ASHCAKE Family Physicians

# New Patient Workbook

Instructions:
Print this booklet out and fill out all of the pages. Don't forget to bring it in with you on your visit!

# HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is provided to you pursuant to the Health Insurance Portability and Accessibility Act of 1996 and its implementing regulations (HIPAA). It is designed to tell you how we may, under federal law, use or disclose your Health Information.

**I. We May Use or Disclose Your Health Information for Purposes of Treatment, Payment or Healthcare Operations without Obtaining Your Prior Authorization and Here is One Example of Each:**

- We may provide your Health Information to health care professionals including doctors, nurses and technicians -- for purposes of providing you with care.
- Our billing department may access your information and send relevant parts to other insurance companies to allow us to be paid for the services we render to you.
- We may access or send your information to our attorneys or accountants in the event we need the information in order to address one of our own business functions.

**II. We May Also Use or Disclose Your Health Information Under the Following Circumstances without Obtaining Your Prior Authorization:**

- To Notify and/or Communicate with your Family. Unless you tell us you object, we may use or disclose your Health Information in order to notify your family or assist in notifying your family, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in any communications with your family and others.
- As Required by Law.
    - For Public Health Purposes: We may use or disclose your Health Information to provide information to state or federal public health authorities, as required by law to prevent or control disease, injury or disability; to report child abuse or neglect; report domestic violence; report to the Food and Drug Administration problems with products and reactions to medications; and report disease or infection exposure.
    - For Health Oversight Activities: We may use or disclose your Health Information to health agencies during the course of audits, investigations, certification and other proceedings.
    - In Response to Subpoenas or for Judicial and Administrative Proceedings. We may use or disclose your Health Information in the course of any administrative or judicial proceeding. However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your Health Information prior to providing it to another person.
    - To Law Enforcement Personnel. We may use or disclose your Health Information to a law enforcement official to identify or locate a suspect, fugitive, material witness or missing person, comply with a court order or subpoena and other law enforcement purposes.
    - To Coroners or Funeral Directors. We may use or disclose your Health Information for purposes of communicating with coroners, medical examiners and funeral directors.
    - For Purposes of Organ Donation. We may use or disclose your Health Information for purposes of communicating to organizations involved in procuring, banking or transplanting organs and tissues.
    - For Public Safety. We may use or disclose your Health Information in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
    - To Aid Specialized Government Functions. If necessary, we may use or disclose your Health Information for military or national security purposes.
    - For Worker's Compensation. We may use or disclose your Health Information as necessary to comply with worker's compensation laws.
    - To Correctional Institutions or Law Enforcement Officials, if You are an Inmate.

**III. For All Other Circumstances, We May Only Use or Disclose Your Health Information After You Have Signed an Authorization.** If you authorize us to use or disclose your Health Information for another purpose, you may revoke your authorization in writing at any time.

**IV. You Should Be Advised that We May Also Use or Disclose Your Health Information for the Following Purposes:**

- Appointment Reminders. We may use your Health Information in order to contact you to provide appointment reminders or to give information about other treatments or health-related benefits and services that may be of interest to you.
- Change of Ownership. In the event that our entity is sold or merged with another organization, your Health Information/record will become the property of the new owner.
- Providing Information to Our Plan Sponsor [If a Health Plan]. We may disclose your Health Information to our Plan Sponsor.

**V. Your Rights**

1. You have the right to request restrictions on the uses and disclosures of your Health Information. However, we are not required to comply with your request.
2. You have the right to receive your Health Information through confidential means through a reasonable alternative means or at an alternative location.
3. You have the right to inspect and copy your Health Information. We may charge you a reasonable cost-based fee to cover copying, postage and/or preparation of a summary.
4. You have a right to request that we amend your Health Information that is incorrect or incomplete. We are not required to change your Health Information and will provide you with information about our denial and how you can disagree with the denial.
5. You have a right to receive an accounting of disclosures of your Health Information made by us, except that we do not have to account for disclosures: authorized by you; made for treatment, payment, health care operations; provided to you; provided in response to an Authorization; made in order to notify and communicate with family; and/or for certain government functions, to name a few.

**VI. Our Duties.**

1. We are required by law to maintain the privacy of your Health Information [and to provide you with a copy of this Notice.]
2. We are also required to abide by the terms of this Notice.
3. We reserve the right to amend this Notice at any time in the future and to make the new Notice provisions applicable to all your Health Information ∆ even if it was created prior to the change in the Notice. If such amendment is made, we will immediately display the revised Notice at our office and provide you with a copy of the amended Notice. We will also provide you with a copy, at any time, upon request.

**VII. Complaints to the Government.**

You may make complaints to the Secretary of the Department of Health and Human Services if you believe your rights have been violated.

We promise not to retaliate against you for any complaint you make to the government about our privacy practices.

**VIII. Contact Information.**

You may contact us about our privacy practices by calling the Ashcake Family Practice, 804-559-2916.

You may contact the DHHS at:

U.S. Department of Health & Human Services, 200 Independence Avenue, S.W. ¥ Washington, D.C. 20201, Telephone: 202-619-0257, Toll Free: 1-101-515-8000.

**Ashcake Family Physicians**

**Patient Registration**

Please present your insurance card(s) and picture ID to the receptionist

Personal information: **(please print)**

Circle: Miss Mrs. Ms. Mr. Dr. Social Security #: _____

Name: _____
Last First M.I

_____
Address City State Zip Code

Telephone #: Home:_____ Work: _____ Cell: _____

Date of Birth: _____ Gender: _____ Male _____ Female

Employer : _____

Work Address: _____ Occupation: _____

_____ How long have you worked there? _____

Spouse's Name:_____

Spouse's Employer: _____ Spouse's work Telephone: _____

**In Case of Emergency, Notify:**

Name: _____

Address: _____

_____

Telephone #: _____

Relationship to Patient: _____

**Account Guarantor** (financially responsible):

Name: _____

Social Security #: _____

Address: _____

_____

Telephone #: _____

Relationship to Patient: _____

**Primary Insurance Information:**

Insurance Co: _____

Policy Holder: _____

Relationship to policy holder: _____

Policy #: _____

Group #: _____

**Secondary Insurance Information:**

Insurance Co: _____

Policy Holder: _____

Relationship to policy holder: _____

Policy #: _____

Group #: _____

# Ashcake Family Physicians
# Patient History Questionnaire

Name: _____ Date of Birth:_____ Date: _____

**Past Medical History/ Chronic Illnesses:**

1. _____
2. _____
3. _____
4. _____
5. _____

**Past Surgeries (surgery/date):**

1. _____
2. _____
3. _____
4. _____
5. _____

**Medications (name/strength/dosage):**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

**Allergies (cause/symptoms):**

1. _____
2. _____
3. _____
4. _____

**Social history:**

__ Single __ Married __ Divorced __Widowed Spouse's Name: _____

Children? _____ How Many? _____

Occupation: _____

Do you smoke? _____ if yes, how many packs per day ____/ ____years

Do you drink alcohol? _____ if yes, how many drinks _____ day/week/month

Do you use illicit drugs? _____ if yes, which drugs and how often:_____

**Family History:** Who in your family has been diagnosed with the following diseases?

High blood pressure: _____ Diabetes: _____

Heart attack: _____ Stroke: _____

Blood clots: _____ Asthma: _____

Cancer (what kind): _____

**Ashcake Family Physicians**
7493 Right Flank Road, Suite 400
Mechanicsville, VA 23116
Phone: (804) 559-2916 Fax: (804) 559-9206

# AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

1. I, (Patient's name): _____
Address: _____
Street Address City State Zip
Telephone: _____ Date of Birth: _____ Social Security Number: _____
Please print any previous names under which records may be found:
_____

2. Hereby authorize ____ AFP ____ (Other) _____

3. To release the following information: _____

Records of other providers on file with AFP (if any), (We must impose our standard copying fees. AFP does not represent that these records are the complete records of the other providers. If you want a complete copy of the records created by the other providers for this patient, you may wish to contact each provider.) I understand that if the records requested to be released include information relating to sexually transmitted disease, AIDS or HIV, alcohol or drug abuse, or mental health information, this information may be released pursuant to this authorization.

4. To: Ashcake Family Physicians _____ Myself _____
Other _____

5. Purpose of access or release: _____ Medical Care; _____ Insurance or Other Payment;
____At Request of the Patient; ____Other (explain) _____(3/2005HIPAA)

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I understand the following: (A) the nature of the information to be released; (B) to whom the information is being released; (C) why the information is being requested/released; (D) once the above information is disclosed, it may be re-disclosed by the designated recipient and the information may no longer be protected by Federal privacy laws and regulations; and (E) repercussions which might occur due to my release of or failure to release the information specified above have been explained to me. I also understand that I may refuse to release confidential information or revoke this authorization at any time by giving written notice to AFP. A revocation of this authorization will not apply to records already released in reliance upon the authorization. A photocopy of this signed authorization shall constitute a valid authorization. AFP, its employees and providers are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. AFP will not condition treatment, payment, enrollment, or eligibility for benefits on your signing of this authorization. I agree to pay the copying cost, including other expenses allowed by law, such as the cost of any supplies, labor of copying, postage, or other expenses incurred by AFP to provide the copies requested. This authorization will expire in 90 days from the date on which it was signed unless I specify a shorter time period.

Expiration date or event: _____
Patient's Signature _____ Date signed _____
Witnessed by: _____ Type of identification presented: _____

Name: _____ Home #: _____

Address: _____ Work #: _____

_____ Date of Birth: _____

## Treatment Permission:

You consent and understand the following:

- The physician taking care of you, the clinical staff and technical employees may give any treatment or perform any procedures as advised for your care and treatment.
- You have the chance to discuss other plans for treatment.
- In the event that a healthcare worker has come in contact with your blood or body fluid in a way which may transmit HIV, Hepatitis B virus, or Hepatitis C virus, you consent to the testing of blood and/or body fluids for these infections and to report your test results to the healthcare worker who has been exposed.

****If the patient is a minor by the Commonwealth of Virginia, please provide the following information:**
Parent/Legal Guardian's Name: _____
Telephone Number: _____ Are you able to give permission to treat? _____

## Privacy and Disclosure:

Our Notice of Privacy Practices (NPP) provides information about how we may use and release your Personal Health (PHI). Our NPP may change according to Federal Regulations. You may request a current copy at any time or review the notice in our waiting room or on our website.

- You have the right to review the NPP before signing this agreement.
- You have the right to ask that we limit how your PHI is used or released.
- By signing this paper, you allow our use and release of PHI for treatment, payment and healthcare operations (e.g. appointment reminders, lab results, mailed materials, etc.).
- You have the right to revoke this agreement in writing **except** in the case where release was already made with prior consent.
- You have the right to ask employees of the medical office or the Privacy Officer questions about the NPP.

I have read, understand and agree to the Treatment and Privacy Policies described above.

_____ _____ _____
Signature (Patient or Guarantor) Relationship to Patient Date

# Permission to Disclose Private Health Information

Patient's Name _____
DOB _____
SS# _____

I give permission to the persons listed below to receive Private Health Information. I understand this form is legally binding and that I may revoke my authorization at any time by submitting my request to change, add or terminate such permission in writing.

| Date of Permission | Name of Individual | Date Permission Revoked | Patient Initials |
|---|---|---|---|
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Comments or limitations on above:
_____
_____
_____.

In order to obtain information by telephone, the party calling the practice must be able to share the patient identifier/password with the staff.

Patient Identifier/Password: _____

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Printed Name of Patient or Guardian Relationship (If not self)

# Ashcake Family Physicians

## Receipt of Notice of Privacy Practices
## Written Acknowledgement Form

I, _____, have received a copy of Ashcake Family Physicians' Notice of Privacy Practices.

I have had an opportunity to read the 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.

_____ _____

Patient Signature Date

_____ _____

Authorized Representative of Patient Relationship to Patient

# Review of Symptoms

**Please check if you have experienced any of the following symptoms**.

**General:**
___ Weight loss/gain
___ Fever
___ Night sweats
___ Fatigue

**Eyes:**
___ Wear glasses/contacts
___ Eye disease
___ Blurred or double vision
___ Glaucoma
___ Cataract

**ENT/Mouth**
___ Hearing loss
___ Ringing in ears
___ Ear aches
___ Chronic sinus problems
___ Nose bleeds
___ Mouth sores
___ Swollen glands
___ Sore throat
___ Voice change

**Cardio:**
___ Chest pain
___ Angina
___ Heart attack
___ Palpitations
___ Shortness of breath
___ Swelling of feet

**Respiratory:**
___ Coughing
___ Coughing up blood
___ Asthma
___ Wheezing

**GI:**
___ Change in appetite
___ Nausea
___ Vomiting
___ Diarrhea
___ Constipation
___ Dark stools
___ Blood in stools
___ Heartburn
___ Ulcer
___ Hemorrhoids

**GU:**
___ Frequent urination
___ Bloody urination
___ Burning urination
___ Painful urination
___ Kidney stones
___ Incontinence
___ Dribbling
___ Change in libido
___ Testicular pain
___ Impotence

**OB/GYN:**
___ # of pregnancies
___ # of children
___ Age of 1st menstrual period
___ Age of last menstrual period
___ When was last Pap
___ When was last Mammogram
___ Abnormal pap smear
___ Abnormal Mammogram
___ Vaginal discharge
___ Abnormal bleeding
___ Irregular bleeding
___ Pain with intercourse

**Hemo/Lymph:**
___ Easy bleeding/bruising
___Anemia
___ Past transfusion
___ Enlarged glands
___ Blood clots

**MS:**
___ Joint pain
___Stiffness or swelling
___ Weakness
___ Muscle pain/cramps
___ Difficulty walking
___ Cold extremities

**Skin/Hair/Nails:**
___ Rash
___ Itching
___ Change in skin color
___ Change in hair/nails
___ Varicose veins
___ Breast pain
___ Breast lump
___ Breast discharge

**Neuro:**
___ Frequent/recurrent headaches
___ Light headnessness/ dizzy
___ Seizures
___ Numbness/tingling
___ Tremors
___ Stroke
___ Head Injury

**Psch:**
___ Depression
___ Anxiety
___ Memory loss
___Confusion
___ Difficulty sleeping

**Endo:**
___ Increased thirst/ Urination
___ Heat/Cold intolerance
___ Dry skin
___ Change in hat/glove size
___ Thyroid disease
___ Diabetes

How did you hear about Ashcake Family Physicians?
___ Friend/neighbor ___ Newspaper ad ___ Other _____

# PAYMENT ARRANGEMENTS

- By signing this paper, you allow all payments to the Medical Practice of any insurance benefits otherwise payable to you for services provided under any insurance policy (hospitalization, major medical, worker's compensation, or any other insurance benefit plan).

- By signing this paper, you allow release of information to the insurance companies or other third party payers or their agents which may be necessary to determine coverage which may be required for review, quality and management.

- You agree to pay, at the time of service, any required co-pay, co-insurance and or/deductibles, as well as charges for services not covered by insurance.

- Unpaid balances will be billed to your permanent address.

- You are responsible for paying the bill in full unless other arrangements have been approved in advance. If the patient is a minor, the guarantor of the account will be financially responsible.

- **There is a *fee of $30 for returned checks*. More than two (2) returned checks will result in patient being placed on cash or credit card only status.**

- **There is a *fee of $25 if appointment is not cancelled at least 24 hours in advance.***

- **There is a *fee of $15 for completion of forms* (e.g. FMLA, short- or long-term disability, underwriting).**

- Past-due accounts will be turned over to a collection agency and you will be responsible for collection charges as well as all associated legal fees in addition to the amount owed.

I have read, understand and agree to the above listed Payment Policies.

| _____ | _____ | _____ |
|---|---|---|
| Signature (Patient or Guarantor) | Relationship to Patient | Date |