB:_____

Preventative Health Questions: (Put a check mark in front of your answer if applicable)
(Meaningful Use Questions Required By Law)

___Keeping Your Blood Sugar Under Control

___Using Any Therapy to Avoid Heart Failure

___Using Any Therapy to Avoid Coronary Artery Disease

___Have had a Diabetic Eye Exam

___Have had a Screening or Therapy for Osteoporosis

___Have Completed a Spirometry Evaluation

___Have had a Breast Cancer Screening

___Have had a Colorectal Cancer Screening

___Have had a Diabetic Foot Exam

___Have had a Rheumatoid Arthritis Functional Status Assessment

___Are Using Any Therapy for Ischemic Vascular Disease

___Are You Doing Anything to Help Control High Blood Pressure

___Have had an Adult Screening for Depression

___Have had Psychiatric Evaluation

___Have had a Suicide Risk Assessment

___Have had an Assessment of Coping Support

___Have had an Evaluation of Emotional Support

___Consulted a Dietician of Lifestyle Coach

___Participate in an Exercise Program

___Have had a Monofilament Wire Test of the Leg/Foot

___Single Bright White Flash Electroretinography

___Ophthalmoscopy

___Optic Disc

___Indirect funduscopic Exam Following Mydriasis

___Binocular Indirect Funduscopic Exam

___Monocular Indirect Funduscopic Exam

___Indirect Funduscopic Exam

___Camera Funduscopic Exam

___Received Any Education about Renal Dialysis

___Echocardiography: Left Ventricular Ejection Fraction

___Had an Assessment for Future Fall Risk: Impression and Scope

___Macula

___Macular Edema Absent

___Macular Retinal Edema in Left/Right Eye

___Pre-Proliferative Diabetic Retinopathy

___Pre-Proliferative Diabetic Retinopathy of Left/Right Eye

___Diabetes with Mild Non-Proliferative Diabetic Retinopathy

___Diabetes with Moderate Non-Proliferative Diabetic Retinopathy

___Diabetes with Severe Non-Proliferative Diabetic Retinopathy

___Pre-Proliferative Diabetic Retinopathy

___Currently Dieting or Consulting with Dietician

___Retinal Vessels

___Retinal Edema

___Macula

___Macular Edema Absent

IF YOU SAID YES TO ANYTHING ABOVE PLEASE EXPLAIN: _____

_____

_____

_____

_____