Richmond Lipic Clinic

REGISTRATION FORM

PATIENT INFORMATION

Name: ____ Social Security#: ______________________
First Middle Last

Address: ____ Suite/Apt. #: _______________

City: ____ State: _____________ Zip Code: _____________

Home #: _______________________ Work #: _______________________ Cell #: _____________________

May leave message at: ☐Home ☐Work ☐Cell Web Enable: ☐YES (Fill in email address below) ☐NO

Email address: ___________________________________

Gender: ☐F ☐M DOB: ___/___/_____ Marital Status: __________ Preferred Language: _______________

Race/Ethnicity: ☐ American Indian ☐ Black/African American ☐ Hispanic/Latino

☐ Native Hawaiian ☐ White ☐Asian ☐Other ____________________

Pharmacy Name and Address: ____ Phone #:________________

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

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

Name: ____ Social Security#: ______________________
First Middle Last

Address: ___________________________________ City/State: ______________/________ Zip: ___________

Home #: _______________________ Work #: _______________________ Cell #: _____________________

EMERGENCY CONTACT

Name: ____ Relationship to Patient: _________________
First Middle Last

Address: ___________________________________ City/State: ______________/________ Zip: ___________

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.

____

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

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.

____

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

**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.*

FINANCIAL POLICY

General Information: Payment in full is due at the time of service. We accept cash, check, American Express, Discover, MasterCard and Visa.

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 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.

Returned Checks: There will be a $25 returned check fee on all returned checks. In the event that a check is returned for insufficient funds, we reserve the right to call your bank to verify funds for any future checks that are presented for payment.

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 cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the minimum rate of $25 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.

I have read, understand and agree to this Financial Policy:

____

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

Authorization for Release of Protected Health Information

Name of Patient: ____ **Date of Birth:** ___________________________

The office of Virginia Physicians, Inc is authorized to release protected health information as described below for the identified patient.

Entity to Receive Information. Check each person or class of persons that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐**Voice Messages on** _______________________ **number.**	☐**Appointment Reminders** ☐**Lab Results** ☐**Other**
☐**Spouse or Significant Other:** _________________________________ **Phone Number:** ______________________	☐**Appointment Reminders** ☐**Lab Results** ☐**Treatment Notes and Record** ☐**Discuss Treatment**
☐**Other Person** _________________________________ **Relationship:** ________________________ **Phone Number:** ______________________	☐**Appointment Reminders** ☐**Lab Results** ☐**Treatment Notes and Record** ☐**Discuss Treatment**
☐**Other Person:** _________________________________ **Relationship:** ________________________ **Phone Number:** ______________________	☐**Appointment Reminders** ☐**Lab Results** ☐**Treatment Notes and Record** ☐**Discuss Treatment**

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.

____Date ___________________

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

Virginia Physicians, Inc.

Richmond Lipid Clinic

Virginia Physicians, Inc.

Richmond Lipid Clinic

New Patient Health Questionnaire

PATIENT INFORMATION:

Name:______________________________ Date of Birth: ______________ Gender: ____________

Home Phone: ________________ Cell Phone: __________________ Work Phone: ____________________

Email Address: _________________________________

CURRENT MEDICATION LIST (Please include dose and frequency)			
Drug Name	Dose	Frequency	Quantity

Pharmacy Name: ______________________ Pharmacy Phone Number: __________________

Do you have any medication allergies? ☐ No ☐ Yes, please list: __________________________

PERSONAL HEALTH HISTORY			
☐ High Cholesterol/Lipid Disorder	☐ Heart attack	☐ Rheumatoid arthritis	Female Only:
☐ Hypertension	☐ Coronary artery disease	☐ Lupus	☐ Gestational Diabetes
☐ Diabetes, Type ___	☐ Coronary stent	☐ Psoriasis	☐ PCOS
☐ Pre-diabetes or metabolic syndrome	☐ CABG (bypass)	☐ HIV	☐ Pre-eclampsia
☐ Hypothyroidism	☐ Peripheral artery disease	☐ Aortic stenosis	☐ Other pregnancy complications
☐ Chronic Kidney Disease	☐ Stroke	☐ Other past medical illness and surgeries:	
☐ Congestive Heart Failure	☐ TIA		

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New Patient Health Questionnaire
(Continued)

FAMILY HEALTH HISTORY

Family Member			Age	(Indicate Healthy or high cholesterol, diabetes, high blood pressure, heart disease, stroke, cancer or any other medical illness)
Mother		☐ Living ☐ Deceased		
Father		☐ Living ☐ Deceased		
Grandmother Mother's Side		☐ Living ☐ Deceased		
Grandfather Mother's Side		☐ Living ☐ Deceased		
Grandmother Father's Side		☐ Living ☐ Deceased		
Grandfather Father's Side		☐ Living ☐ Deceased		
Sibling	☐ M ☐ F	☐ Living ☐ Deceased		
Sibling	☐ M ☐ F	☐ Living ☐ Deceased		
Sibling	☐ M ☐ F	☐ Living ☐ Deceased		
Sibling	☐ M ☐ F	☐ Living ☐ Deceased		
Sibling	☐ M ☐ F	☐ Living ☐ Deceased		
Sibling	☐ M ☐ F	☐ Living ☐ Deceased		

SOCIAL HISTORY

Alcohol Use: ☐ Yes ☐ No If Yes, Number of Drinks per Week: __________

Tobacco Use: ☐ Yes ☐ No If Yes, Number of Packs per Day: ____________ Years Quit: _________

Exercise: ☐ Yes ☐ No If Yes, what type, number of minutes per week: ___________________________

Occupation: ____

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 _____________