Welcome to ICA Cardiology

Our core values are embedded in our initials:

Integrity
Compassion
Accountability

We look forward to serving your cardiac needs.

www.icacardiology.com

Tel# 713-790-9125
Fax# 713-790-1802

Texas Medical Center
Smith Tower
6550 Fannin, Suite 2021
Houston, Texas 77030

Sugar Land
Medical Office Building 2
16659 SW Freeway, Suite 215
Sugar Land, Texas 77479

Albert E. Raizner, M.D.
Clement A. DeFelice, M.D.
Gopi A. Shah, M.D.
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Alireza Nazeri, M.D.

PATIENT DEMOGRAPHICS

Patient Information

Last Name	First Name	Middle Name	Suffix	Social Security #

Gender (circle) M/F	Date of Birth	Marital Status (circle) *Divorced – Married – Separated – Single – Widowed – Other*	Primary Care Physician

Preferred Language (circle) *English – Spanish - _____*	Race (circle) *Asian – Black – White – Other: _____*	Ethnicity (circle) *Hispanic – Not Hispanic - Unknown*

Mailing Address	Apt / Lot	City / State	Zip Code	Phone #s	Home ( ) Mobile ( ) Work ( )

Email Address	How did you hear about us?	Referring Physician

Responsible Party

Check if same as: [ ] Patient

Last Name	First Name	Gender (circle) *M / F*	Date of Birth	What is Patient's Relationship to Responsible Party?

Mailing Address	Apt / Lot	City / State	Zip Code	Phone #s	Home ( ) Mobile ( ) Work ( )

Employer	Address	City / State	Zip Code

Emergency Contact

Check if same as: [ ] Responsible Party

Last Name	First Name	Gender (circle) *M / F*	Date of Birth	What is Patient's Relationship to Emergency Contact?

Mailing Address	Apt / Lot	City / State	Zip Code	Phone #s	Home ( ) Mobile ( ) Work ( )

Guardian Contact

Check if same as: [ ] Responsible Party [ ] Emergency Contact

Last Name	First Name	Gender (circle) *M / F*	Date of Birth	What is Patient's Relationship to Guardian?

Mailing Address	Apt / Lot	City / State	Zip Code	Phone #s	Home ( ) Mobile ( ) Work ( )

Insurance Information

Check if: [ ] Self Pay

Check if same as: [ ] Responsible Party			Check if same as: [ ] Responsible Party		
Subscriber/Member Name		Date of Birth	Subscriber / Member Name		Date of Birth
What is Patient's Relationship to Subscriber		Gender (circle) *M / F*	What is Patient's Relationship to Subscriber?		Gender (circle) *M / F*
Primary Insurance Company		Begin Date	Secondary Insurance Company		Begin Date
Insurance Mailing Address	City / State	Zip Code	Insurance Mailing Address	City / State	Zip Code
Subscriber / Member #	Group #		Subscriber / Member #	Group #	

Patient/Legal Guardian Signature Date

Patient/Legal Guardian Print

CONSENT TO TREAT AND FINANCIAL RESPONSIBILITY

Consent to Treat

I hereby authorize employees and agents of ICA Cardiology, PLLC (including physicians, physician assistants, nurse practitioners and other employees and staff members) to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

_____ Patient Name (please print)	
_____ Signature of Patient, Parent or Legal Guardian	_____ Date

Complete this section ONLY if the patient is a minor

I consent for_____to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

_____ Signature of Parent or Legal Guardian	_____ Date

Financial Responsibility

I hereby authorize payment of medical benefits directly to ICA Cardiology, PLLC and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by patient's insurance companies. I agree that all amounts are due upon request and are payable to ICA Cardiology, PLLC. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of ICA Cardiology, PLLC, if any.

_____ Patient Name (please print)	
_____ Signature of Patient, Parent, or Legal Guardian	_____ Date

POLICIES AND FORMS

Office Appointments

Business hours are Monday through Friday, 9:00 AM to 5:00 PM, excluding holidays.

Please bring your insurance card(s), a photo ID, and a current list of medications (including the name of each medication, dosage, and frequency taken) to your appointment. Update us with any changes in insurance information, address, phone number, or other necessary contact information.

New Patients: For appointments, please call (713)790-9125. A new patient packet will be given to you. Please complete it and bring to your first appointment. We request you arrive 30 minutes early to your new patient appointment.

Existing Patients: For appointments, please call (713)790-9125, or use the Patient Portal.

Late Arrival Policy

As a courtesy to our other patients, those who arrive more than 15 minutes late for an appointment may need to be rescheduled. Advanced notice of your late arrival is necessary for any special circumstances or allowances.

Cancellations/Missed Appointments Policy

Please notify us as far in advance as possible if you need to cancel. This allows another patient accessibility to that time slot. At the very least, we kindly ask you call us 24 hours in advance for cancellation of appointments.

Completion of Forms and Letters

Please allow up to 5 business days for completion. The practice may charge fees as permitted by applicable law.

Medical Records

Patients must complete a medical records release form to have their records sent to a third party, or for personal use. Forms may be completed in the office, or faxed to (713)790-1802. the practice may charge fees as permitted by applicable law.

Request for Pre-Operative Clearance

In order to provide pre-operative clearance for surgical procedures, ICA Cardiology may necessitate patients to have been seen in our office within the past 90 days.

Prescription Refill Policy

Please allow 5-7 business days for a refill request at a local pharmacy and up to 2-3 weeks for mail order prescriptions.

After Hours Calls

The on-call physician is available by answering service after hours, weekends, and holidays for urgent circumstances and emergencies. Please do not contact the on-call physician after hours for routine appointment scheduling.

Insurance and Contact Information

Please provide us a new copy of your insurance card(s) every twelve months, or whenever your insurance coverage changes so we have the most up to date information on file. If you are a new patient, have not been since in our office in over a year, and/or this information has changed since your last visit, please update your insurance and contact information as indicated.

_____ _____

Patient/Legal Guardian Signature Date Patient/Legal Guardian Print

NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability and Accountability Act of 1996, as may be amended from time to time, and regulations promulgated thereunder (collectively referred to as "HIPAA"), requires that we maintain the privacy of your personal health information and provide you with this notice about how we may use or disclose such information. You have the right to receive a paper copy of this notice at any time even if you have agreed to receive this notice electronically.

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms of that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without Your Consent. Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

As Required By Law. We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. Examples of instances in which we are required to

disclose your personal health information include disclosures regarding victims of abuse, neglect, or domestic violence; judicial and administrative proceedings in response to an order of a court or other lawful process; law enforcement purposes for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies; or to avert a serious threat to health or safety.

All Other Situations, With Your Specific Authorization. Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Miscellaneous Activities, Notice. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Your Rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right To Request Restrictions On Use Or Disclosure: You have the right to make a written request to limit the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on your medical information that we disclose to someone involved in your care or the payment for your care, like a family member or friend. While we are not required to agree to any requested restriction, if we agree to a request for restriction, then we will comply with your request unless the information is needed to provide you with emergency treatment or to make a disclosure that is required under law. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Right To Receive Confidential Communications: You have the right to receive confidential communications of your personal health information. You have the right to make a written request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only at work or by mail. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations.

Right To Inspect And Copy Your Personal Health Information: You have the right of access in order to inspect and obtain a copy your personal health information contained in your medical and billing records that are held by the practice in a designated record set, unless in certain

instances the law restricts or prohibits access. You have the right to see or get an electronic or paper copy of your records. We may require written requests. We may provide you with a summary of the personal health information requested, in lieu of providing access to the personal health information or may provide an explanation of the personal health information to which access has been provided, if you agree in advance. We will provide you with access as requested in a timely manner. If you request a copy of your personal health information or agree to a summary or explanation of such information, we are allowed by law to charge a reasonable cost - based fee for labor, supplies, postage and the time to prepare any summary as agreed upon in advance. We reserve the right to deny you access to and copies of certain personal health information as permitted or required by law. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us.

Right To Amend Your Personal Health Information: You have the right to request that we amend your personal health information or a record about you contained in your designated record set, for as long as the designated record set is maintained by us. We may require that you submit written requests and provide a reason to support the requested amendment. We have the right to deny your request for amendment. If we deny your request, we will provide you with a written denial stating the basis of the denial. You have the right to submit a written statement disagreeing with the denial and you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services ("DHHS"). You may request that we include your request for amendment and the denial with any future disclosures of your personal health information that is the subject of the requested amendment. Copies of all requests, denials, and statements of disagreement will be included in your designated record set. All requests for amendment shall be sent to **ICA Cardiology, PLLC 6550 Fannin Street, Smith Tower, Suite 2021 Houston, TX 77030.**

Right To Receive An Accounting Of Disclosures Of Your Personal Health Information: You have the right to make a written request for a list of certain disclosures of your medical information within a certain period of time. This list is not required to include all disclosures we make. For example, disclosure for treatment, payment, or practice administrative purposes, disclosures made to you or that you authorized are not required to be listed. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but may impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent to ICA Cardiology, PLLC, 6550 Fannin Street, Smith Tower, Suite 2021 Houston, TX 77030.

Complaints

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. You may submit your complaint in writing by mail or electronically to our privacy officer, Dennis Gabriel at ICA Cardiology, PLLC, 6550 Fannin Street, Smith Tower, Suite 2021 Houston, TX 77030 or dgabriel@icacardiology.com. A complaint must name the entity that is the subject of the complaint and describe the acts or

omissions believed to be in violation of the applicable requirements of HIPAA or these privacy practices. Generally, a complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be denied care or retaliated against for filing any complaint.

Amendments to this Notice

We reserve the right to revise or amend this notice at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or, amendment. We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: April 1, 2019

Patient and/or Guardian's Receipt of Notice of Privacy Practices

I, the undersigned, have received a copy of ICA's Notice of Privacy Practices as part of my patient packet.

_____
Patient's Name (Printed)

_____
Guardian's Name (Printed) (if applicable)

_____
Patient's or Guardian's Signature

_____
Date

TELEMEDICINE INFORMED CONSENT

---

1) **Purpose and Benefits.**
Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites. The purpose of this form is to obtain your consent to participate in the telemedicine visit(s)/consultation(s) with your ICA Cardiology, PLLC d/b/a Interventional Cardiology Associates attending physician, nurse practitioner, as well as other ICA Cardiology, PLLC healthcare providers/staff as indicated.

Expected Benefits:

- Improved/Alternative access to medical care
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

2) **Nature of Telemedicine Consultation**: During the telemedicine visit(s)/consultation(s):
   a) Details of your medical history, examinations, and tests will be discussed with you, other consented caregivers such as family members, and/or other consented healthcare professionals through the use of interactive video, audio and telecommunications technology.
   b) Physical examination as indicated and feasible during the telemedicine visit/consultation
   c) Nonmedical technical personnel may be present in the telemedicine studio to aid in video transmission.
   d) Video, audio, and/or digital photo may be recorded during the telemedicine consultation visit.
   e) I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.

3) **Medical Information and Records.** All existing laws regarding your access to medical information and copies of your medical records apply to the telemedicine visit/consultation. Additionally, dissemination of any patient-identifiable images or information from the telemedicine interaction to other healthcare providers or entities shall not occur without your consent, unless authorized under existing confidentiality laws. I understand that this Telemedicine Informed Consent document will become a part of my medical record.

4) **Confidentiality.** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation. All existing confidentiality protections under federal and Texas state law apply to information disclosed during this telemedicine consultation.

5) **Risks and Consequences.** I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties. If determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit. The use of video technology to deliver healthcare and educational services may not be equivalent to direct patient to physician/healthcare provider contact. Following a telemedicine visit/consultation, your physician/healthcare provider may recommend a visit to a hospital for further evaluation.

6) **Rights.** You may withhold or withdraw consent to the telemedicine visit/consultation at any time without affecting your right of future care or treatment. You have the option to consult with the physician/healthcare provider in person if you travel to his or her location. To withhold or withdraw your consent to the telemedicine visit/consultation, please notify ICA Cardiology, PLLC d/b/a Interventional Cardiology Associates at 713-790-9125.

7) **Financial Agreement.** I hereby authorize payment of medical benefits directly to ICA Cardiology, PLLC d/b/a Interventional Cardiology Associates and/or the attending physician and/or the nurse practitioner for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical insurance claim. I understand that I am financially responsible for the total charges for services rendered which may include services not covered by patient's insurance companies. I agree that all amounts are due upon request and are payable to ICA Cardiology, PLLC. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of ICA Cardiology, PLLC, if any.

8) **Notice of Privacy Practices and Complaint Process.** Please reference and review the ICA Cardiology, PLLC Notice of Privacy Practices located on the company website, https://icacardiology.com/ . Please note the section in the ICA Cardiology, PLLC Notice of Privacy Practice describing the process for Complaints.

By signing this form, I attest that (1) I have personally read this form and fully understand and agree to its contents; (2) the risks, benefits, and alternatives to telemedicine visits/consultations were shared with me and I understand; and (3) I am located in the state of Texas and will be in Texas during my telemedicine visit(s)/consultation(s).

Patient Name (Type or Print)	
Signature of Patient, Parent, or Legal Guardian	
Date	

Medical History Form

Name_____ **Date of Birth**____/____/____ **Today's Date**____/____/____

Referring Physician: _____

Reason for Visit : _____

Medications **(List all prescription and over-the-counter medications that you are currently taking. Include vitamins, herbal supplements, and medications taken as needed.**

Medication e.g.: Aspirin	**Dosage** e.g.: 81mg	**Frequency** e.g.: once daily	**Prescribing Doctor** e.g.: Dr. Lewis	**Start Date** If known

Allergies	No known drug allergies	
Drug/Substance	**Reaction**	**Date of Onset**

Problems		
Conditions currently being treated by your physicians	**Date of Onset**	**Physician**

Prior Cardiac Testing/Procedures		
Test/Procedure	**Date Performed**	**Result**
Echo		
EKG		
Cardiac Catheterization		
Carotid Duplex (ultrasound of arteries in the neck)		
LE Doppler/ABI (testing circulation to your legs)		

Stress Test Treadmill Only		
With Imaging Cardiovascular Surgery (specify type)_____		
Other (please specify)_____		
Other (please specify)_____		

History of Present Illness (Check all that apply to your visit today.)

Condition/Symptom	X	Condition/Symptom	X
Coronary Artery Disease		Palpitations	
Chest Pain		Syncope (Fainting)	
Myocardial Infarction (Heart Attack)		Cardiac Arrhythmias	
Coronary Artery Bypass Surgery (CABG)		Stroke or TIA	
Congestive Heart Failure (CHF)		Carotid Artery Disease	
Edema		Peripheral Artery Disease (PAD/PVD)	
Dyspnea (Shortness of Breath)		Heart Valve Disorders	

Risk Factors

Tobacco **used**_____

Type of Tobacco: Chew Cigar Cigarettes Pipe Smokeless

Diabetes No Yes Type 1 or Type 2 Year Diagnosed_____

No Yes

No Yes Unknown

Hypertension (High Blood Pressure) No Yes Year Diagnosed_____

No Yes

Past Medical History	(Please include prior illnesses and surgeries not previously mentioned.)		
Previous Major Illnesses	**Year**	**Previous Surgeries**	**Year**

Social History

Tobacco

Never

Former Quit: Date_____

Current

Type: _____

Frequency_____

Exposure to secondhand smoke? Yes No

Lifestyle

Exercise Frequency:

Alcohol

Never

Former Quit: Date_____

Current

Frequency:_____

Drug Use

Never

Former Quit: Date_____

Current

Type:

Family History

Member	Age				
Mother		Living Deceased	Irregular Heart Rhythm Stroke	Enlarged Heart Heart Attack	Congestive Heart Failure Sudden Death
Father		Living Deceased	Irregular Heart Rhythm Stroke	Enlarged Heart Heart Attack	Congestive Heart Failure Sudden Death
Sister		Living Deceased	Irregular Heart Rhythm Stroke	Enlarged Heart Heart Attack	Congestive Heart Failure Sudden Death
Brother		Living Deceased	Irregular Heart Rhythm Stroke	Enlarged Heart Heart Attack	Congestive Heart Failure Sudden Death

Review of Symptoms (Please check all of our current symptoms.)

Cardiac	Chest Pain Palpitations	Excessive Sweating Syncope	Shortness of breath lying flat Shortness of breath that awakens you at night
Vascular	Painful, aching, or tired feeling in legs while walking		Swelling of ankles and feet
Constitutional	Weight Gain	Weight Loss	Fever
HEENT	Visual Changes		Hearing Loss
Respiratory	Snoring	Coughing Blood	Shortness of Breath
Gastrointestinal	Nausea	Heartburn	Rectal Bleeding/Bloody Stool
Genitourinary	Blood in Urine		Excessive Nighttime Urination
Neurological	Dizziness	Memory Loss	Seizure
Psychiatric	Depression		Hallucinations
Hematologic	Acute Anemia		Thrombocytopenia (low platelet count)
Reproductive	Erectile Dysfunction		
Endocrine	Goiter		Tremors
Dermatologic	Rash		Skin Sores
Musculoskeletal	Joint Pain		Muscle Pain

Statement of Non-Discrimination

ICA Cardiology, PLLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, religion, age, disability, or sex. ICA Cardiology, PLLC does not exclude people or treat them differently because of race, color, national origin, religion, age, disability, or sex.

ICA Cardiology, PLLC provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

ICA Cardiology, PLLC provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact our office administrator. If you believe that our office administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, religion, age, disability, or sex, you can file a grievance with:

Office Administrator
6550 Fannin Street
Houston, TX 77030
Phone: (713) 790-9125

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our office administrator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
https://www.hhs.gov/hipaa/filing-a-complaint/index.html

Español
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

繁體中文
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電。

Tiếng Việt
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.

한국어
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 번으로 전화해 주십시오.

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.

Р у с с к и й
В Н И М А Н И Е: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.

العربية
ملحوظة- :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان .اتصل برقم 1.

Français
ATTENTION : Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement.

Deutsch
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.

日本語
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。

رسی
توجه :اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد .با 1

हिंदी
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।

ગુજરાતી
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો

ردُو
خبردار :اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1

ພາສາລາວ
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ