

---

We would like to welcome you to our practice. Please bring your **completed forms, insurance card(s), and driver's license** to your appointment. Patients who arrive with incomplete forms may be asked to reschedule.

If you have not already provided your current insurance information, please contact our office before your appointment. This helps expedite check-in and ensures we have the correct paperwork prepared. Please note that we verify eligibility only based on the information provided; we do not verify specific insurance benefits.

**If you have had an X-ray, CT scan, or MRI within the last year, you MUST bring a CD containing your images and reports to your appointment. Failure to bring the CD may result in your appointment being rescheduled, as not all providers have access to outside imaging systems.**

Please be prepared to pay your copay at check-in. To confirm copays and benefits, you should contact your insurance carrier using the member services number on your insurance card. If your insurance requires a referral, it is your responsibility to obtain it before your appointment. Many insurance plans do not issue retroactive referrals or authorizations, and you may be responsible for the full cost of services if seen without an active insurance referral.

Patients without insurance will receive a **10% discount** when payment is made in full on the date of service.

**Appointment Policy:** If you are unable to keep your appointment, please provide **at least 24 hours' notice** by calling **540-232-8405**.

**New Patients that no-show or late cancel are subject to the following:**

- \$100 fee for no-show or late cancellation. This is not billable to your insurance and must be paid prior to scheduling another appointment.
- Patients who miss **two consecutive initial appointments** without proper notice may not be permitted to schedule future appointments

**Established Patients that no-show or late cancel are subject to the following:**

- \$50 fee for no-show or late cancellation. This is not billable to your insurance and must be paid prior to scheduling another appointment.
- Patients who miss **two appointments within a 12-month period** without proper notice may be dismissed from the practice

**Late Arrivals**

- Patients arriving **more than 10 minutes late** may be asked to reschedule

If you should have any questions, please feel free to contact our clinic at (540) 232-8405.

Thank you for trusting us for your medical care. We look forward to seeing you soon!

## PATIENT MEDICAL HISTORY

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_  
 School (students only) \_\_\_\_\_ Who referred you? \_\_\_\_\_  
 Personal Physician \_\_\_\_\_ Address \_\_\_\_\_

What is the main problem for which you are seeking medical attention? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date of injury or pain onset? \_\_\_\_\_ Date you first sought medical attention? \_\_\_\_\_

My joint pain has associated (circle any)? joint swelling locking/catching giving way buckling

Is this problem a result of (circle one)? MVA Personal Injury Sports Work Other

For Trauma: Driver? Y / N Passenger? Y / N Aware of impending Impact or fall? Y / N

I braced for impact with my ... body head right arm left arm right leg left leg

Please give details of how your pain/injury occurred: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List all previous medical provider(s) names seen & treatment(s) you have you tried for THIS problem?

	Who	Dates	Please Describe Imaging/Labs or Treatment given
ER			
PCP			
Specialist 1			
Specialist 2			
Specialist 3			
Manipulation			
Physical Therapy			
Medications			

What diagnostic studies have been done for THIS problem?

	Dates	Results		Dates	Results
X-rays			MRI		
Ultrasound			CT Scan		
Bone Scan			other		

CURRENT MEDICATIONS (including vitamins) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

ALLERGIES (describe reaction) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Work Activity	
<b>Job Description:</b>	
Describe your activity level or any specific repetitive behaviors:	

Athletic / Sporting Activities		
	Amounts/Times per week	Previous Injuries
Sport 1:		
Sport 2:		
Sport 3:		

Do you currently smoke: \_\_\_\_\_ packs/day.

Have you ever smoked? Y / N \_\_\_\_\_ packs/day. Year Quit \_\_\_\_\_.

Caffeine? \_\_\_\_\_ cups/day Alcohol? type \_\_\_\_\_ # Years amount \_\_\_\_\_

**PAIN ASSESSMENT**

How would you rate the SEVERITY of your pain on a BAD DAY or Time ? (circle all that apply):

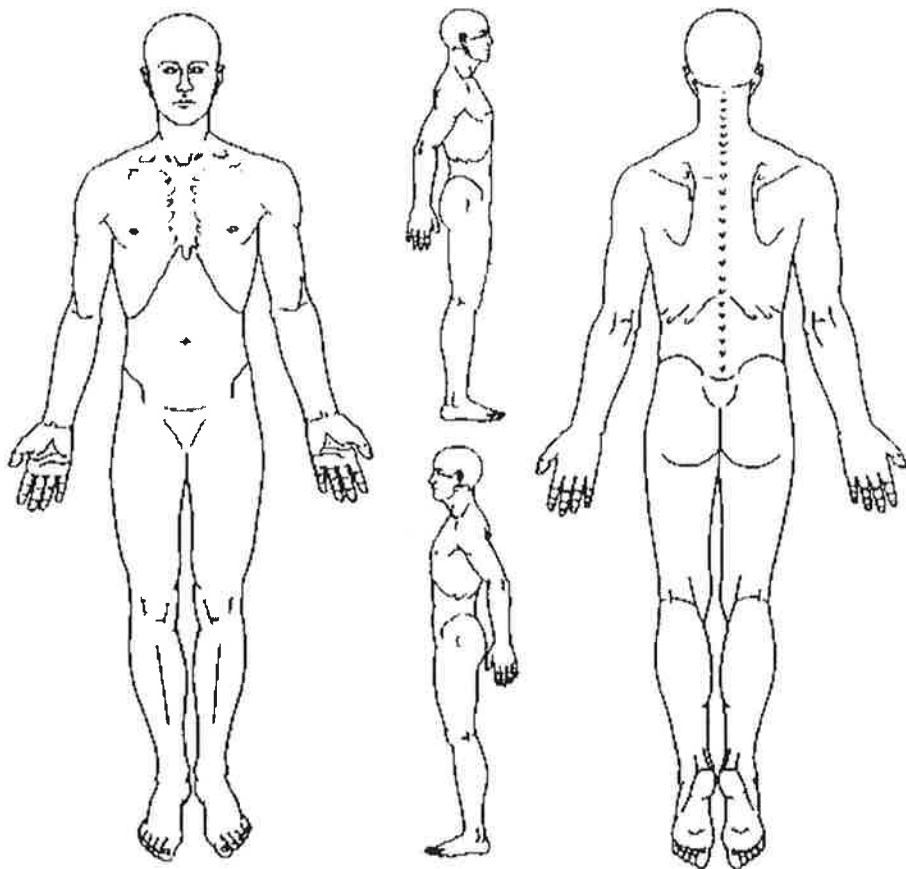
1	2	3	4	5	6	7	8	9	10
MILD PAIN		DISCOMFORTING		DISTRESSING		INTENSE		EXCRUCIATING	
annoying		troublesome		miserable		dreadful / horrible		unbearable	
nagging		irritating		agonizing		vicious		torturing	
		numbing		gnawing		nauseating		crushing / tearing	

How would you rate the SEVERITY of your pain on a GOOD DAY or Time ? (circle one):

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Please indicate both the location and nature of your pain on the diagram below:

Numbness      Pins & Needles      Burning      Ache      Stabbing  
 = = =            O O O            X X X            Λ Λ Λ            ///



Please rate your typical pain in these specific situations below:

(circle closest response)  
 ↑↑ = markedly increased  
 ↑ = increased,  
 ↓ = decreased,  
 ↓↓ = markedly decreased

- First thing AM:      ↑↑    ↑    +/-    ↓    ↓↓
- Mid-day:            ↑↑    ↑    +/-    ↓    ↓↓
- Evening:            ↑↑    ↑    +/-    ↓    ↓↓
- Middle night:      ↑↑    ↑    +/-    ↓    ↓↓
- Prolonged Sitting:    ↑↑    ↑    +/-    ↓    ↓↓
- Prolonged Standing:    ↑↑    ↑    +/-    ↓    ↓↓
- Walking:            ↑↑    ↑    +/-    ↓    ↓↓
- Running:            ↑↑    ↑    +/-    ↓    ↓↓

Overall ... my pain is getting (circle one):    Getting Better            Getting Worse    Staying the Same

What makes your pain worse? \_\_\_\_\_

What makes your pain better? \_\_\_\_\_

How would you describe the QUALITY (NATURE or CHARACTER) of your pain ? (circle all apply)

lacerating		electrical	burning	aching	<i>intermittent</i>	throbbing	punishing
stinging	<i>deep</i>	shocking	shooting	heavy		pounding	pulling
sharp		cramping	flashing	hot	<i>variable</i>	aching	tugging
knife-like	<i>on surface</i>	squeezing	tingling	itching		numb	prickling
piercing		tight		cold	<i>constant</i>	tender	pins / needles

Does your pain or symptoms travel or radiate to other areas? Yes No (circle one)

If yes, describe ... is the QUALITY and DEPTH of the pain different than the primary area ?

**FAMILY HISTORY**

	If Living		If Deceased	
	Age	Health Problems	Age	Cause of Death / Health Problems
Father				
Mother				
Brother(s)				
Sister(s)				

**CURRENT MEDICAL PROBLEMS (FOR WHICH YOU ARE UNDER TREATMENT WITH OTHER PHYSICIANS)**


**HOSPITALIZATIONS AND SURGERIES**

Date	Reason	Date	Reason

**MEDICAL HISTORY (please CHECK all PRESENT conditions - "X" all PAST conditions):**

HEENT	RESPIRATORY	MUSCULOSKELETAL
Headaches	Asthma	Herniated Disc
Migraines	Bronchitis	Location:
Concussion	Pneumonia	Broken bones
Head injury	Shortness of breath w/exercise	(specify)
Eye problems	Coughing during / after exercise	Chronic back pain
Wear glasses / contacts	Use an inhaler	Chronic neck pain
- last eye exam:	<b>GASTRO-INTESTINAL</b>	Joint pain
Hearing problems	Heartburn / indigestion	(specify):
Sinus problems	Ulcers	Whiplash injury
Frequent colds / illnesses	Diarrhea	Shoulder injury
<b>CARDIOVASCULAR</b>	Constipation	Knee injury
High blood pressure	Gall bladder problems	Sprained ankle
Angina	Use antacids	Wear orthotics in shoes
Chest pain with exertion	Hemorrhoids	Scoliosis
Palpitations	Irritable bowel	Tendonitis
Irregular heart beat	Colitis / Crohn's disease	Bursitis
Heart failure	Blood in stool/black tarry stool	Rheumatoid arthritis
Get lightheaded / faint w/exercise	Diverticulosis / Diverticulitis	Degenerative arthritis
Heart murmur	Excess gas / bloating	Short leg
High cholesterol	<b>GENITOURINARY</b>	Osteoporosis
Stroke	Frequent urinary infections	<b>ENDOCRINE</b>
Aneurysm	Kidney stones	Diabetes (insulin-dependent)
Phlebitis / blood clots in legs	Prostate trouble (men only)	Diabetes (non-insulin depend)
Varicose veins	Burning while urinating	Hypothyroid (underactive)
<b>NEUROLOGICAL/PSYCHIATRIC</b>	<b>FEMALE ONLY</b>	Hyperthyroid (overactive)
Nerve injury (specify)	Age first menstrual period:	Gout
	Age menopause:	Easily fatigued
Anxiety	Frequency of periods:	<b>OTHER</b>
Depression	Irregular menstrual cycles	Cancer
Panic attacks	Irregular bleeding / spotting	Type:
Dizziness	Frequent yeast infections	Anemia
Convulsions / seizures	# of pregnancies	
Anorexia / Bulimia	# of deliveries	

**PHYSICIANS NOTES:**




Patient Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Preferred Name: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M / F / T  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home #: \_\_\_\_\_ Cell#: \_\_\_\_\_ Work#: \_\_\_\_\_  
Email address: \_\_\_\_\_  
Preferred method of communication (circle one):  Voice  SMS/TEXT Message  Email (for appt reminder only)

Marital Status: Married Single Divorced Widowed Partner  
Race: African American American Indian Asian White Hispanic Pacific Islander Other  
Ethnicity: Hispanic Non-Hispanic Prefer Not to Report Preferred Language: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Student Status: Full Time / Part Time Location/ School: \_\_\_\_\_

Responsible Party Info: (if patient is a minor):  
Name: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_  
Relation to Patient: \_\_\_\_\_ Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Is this a foster child? Yes / No If yes, Primary Caregiver/Legal Guardian's Name: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

Do you have Medical Insurance? Yes / No  
Primary Insurance Company: \_\_\_\_\_  
Policy Holder Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Policy Holder's Info: (if different from the patient):  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Secondary Insurance Company: \_\_\_\_\_  
Policy Holder Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Policy Holder's Address: (if different from the patient):  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_

Patient / Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Demog Packet 01/14/2021



**Consent for Treatment**

I hereby consent to medical treatment, diagnostic tests, laboratory, and other medical procedures, which the physician(s) or healthcare provider(s) of VSOM may consider or advise in my treatment, or in treatment of my dependent. This agreement will remain in effect until I choose to revoke it in writing.

Patient / Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Notice of Privacy Practices**

I acknowledge that I have access to a copy of VSOM Privacy Practices and that it is my responsibility to read the notice to understand how my or my child(ren)'s Protected Health Information may be used.

I understand no authorization is required from me for VSOM to use my or my child(ren)'s Protected Health Information for purposes of treatment, payment or health care operations. Other uses or disclosures may require my written authorization. **\*\*If you would like a copy of VSOM's Privacy Practices, please ask the receptionist.\*\***

Patient / Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Acknowledgement of Deemed Consent for HIV / Hepatitis B or C Virus Blood Testing**

Virginia Law authorizes health care providers to test their patients for HIV antibodies or Hepatitis B or C viruses when the health care provider is exposed to body fluids (ie: needlestick) of a patient in a manner which may transmit HIV or Hepatitis B or C viruses. Pursuant to this law, in the event of such an exposure, you will be deemed to have consented to such testing and to have consented to the release of the test results to the health care provider who may have been exposed. However, you would be informed before any of your blood would be tested for these antibodies pursuant to this provision, the testing would be explained, and the testing would be explained, and you would be given the opportunity to ask any questions you might have. Patients who test positive will also be afforded the opportunity for individual face-to-face disclosure of test results and appropriate counseling.

Patient / Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Payment Agreement**

I agree to be financially responsible for costs incurred in my or my dependents care. I understand that charges for services provided shall be paid for at the time of each visit. If medical claims are submitted to an insurance company by VSOM on my behalf, I understand that the copayment or deductible is due at the time care is rendered. I hereby authorize any benefits due me to be paid directly to VSOM (assignment of benefits). I understand and agree that I am financially responsible for all deductible amount s, co-insurance, non-covered services or services deemed as "non-medically necessary" by my insurance carrier. I agree that I am responsible for satisfying any conditions (referrals) necessary for insurance or health benefits.

In consideration for medical services rendered, I (we) acknowledge that I (we) have received services rendered by VSOM and agree to pay for said medical services according to such terms.

Patient / Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Self-Pay Agreement**

I agree to pay for medical services rendered at VSOM. I understand that there are payment plans available at my request. I understand that these plans will be based on my financial income and will be reviewed prior to approval.

Patient / Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Authorization to Treat in Absence of Parent or Guardian (optional)**

If my child(ren) is/are brought in to the office by \_\_\_\_\_, I consent for my child(ren) to be treated and agree to be financially responsible for the cost of such care. I understand that by not signing this section my child(ren) cannot be seen at VSOM without myself or another legal guardian present.

Patient / Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Authorized Person(s) for Protected Health Information Disclosure**

I hereby authorize VSOM to disclose my medical and Protected Health Information to the person(s) indicated below:

Name	Relationship	Phone #
_____	_____	_____
_____	_____	_____

Patient / Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Authorization for Release of Confidential Health Care Information**

This authorizes VSOM to request and receive from the Virginia Department of Health Professions any and all records held by the department relating to schedule 2-5 controlled substances dispensed to the patient named above. I understand that this authorization permits the Dept. of Health Professions to disclose confidential health care records to the prescriber named above (VSOM). A copy of this authorization shall be included with my original records. There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure as permitted or required by law. I understand that, if not previously revoked, this consent will expire one year after the date of my signature, unless otherwise specified.

Patient / Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Notification of Appointments /Treatments**

VSOM makes every effort to use your preferred method of communication for appointment reminders, clinical care including laboratory results or any other issues regarding your account with us. With this consent, VSOM may call home, cell or other designated location and leave message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment or healthcare operations, such as appointment reminders, insurance items and calls pertaining to my clinical care, including laboratory results among others. We will use the information you have provided, and may consist of leaving messages on voicemail, email, letters, etc.

By signing below, you are giving permission for VSOM to leave messages on voicemail and speak with the designated person(s) that are listed on the PHI Disclosure.

Patient / Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



### Late Cancellation and No-Show Policy

Late cancellation and no-shows for appointments unnecessarily delay the delivery of health care to other patients.

Late Cancellation and No-Show Policy:

- A late cancellation is defined as failure to contact the office at least 24 hours in advance to cancel the appointment. There will be a \$50 charge for late cancellations all patients. This is not billable to the insurance and is due prior to scheduling another appointment.
- A no-show is defined as missing a scheduled appointment. There will be a \$50 charge for no-show appointments. This is not billable to the insurance and is due prior to scheduling another appointment.
- NEW PATIENTS who miss TWO consecutive initial office without giving the office at least 24-hour notice may not be permitted to schedule another appointment.
- ESTABLISHED patients who miss THREE scheduled appointments (within a year) without giving the office at least 24-hour notice may be dismissed from the practice.

Late Arrivals Policy:

If you are more than ten minutes late, you may be asked to reschedule your appointment. Every effort will be made to see the patient the same day but is not always an option.

Patient / Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### VSOM Notice

VSOM is a teaching facility. This practice is a place where medical students come to learn how to be doctors. It is important for them to talk to people about their health and illnesses. This helps them understand how illnesses affect people and how they cope. We would be grateful if you could help us in this teaching. However, this is entirely voluntary. No one will mind if you would rather not see a student, change your mind, or want the student to leave at any time. You can also refuse to see particular students, such as those of a different sex or those you have met outside of the practice. Of course, the care provided to you by the practice will not be affected in any way. By signing this section, I understand my rights as a patient regarding medical students being involved in my care. I also understand that said medical students and physicians may use my medical information (may include but is not limited to medical notes, x-ray, photo, ultrasound) may be de-identified and used for the purpose of case presentations, lectures, poster presentations or papers for further teaching.

Patient / Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Are you (or the person being seen) a VCOM student or a VCOM student family member? Yes \_\_\_ No \_\_\_

Please note: If you answered yes to the above question, it is the policy of VSOM that no other medical student be involved in your or your dependents care. Please notify your nurse upon triage.