Virginia ID Doctors LLC

Today's Date______________________

Patient Name: Last_________________________First__________________________MI___DOB___/___/___

Marital Status ( ) Married ( ) Single ( ) Other____

Address ________________________________City ____________________State _______Zip ___________

Home Phone ______________________Work ______________________Ext _____ Cell _________________

Email ____Social Security # ______________________

Emergency
Contact:__________________________________Relationship __________________Phone________________

Who is your Primary Care Physician?________________________________Phone __________________________

Who may we thank for referring you? ____

Complete the following only if the patient is a minor

Responsible Party Name_____________________________Relationship________________________________

Responsible Party Home#___________________________Work or Cell #_______________________________

....

Insurance Information: Please allow us to scan in your Insurance card(s) and Photo ID

Primary Insurance Company Name____ ( )*HMO ( )*POS ( )*PPO

Policy Holder Name __________________________________DOB____/_____/_____ SS#__________________

ID Number_______________________Group Number______________________________

Patient relationship to policy holder/Insured party: ( ) Self ( ) Spouse ( ) Child ( ) Other

***Please be aware that when Insurance requires a patient to obtain a written referral to see a specialist it is the patient's responsibility to bring this to the appointment or confirm with our office that your Primary Care Physician office has done this for you, prior to your appointment. If you are not sure if a referral is required please contact your Insurance Company.**

Secondary Insurance Company Name____ ( )*HMO ( )*POS ( )*PPO

Policy Holder Name ____________________________________DOB___/___/___

ID Number ____Group Number __________________________________

If you have a secondary or supplemental insurance we will file for you after your primary has processed the claim. However, in the event that the secondary does not pay within 60 days, patient will be billed balance due.

*In case of default on payment on this account, I agree to pay collection cots and reasonable attorney fees incurred in attempting to collect this amount or any future outstanding account balances.

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HIPAA Consent &Financial Policy

Patient Name:____DOB: ____/____/____

HIPAA: The practice provides this information to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a patients' rights section describing your rights under the law. By signing below, the patient understands:

*Protected health information may be disclosed or used for treatment, payment, or health care operations.
*The patient has the right to review and request a copy before signing. (Please ask our staff if you wish to review or obtain a copy of our privacy practices.)
*The patient has the right to restrict the uses of their information, but the practice does not have to agree to those restrictions.
*The practice may condition receipt of treatment upon the execution of this consent.
*The patient may revoke this consent in writing at any time and all future disclosures will then cease.

Release of information:

Besides myself, I authorize this practice to discuss personal medical information with the following person(s):___________________________and/or________________________

Relationship____

Messages may be left: (regarding appointments and call back information only)

Check all that are authorized: ( ) Home ( ) Answering Machine ( ) Email ( ) Cell ( ) Work

Insurance and Assignment of Benefits:

I hereby authorize this practice and its providers to apply for benefits on my behalf for covered services rendered. I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier (or in the case of Medicare Part B benefits, to the Social Security Administration and health Care Financing Administration). A copy of the authorization may be used in please of the original. This authorization may be revoked by either me or my insurance carrier at any time in writing.

I hereby authorize payment of all medical insurance benefits to be paid directly to this practice and or/its providers for services rendered. I understand and agree that I am financially responsible for charges not paid by insurance company. I understand that in certain instances my insurance may decide that medical services are not medically necessary and that payment may be denied for these services. I agree to be personally and fully responsible for payment of any denied charges. If I have Medicare, I understand that I may be asked to sign an advanced notice/waiver for certain services or procedures.

I hereby certify that the information I have provided is correct. I hereby certify that I have read, understand, and agree with the above HIPAA and Financial Policies. I further agree to pay bank charges for insufficient funds, finance charges and/or collection fees assessed to my account for any overdue balances.

Patient Signature______________________________Date___/___/___

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Cancellation/ No-show policy
If you are unable to keep your scheduled appointment, please notify us at least 24 hours in advance so we can accommodate our other patients. You may also reschedule your appointment at that time.

No-Show Policy
We do require a 24 hour notice of cancellations. If you do not show up to your appointment without notifying us, you will be charged $50 for the time we were not able to fill when you were a no-show.

Medical record policy
Each patient has a complete record of all medical care received at our office. Your personal medical record provides a history of treatment, medication, and diagnostic information that enables your health care team to make comprehensive medical evaluations. We consider your record to be confidential. Therefore, information will not be released without your written consent, unless required by law. Copies of your medical record will be released to you or transferred to another physician upon written consent. There will be a $25.00 to a $50.00 copying fee for this service.

Referrals
Please be advised that patients are responsible for managing their own referrals and making sure they are covered at the time of service. Upon verbal request, our office, as a courtesy, will only be able to provide the referral start date and end date to assist in helping determine when referrals will expire. As the patient, this will allow you to request a new referral or extension in a timely manner. Patients are also responsible for communicating with their own PCP and/ or insurance companies. We thank you in advance for your understanding and support.

Medication Refills
Please allow 24 business hours for medication refills. Please contact your pharmacy and ask them to fax us a request for your medication refill.

Preferred Pharmacy info

Name: ____________________________________ Location: __________________________

Phone:_______________________________________

Signature_______________________________________Date___/___/____

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Waiver Form

Patient:____

DOB:____

Insurance:______________________________________

Your signature below signifies that you clearly understand that:

1. Our office will file a claim to your carrier.
2. Certain types of plans will not reimburse any money if:

   * The patient requires and seeks services from a physician that is not part of the plan or in network.
   * The patient requests and seeks services from a physician without the proper referral.

Do not sign this form unless you positively understand the consequences of your visit and the charges you may have to encounter.

Signature of patient:____

Date:____

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Health Questionnaire

Patient Name: ______________________________________ DOB ___/___/___

Are you allergic to any medication? ____
____

What was the reaction to the medication:____

Current Medications: (please list all current medications and the dosage that you are taking)

Name	Dose	Frequency
_____________________________	_____________	________________
_____________________________	_____________	________________
_____________________________	_____________	________________

Are you allergic to:

Shell fish ( ) Yes ( ) No   Latex ( ) Yes ( ) No

X-Ray Contrast ( )Yes ( ) No   Dye Local Anesthetic ( ) Yes ( ) No

Hospitalizations/Operations

Reason/Date:
____
____
____

Reason for your visit today: ____
____
____

Review of Health Systems: *(please include any problems you have had in the past six months)*

Circle all that apply

Weight gain-more than 10 lbs	Weight Loss-more than 10 lbs	Appetite Change
Marked fatigue	Unexplained night fever	Night Sweats
Difficulty sleeping	Psychological difficulties	Rash or itching
Rash or itching	skin change	Lump
Chest Pain	Recurring cough	Wheezing
Shortness of breath	Chest pain/tightness/pressure	Palpitations
Lightheadedness/fainting	Chronic sinus problems	Hearing loss
Nose bleeds	Liver disease	Jaundice
High cholesterol	hepatitis	Diabetes
Persistent, recurring belly pain	Uncontrolled loss of stool	heartburn/indigestion
Pain with bowel movement	Diarrhea	Blood in stool
Constipation	Difficulty with urination	Pain/with urination
Uncontrolled loss of urine	Urinary tract infection	Joint pain
Joint stiffiness	Joint redness	Joint swelling
Tremors	Headaches	Numbness
Dizziness/vertigo	Seizures	Anemia
Sickle cell trait or disease	Enlarged glands	Mononucleosis
Vericose veins, blood clots, phlebitis	Bleeding disorder	Blood transfusion

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Health Questionnaire (Continued)

Patient Name: ____DOB: _____/_____/_____

Have you ever had any of the following conditions: (please circle all that apply)

Anemia	Arthritis	Asthma/lung disease
Bleeding tendencies	Blood clots	Blood/plasma transfusion
Cancer	Colitis	Depression
Diabetes	Exposure to hazardous chem..	Epilepsy
Gall bladder disease	Glaucoma	Gout
Heart disease	Hemorrhoids	Hepatitis
High blood pressure	HIV/AIDS	Kidney stones
Kidney failure	Liver disease	Migraine headaches
Psoriasis	Stomach ulcers	Stroke
Tuberculosis	Venereal disease	other (please describe)

____
____

Family History: Please list immediate family members with the following conditions:

Diabetes: ( ) Yes ( ) No Who:____
Cancer: ( ) Yes ( ) No Who:____
Gout: ( ) Yes ( ) No Who:____
Heart Disease: ( ) Yes ( ) No Who: ____
Hypertension: ( ) Yes ( ) No Who: ____
Stroke: ( ) Yes ( ) No Who: ____
Tuberculosis: ( ) Yes ( ) No Who: ____
Seizures: ( ) Yes ( ) No Who: ____
Colitis: ( ) Yes ( ) No Who: ____
Bleeding: ( ) Yes ( ) No Who: ____
Kidney disease: ( ) Yes ( ) No Who: ____

Dietary & Social History:

Vitamin: ( ) Yes ( ) No Type/Frequency: ______________________________________
Calcium: ( ) Yes ( ) No Type/Frequency: ______________________________________
Estrogen: ( ) Yes ( ) No Type/ Frequency: ______________________________________
Tobacco: ( ) Yes ( ) No Type/Frequency: ______________________________________
Have you ever used/smoked tobacco: ( ) Yes ( ) No If so, quit date: __________________________
Alcohol: ( ) Yes ( ) No Type/Frequency: ______________________________________
Drug use: ( ) Yes ( ) No Type/Frequency: ______________________________________
History of alcohol or drug use: ( ) Yes ( ) No If so, quit date: __________________________
Caffeine: ( ) Yes ( ) No Type/Frequency: ______________________________________
Exercise: ( ) Yes ( ) No Type/Frequency: ______________________________________

Have you been married more than once? ( ) Yes ( ) No
Did you serve in the Military? ( ) Yes ( ) No
Are you sexually active? ( ) Yes ( ) No
Any food customs or restrictions? ( ) Yes ( ) No
Do you have any sex issues? ( ) Yes ( ) No
Have you had homosexual relationships? ( ) Yes ( ) No
Recently lived or traveled outside the USA ( ) Yes ( ) No If yes, where?_______________________