PATIENT INFORMATION

Name: _____ Social Security#: _____
First Middle Last

Address: _____ Suite/Apt. #: _____ City/State: _____/_____ Zip:_____

Email address: _____ Web Portal: ☐Y ☐N Gender: ☐F ☐M DOB: ___/___/_____ Marital Status:_____

Home#:_____Work#:_____Cell#_____

Race: ☐American Indian/Alaska Native ☐Hispanic
☐Black/African American ☐ Asian ☐White
☐Native Hawaiian/Other Pacific Islander
☐Other _____ ☐Unreported/Refused to Report

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Refused to Report

May Leave Confidential/detailed message regarding: **(check all that apply)**

	Home	Work	Cell	Text	Email/ Portal
Appointments					
Lab Results					
Health Maintenance					
Rx confirmations					
General Messages					

Insurance Company Name(s): _____ (Primary)

Insurance Company Name(s): _____ (Secondary)

Preferred Language_____
(if other than English)

Pharmacy Name and Address: _____ Phone #:_____

RESPONSIBLE PARTY *(PLEASE COMPLETE IF OTHER THAN SELF)*

Relationship to Guarantor: ☐Self ☐Spouse ☐ Child ☐ Other _____ DOB: _____/_____/_____

Name: _____ Social Security#: _____
First Middle Last

Address: _____ Suite/Apt. #: _____ City: _____ State:_____ Zip:_____

Home#: _____ Work#: _____ Cell#: _____ May leave message at: ☐ Home ☐ Work ☐ Cell

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____
First Middle Last

Address: _____ Suite/Apt. #: _____ City: _____ State:_____ Zip:_____

Home#: _____ Work#: _____ Cell#: _____ May leave message at: ☐ Home ☐ Work ☐ Cell

E-PRESCRIBING MEDICATION HISTORY CONSENT

I understand that Virginia Physicians, Inc. has implemented e-prescribing for its patients. I also understand that e-prescribing involves the ability for the practice to send prescriptions electronically to pharmacies, eliminating the need for a more time-consuming, and sometimes more costly, approach to prescribing through paper, phone and fax. E-Prescriptions are fast, convenient, legible, secure, cost-effective and safe. The e-prescribing process also allows the health care provider to access critically important information about their patient's current and past medications from pharmacy benefit managers and community pharmacies. This information helps alert the provider to other potential medication issues with their patients and can improve safety and quality.

I have been given an opportunity to ask questions about the e-prescribing process and have had those questions answered to my satisfaction. I hereby consent to the practice requesting and using my medication history from other health care providers or third party pharmacy benefit payors for treatment purposes in connection with the e-prescribing process.

NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

Our Notice of Privacy Practices (available upon arrival to our office) provides information about how we may use and disclose protected health information (PHI) about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I have received* a copy of Virginia Physicians, Inc.'s Notice of Privacy Practices. I understand that I may ask questions to the Medical Practice if I do not understand any information contained in the Notice of Privacy Practices.

If you are completing this form prior to your scheduled appointment please note that the Notice of Privacy Practices will be made available to you upon arrival to our office.

Please complete front and back

AUTHORIZATION AND ASSIGNMENT- REQUIRED FOR ALL PATIENTS

I authorize Virginia Physicians, Inc. to release information required by my insurance company. I authorize payment of benefits directly to Virginia Physicians, Inc. I understand that I am financially responsible to Virginia Physicians, Inc. for charges not covered by this assignment and in the event of default; I agree to pay all costs of collections including reasonable attorney's fees. This authorization and assignment will remain in effect until a notification of change is received by Virginia Physicians, Inc.

Medicare Assignment Agreement- Medicare Patients Only

I authorize Virginia Physicians, Inc. to release information needed for Medicare claims to the Centers for Medicare & Medicaid Services or its intermediaries or carriers.

FINANCIAL POLICY

Thank you for choosing Reynolds Primary Care (a Division of Virginia Physicians, Inc.) as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete this information before seeing the doctor.

General Information: Payment in full is due at the time of service. Please understand that there are circumstances where we may request payment in the form of cash, credit card, or debit card only.

Regarding Insurance: We accept most major insurance plans, but you are responsible for checking with your carrier to see if services at our office will be covered. We *do not* participate with any Medicaid- HMO plans. We may accept assignment of insurance benefits; however we do require that all co-payments be made at the time of service. The balance is your responsibility whether your insurance company pays or not. It is your responsibility to notify us of any changes in your policy information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered and not considered reasonable and necessary under the Medicare Program and/or other medical plans. You will be responsible for these balances. Additionally, it is your responsibility to obtain and track referrals for your visits.

Minor Patients: The adult accompanying a minor and/or the parents (or guardians of the minor) are responsible for full payment.

Returned Checks: There will be a $25 fee on all returned checks. Future payments must be made by cash or credit card only.

Collection Fees: In the event that your account is turned over to a collection agency, you will be responsible for all collection costs including reasonable attorney's fees.

Missed Appointments: Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the **minimum** rate of **$60** per missed appointment. Please help us serve you better by keeping your scheduled appointments.

Fees for Letters and Forms: Your physician will be happy to fill out any necessary form that you may need. Please be advised that due to the time required to dictate and complete letters and forms there will be a fee for this service. These costs are considered non-covered by insurance companies and will be your personal responsibility.

_____ _____

Patient Signature (or Authorized Patient Representative)** ***Date***

**This signature is applicable to all items covered on this form, both front and back

HIPAA Authorization for Release of Information – Compound Release

Patient Name:	**Patient Date of Birth:**
Virginia Physicians Inc. is authorized to release the protected health information described below for the above-identified patient.	
Entity to Receive Information Check each person or class of persons that you approve of to receive information.	**Description of Information to be Released** Check each type of information that can be shared with the person or class of persons listed to the left.
☐ Voice Messages at _____	☐ Appointment Reminders ☐ Lab Results ☐ Other:
☐ Email or Text Messages For email and/or text messaging, I understand that information may not be sent in an encrypted manner and could result in unauthorized access by third parties.	☐ Appointment Reminders ☐ Lab Results ☐ Discuss Treatment
☐ Spouse or Partner _____	☐ All Health Information Except:
☐ Other Individual _____	☐ All Health Information Except:
☐ Other Individual _____	☐ All Health Information Except:

Patient Rights:

1. I have the right to revoke this authorization at any time.
2. I may inspect or copy the protected health information to be disclosed as described in this document.
3. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
4. Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
5. I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing

This authorization will remain in effect until I revoke it in writing, or on the date listed below:

Signature of Patient or Personal Representative: **Date:**

Description of Personal Representative's Authority (attach necessary documentation:

☐ Mother ☐ Father ☐ Legal Guardian ☐ Power of Attorney ☐ Other:

Date this Authorization Expires: _____

Virginia Physicians, Inc.

Reynolds Primary Care
Health Questionnaire

Today's Date: _____

PATIENT INFORMATION:

Name: _____ Date of Birth: _____ Gender: M F

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail Address: _____

Spouse's Name: _____ Number of Children: _____

CURRENT MEDICATIONS LIST (Please include dose, frequency and quantity)

_____

_____

_____

Pharmacy Name and Phone Number: _____

Medication Allergy: _____

IMMUNIZATIONS:

Diphtheria/Tetanus within 10 years:	Date _____	Tuberculin PPD:	Date _____
Measles/Mumps/Rubella:	Date _____	Pneumonia:	Date _____
Hepatitis A & B:	Date _____	Other:	Date _____
T-DAP (Diphtheria/Pertussis/Tetanus):	Date _____	Zostavax	Date _____

PAST MEDICAL HISTORY (DATES):

Medical Illnesses: _____

_____

Surgeries: _____

_____

Blood Transfusion? (Circle) Yes No Date if Yes: _____

SOCIAL HISTORY:

Occupation: _____ Smoking (amount): _____

Alcohol (amount): _____ Exercise (amount): _____

Caffeine (amount): _____ (include all coffee, tea, soda)

FAMILY HISTORY:

Mother, living, age: _____ Current Medical Problems: _____

If deceased, age at death: _____ Cause of Death: _____

Father, living, age: _____ Current Medical Problems: _____

If deceased, age at death: _____ Cause of Death: _____

Brothers: age: _____ Medical Problems: _____

age: _____ Medical Problems: _____

Sisters: age: _____ Medical Problems: _____

age: _____ Medical Problems: _____

OTHER PATIENT RELATED MEDICAL INFORMATION:

_____

_____

_____

Virginia Physicians, Inc.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
New Patient Paperwork

Patient's Name _____

Date of Birth _____ SSN _____

Home _____ Work _____ Cell _____

Release records from:

_____

_____

_____

_____

Release records to:

Virginia Physicians, Inc.
6900 Forest Avenue, Suite 300
Richmond, VA 23230
804-346-1515 phone
804-273-6052 fax

Reason for request: _____

Information to be released:

_____ Completed health records

_____ Office notes - dates from _____ to _____

_____ Immunizations Labs only _____ X-Rays only _____

Other: _____

I Do _____ or I Do Not _____ authorize the release of information related to:

- ☐ AIDS (Acquired Immunodeficiency Syndrome)
- ☐ HIV (Human Immunodeficiency Virus) Infection
- ☐ Psychiatric care and/or Psychological assessment
- ☐ Treatment for alcohol and/or drug abuse

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by federal regulations. I need not sign this form in order to assure treatment.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present a written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Signature of Patient/Parent/Guardian/Representative _____ Date _____