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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!



CURRENT MEDICATIONS / SUPPLEMENTS:					
MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

If more, please list on reverse side.

MEDICATION / FOOD ALLERGIES (what type of reaction?) : \_\_\_\_\_

PREVIOUS / CURRENT MEDICAL PROBLEMS:			
Anemia	Anxiety / Depression	Asthma	Bipolar Disease / Schizophrenia
Blood Clot	Blood Clotting Disorder	Cancer	Cirrhosis/Hepatitis
Concussion / Brain Injury	Degenerative Arthritis	Diabetes	Dizziness
Drug / Alcohol Dependency	Emphysema	Enlarged Prostrate	Eye Disease
Gout	Heart Arrhythmia	Heart Attack	Heart Murmur
Herpes / Shingles	High Blood Pressure	High Cholesterol	HIV / AIDS
Kidney Disease / Stones	Menstrual Problems	Multiple Sclerosis	Neuropathy
Osteopenia / Osteoporosis	Paralysis	Pneumonia	Psoriasis
Reflux/Stomach Ulcers	Rheumatoid Arthritis	Seizures	Skin Infection
Stroke	Thyroid Disease (Hyper/Hypo)	Tremor	Tuberculosis
Other:			

PREVIOUS SURGERIES / HOSPITALIZATIONS:		
TYPE/REASON	DATE	SURGEON

**FAMILY MEDICAL HISTORY:**

	Alive / Deceased	Age	Arthritis	Cancer	Diabetes	Heart Disease	High Blood Pressure	Osteopenia / Osteoporosis	Scoliosis	Kidney / Liver Disease	Neck / Spine Disorder	Other
Father												
Mother												
Brother(s)												
Sister(s)												
Paternal Grandfather												
Paternal Grandmother												
Maternal Grandfather												
Maternal Grandmother												
Children												

**SOCIAL HISTORY:**

Do you use tobacco products? YES / NO	If yes, list types used, how much per day, and for how many years?
Have you traveled outside of the United States in the past 12 months? YES / NO	If yes, where?
Do you currently or have used illicit drugs?	If yes, list types used and when last used?
Do you consume alcohol?	If yes, list types used and how many drinks per week?

Please check symptoms you are experiencing.			
<b>GENERAL:</b> <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Night Sweats <input type="checkbox"/> Unintentional Weight Loss <input type="checkbox"/> Unintentional Weight Gain  <b>ENDOCRINE</b> <input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Irregular Menses  <b>RESPIRATORY</b> <input type="checkbox"/> Cough <input type="checkbox"/> Pain with Breathing <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Sputum Production <input type="checkbox"/> Wheezing	<b>CARDIOVASCULAR:</b> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Hand / Foot Turning Blue <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Leg Swelling <input type="checkbox"/> Palpitations  <b>GASTROINTESTINAL:</b> <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting	<b>GENITOURINARY</b> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Decreased urinary output <input type="checkbox"/> Difficulty urinating <input type="checkbox"/> Pelvic Pain <input type="checkbox"/> Urinary Urgency  <b>MUSCULOSKELETAL:</b> <input type="checkbox"/> Joint Redness <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Muscle Cramps	<b>SKIN:</b> <input type="checkbox"/> Discoloration <input type="checkbox"/> Eczema <input type="checkbox"/> Hives <input type="checkbox"/> Rash <input type="checkbox"/> Skin Cancer  <b>NEUROLOGIC:</b> <input type="checkbox"/> Dizziness <input type="checkbox"/> Fecal Incontinence <input type="checkbox"/> Headache <input type="checkbox"/> Numbness / Tingling <input type="checkbox"/> Tremor <input type="checkbox"/> Urinary Incontinence  <b>PSYCHIATRIC:</b> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depressed Mood <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Mental / Physical Abuse <input type="checkbox"/> Stressors

Please list other symptoms you are experiencing: <hr/>
What are your goals for today's visit? <hr/>

FEMALES ONLY	
Age of first menstrual period:	First day of most recent menstrual period:
Are you currently or transitioning into menopause?	
How much time do you have between the start of one period to the start of another?	How many periods have you had in the last 12 months?
What was your longest time between periods?	Is there a chance you may be pregnant?
Number of pregnancies:	Number of full-term births:
Number of pre-term births:	Number of miscarriages / terminations:



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 amounts, 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.