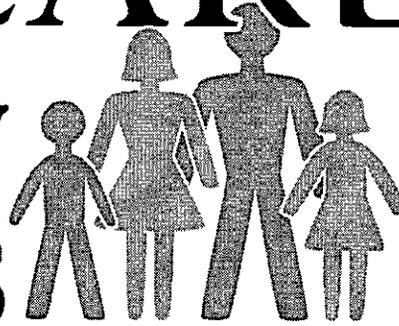


# ASHCAKE

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!

**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 #: \_\_\_\_\_

UPDATED PAYMENT AND BILLING AGREEMENT

Please read and initial each of the following:

It is the responsibility of the guarantor to present accurate insurance information at the time of service. Failure to do so could result in you paying any charges otherwise covered by your insurance. If you do not present a card when checking in, you will be required to sign a waiver.

\_\_ You allow all payments to Ashcake Family Practice of any insurance benefits otherwise payable to you for services provided under any insurance policy.

\_\_ You allow release of information to the insurance company or their agents which may be necessary to determine coverage.

\_\_ At the time of service, you agree to pay 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 mailing address.

\_\_ You are responsible for paying the bill in full unless other arrangements are approved in advance. For minor patients, the guarantor account will be financially responsible.

\_\_ There is a 30.00 fee for returned checks. More than 2 returned items will result in the guarantor being placed on cash or credit card (Visa/Mastercard) status.

\_\_ While we make every effort to make reminder calls, it is your responsibility to remember all appointments. There is a 25.00 fee if an appointment is not cancelled at least 24 hours in advance. *This includes same day sick appointments.*

\_\_ FMLA, short/long-term disability and underwriting are subject to a 15.00 fee.

\_\_ Past due accounts will be turned over to a collection agency. You will be responsible for the account balance plus 33% and legal charges. This last resort will result in you and ALL members in your household being dismissed from the practice.

---

Patient/Guarantor Name

Relationship to patient

Date

Name: \_\_\_\_\_ Home #: \_\_\_\_\_  
Address: \_\_\_\_\_ Work #: \_\_\_\_\_  
\_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Treatment Permission:

You consent and understand the following:

- o 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.
- o You have the chance to discuss other plans for treatment.
- o 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.

- o You have the right to review the NPP before signing this agreement.
- o You have the right to ask that we limit how your PHI is used or released.
- o 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.).
- o You have the right to revoke this agreement in writing **except** in the case where release was already made with prior consent.
- o 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

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

**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. _____ | 3. _____ |
| 2. _____ | 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): \_\_\_\_\_

## 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 1<sup>st</sup> 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 \_\_\_\_\_

# 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  $\Delta$  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.  $\yen$  Washington, D.C. 20201, Telephone: 202-619-0257, Toll Free: 1-101-515-8000.