Family Practice Associates

13911 St Francis Blvd. /Suite 101/Midlothian, VA 23114

Patient Registration

Doctor_____ Date_____

Name _____ Sex___ Age ____SS # _____ Date of Birth _____
Address _____ _____ City _____ State ____ Zip Code _____
Home Number _____ Work Number _____ Cell Number _____
Employer_____ Occupation _____
Address _____
Name of Spouse _____ Spouse's Employer _____
Employer Address/Phone Number _____

Please complete if person responsible for bill is other than above patient:

Name _____ Relationship _____ SS# _____
Address _____ _____ City _____ State ____ Zip Code _____
Home Number _____ Work Number _____ Cell Number _____
Employer_____ Occupation _____
Address _____

Emergency Contact: _____ Relationship _____
Home Number _____ Work Number _____ Cell Number _____

Who may we thank for referring you? _____

INSURANCE INFORMATION

Primary Insurance:

_____ _____
Name of Company Address

_____ _____ _____
Name of Subscriber/ Relationship to Patient Date of Birth
Policy ID # _____ Group # _____ SS # _____

Secondary Insurance

_____ _____
Name of Company Address

_____ _____ _____
Name of Subscriber Relationship to Patient Date of Birth

Policy ID # _____ Group # _____ SS # _____

I understand that my insurance coverage does not relieve me of any responsibility for payment of the account. I agree that I shall be fully responsible in the event that it becomes necessary to refer my account, for any collection costs including agency, lawyer and court fees, as outlined in the Financial Policy.

Signature _____ Date _____

Account No. _____
Initials: _____

Financial Policy

Family Practice Associates
13911 St Francis Blvd. Suite 101
Midlothian, VA 23114

This is an agreement between Family Practice Associates, as creditor and _____, as the patient/debtor.

In this agreement, the words 'you', 'your' and 'yours' refer to the Patient/Debtor. The word 'account' refers to the financial ledger established to which charges and payments are made. The word 'we', 'us' and 'our' refer to Family Practice Associates.

PAYMENT is due at the time of your visit. We shall accept cash, personal check or debit/credit card for any co-payment, balance on account, co-insurance, remaining deductible or non-covered service. The balance on your statement is due upon receipt and past due if not paid within 30 days. Payments can be accepted over the phone, by mail, in person or by logging into our website: fampracticeassociates.com

If you have no insurance:

A. You shall pay by cash, personal check or debit/credit card on the day of service. A deposit of $100 shall be due at check-in. The remaining balance is due at check-out. If your bill is over $200 you may talk with our business office regarding a payment plan.

B. For complete physicals, $325 will be due at check-in. The remaining balance will be due at check-out. Payment plans may be set up if arranged in advance.

If you have insurance:

A. You shall pay any co-pay, unmet deductible or balance on account by cash or debit/credit card on the day of service at check-in.

B. For your convenience, we do offer a 'credit card on file' program which allows you to authorize payments for balances on your account. You can also sign up with your insurance carrier for similar programs.

Co-PAYMENTS are due at the time services are rendered. This is a contractual obligation required by your insurance company. If for any reason you are not prepared to pay your co-payment or request to be 'billed', you will incur an administrative fee of $10.00.

INSURANCE. Your insurance policy is a contract between you and your insurance carrier. We are NOT party to that contract. We cannot predetermine the benefits your specific plan will cover: furthermore it is your responsibility to know and to understand your policy. You shall pay any portion of the charges not covered by your insurance. If your insurance changes, you shall notify us prior to your appointment in order for us to make the necessary updates and help you maximize your benefits.

If your insurance carrier requires lab work and/or testing to be sent to a designated lab or facility, it is your responsibility to notify us upon check-in. Failure to do so may result in out-of-network charges.

ACCOUNT PRIVILEGES. We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at time of service. We reserve the right to require that any unpaid balances be paid before appointments may be scheduled.

FINANCE CHARGES will be added to any account that is not paid within thirty (30) days of the time the service became the patient responsibility. The finance charge will be computed at the rate of one and one-half percent (1.5%) per month or an annual percentage rate of eighteen percent (18%). The minimum monthly finance charge is $0.75.

RETURNED CHECKS will incur a $40.00 service charge. You shall pay the service charge as well as the amount of the check before any future appointments will be scheduled. The payment for these fees and any future visits shall be in the form of cash, debit/credit card or money order.

MISSED APPOINTMENTS. Failure to show or cancel an appointment in a timely manner (i.e. at least 24 hours prior notice) deprives other patients of the opportunity to receive medical treatment. You shall be responsible for paying a missed appointment fee of $25.00 if you fail to appear for your visit and/ or do not provide at least 24 hours notice of cancellation. A fee of $75.00 will be applied to your account if the missed appointment is for an extended visit such as a physical.

For repeat offenders, you may be required to pay a pre-pay fee to hold your appointment time. This pre-paid fee will be applied towards your co-payment and /or co-insurance for your visit. However, if you cancel or do not show, this pre-paid fee will be applied as a no show fee to your account

PAST DUE ACCOUNTS. If your account becomes past due, we will take the necessary steps to collect this debt. If we refer your account out to a collection agency, you agree to pay all of the collection costs which are incurred. If your account is referred to an outside attorney, your will be responsible for paying all reasonable attorney fees and all court costs, which are in addition to your outstanding balance and any applicable interest. In case of a suit, you agree the venue shall be in Chesterfield County, Virginia.

WAIVER OF CONFIDENTIALITY. You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our facility may become a matter of public record.

DIVORCE. The party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for the subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the liable parent according to the terms of the decree.

PERSONAL INJURY. Payment of the bill remains the responsibility of the patient even when the medical services arise due to an event for which a third party may be responsible. You shall pay for services rendered by cash, debit/credit card or personal check at the time of service. We cannot wait for the case to be settled or bill your attorney for charges incurred. At your request, we shall bill your personal insurance and reimburse them when the case is settled and we have been compensated.

WORKERS COMPENSATION. Written authorization/approval by your employer and/or workers compensation carrier shall be required prior to your initial visit. If your claim is denied, you will be responsible for any and all charges incurred.

TRANSFER OF RECORDS. A medical release form must be signed when requesting full or partial records be sent to another physician or facility. You may be responsible for a reasonable copying fee through HealthPort which handles this process for us.

EFFECTIVE DATE. Upon signing this financial policy, you are agreeing to all terms and conditions contained herein and the agreement will be in full force and effect. This agreement has no termination or expiration date and shall remain in effect unless provisions have been made and you have been notified of such changes.

NOTIFICATION. You authorize this office or its designated agents to contact you by mail, by telephone or through the patient portal to discuss this account.

We accept most insurance plans and will gladly file insurance claims on your behalf. Ultimately you hold the financial responsibility for your account.

Printed Name: _____

Responsible Party (if not the patient): _____

Signature: _____ Date: _____

Family Practice Associates of Chesterfield
13911 St. Francis Blvd., Suite 101
Midlothian, VA 23114
(804)320-3999
(804)323-9383 Fax

HIPAA Notice of Privacy Practices

Effective Date: 09/23/2013

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

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment- We may use and disclose Health Information for your treatment and to provide you with treatment related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care.

For Payment- We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received.

For Health Care Operations- We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services- We may use Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care- When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research- Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law-. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety- We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates- We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation- If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement.

Military and Veterans- If you are a member of the armed forces, we may release Health Information as required by military command authorities.

Workers' Compensation- We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks- We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities- We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Law Enforcement, Lawsuits and Disputes- We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors- We may release Health Information to a coroner or medical examiner. We also may release Health Information to funeral directors as necessary for their duties.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief- We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the Medical Records Department. We have up to 30 day to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program.

Right to an Electronic Copy of Electronic Medical Records- If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic cop of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach- You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend- If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the attention of Medical Records.

Right to an Accounting of Disclosures- You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization To request an accounting of disclosures, you must make your request, in writing, to Medical Records.

Right to Request Restrictions- You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to your provider. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments- If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications- You have the right to 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 only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the clerical staff/registration department. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice- A copy of this notice is available on our website for download at www.fampracticeassociates.com. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice on our website. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Practice Manager. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

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HIPAA Notice of Privacy Practices

Effective Date: 09/23/2013

By signing this document you agree that the HIPAA Notice of Privacy Practices has been made available to you to view and you have been given the means, if you choose, of obtaining a copy of this notice.

Patient Name (Print): _____

Patient Signature: _____
(patient signature not required if patient is under the age of 18)

Authorized Representative Name (Print): _____
(parent or legal guardian must sign for any patient under the age of 18)

Authorized Representative Signature: _____

Date: _____

NAME:_____ AGE:_____
DOB:_____ HOME PHONE:_____
DATE:_____ WORK PHONE:_____

ARE THERE ANY OTHER PHYSICIANS INVOLVED IN THEIR/YOUR CARE

ATTENDING PHYSICIAN:_____

CONSULTING PHYSICIAN:_____

ORTHOPEDIST:_____

CARDIOLOGIST:_____

NEUROLOGIST:_____

OPTHALMOLOGIST:_____

PLEASE DESCRIBE THE RECENT EVENTS WHICH HAVE RESULTED IN THIS VISIT:

_____

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY: (Please indicate which, if any, of the listed medical problems are present and any pertinent details such as dates, location, and physicians involved)

ASTHMA_____
EMPHYSEMA_____
BRONCHITIS_____
HIGH BLOOD SUGAR_____
HEART ATTACK_____
STROKE_____
DIABETES_____
ULCERS_____
BOWEL PROBLEMS_____
URINARY PROBLEMS_____
ARTHRITIS_____
JOINT OR BONE PROBLEM_____
_____
_____
_____
DEPRESSION_____
DEMENTIA/ALZHEIMERS_____
OTHER_____
_____

PAST SURGICAL HISTORY: (Please indicate which, if any, of the listed surgical procedures were performed and any pertinent details such as dates, location, and physicians involved.)

HEART BYPASS OR BALLOON

GALL BLADDER REMOVAL

HYSTERECTOMY

APPENDECTOMY

BONE SURGERY

OTHER

MEDICATIONS (Please indicate the name of the medicine, the strength, how often you receive it and how it is received or applied.)

ALLERGIES (Please indicate the name of the allergic substance and how you are affected)

IMMUNIZATIONS (When was the last time, if ever, the following immunizations or tests were done)
TETANUS_____
PNEUMONIA VACCINE_____
FLU VACCINE_____
MAMMOGRAM_____
PAP SMEAR_____
COLONOSCOPY OR FLEXIBLE SIGMOIDOSCOPY_____
BONE DENSITY SCAN_____

FAMILY HISTORY (Is Mom and Dad, Brothers/Sisters alive or have they died/Please indicate age and health problems

_____
_____
_____
_____
_____

SOCIAL HISTORY
WHAT TYPE OF WORK ARE YOU INVOLVED IN_____
_____
MARRIED, SINGLE, DIVORCED OR WIDOWED_____
DID YOU SMOKE/HOW MUCH/HOW LONG_____
DID YOU DRINK ALCOHOL/HOW MUCH PER DAY FOR HOW LONG_____
_____
WAS THERE ANY DRUG DEPENDANCE_____
_____
NEXT OF KIN OR POWER OF ATTORNEY (Please list name, relationship and phone number)_____
_____
REVIEW OF SYSTEMS (Any problems with any of the below over the last couple of days)
EATING_____
DRINKING_____
BREATHING_____
CHEST PAIN_____
PASSING URINE_____
PASSING STOOL_____
FEVER/CHILLS_____
WEIGHT CHANGES_____
BLEEDING_____
MOVING JOINT/LIMBS/BACK_____
CHANGES IN MOOD OR DEPRESSION_____

CURRENT WEIGHT_____
CURRENT HEIGHT_____

Thank you for taking your valuable time to fill this out. It means so much in providing good care and it is truly appreciated.