VCOM | Sports & Osteopathic Medicine

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!

VCOM | Sports & Osteopathic Medicine

Pediatric Patient Medical History

Name _____ Age_____ Date of Birth _____ Today's date_____

Mother/Guardian Name _____ Father/Guardian Name_____

School/Daycare _____ Who referred you?_____

What is the problem that brought you in today? _____

_____

_____

Date or Age Problem Started_____ Is it getting worse/better/unchanged?_____

Have you had any work up/treatment for this before? _____

_____

Have you had any Imaging (X-Ray/US/CT scan/MRI)?_____

Please List all the Health care professionals involved in your care and their address:

Pediatrician/Family Doctor_____

Specalist_____

Specalist_____

Physical Therapist_____

Chiropractor/Manual Therapist_____

Current Medications (include vitamins and herbs):

_____

_____

_____

Allergies - Please describe reaction :

_____

_____

_____

Medical Problems for which you see a doctor:

_____

_____

_____

Previous Surgeries or Hospitalizations (Include date):

_____

_____

_____

Sport(s) Played: _____

Previous traumatic injuries (Concussions, Broken bones, Falls, Stitches):_____

_____

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Family History: Year Born: Health Problems:

Mother: _____

Father: _____

Sister(s): _____

Brother(s): _____

Who do you live with (Include Pets): _____

_____

Have you traveled in the Last year (where/when)? _____

Are you exposed to smoke? Y /N I am a smoker _____Pks/Day **Caffeine?** _____Cups/Day

_____**BELOW IS FOR CHILDREN 5 YEARS OLD OR YOUNGER ONLY**_____

BIRTH HISTORY: Born On Time or Early?_____ Birth Weight?_____

Vaginal Delivery or C-Section?_____ Vacuum/Forceps used? _____

Any problems with the delivery? _____ Any Problems with the Pregnancy?_____

Any problems right after birth (ex Jaundice)? _____

_____**BELOW IS FOR INFANTS 12 MONTHS OLD OR YOUNGER ONLY**_____

Breast Feeding: _____ Minutes every _____hrs (aprox) **I use a Nipple Shield:** Y / N

Supplementation: After/ During / Before breastfeeding _____ounces of: breast milk/formula _____

To supplement I use: a bottle S+S syringe at the breast Syringe with finger finger feed no syringe cup feed

List Lactation consultants you are/have seen _____

I breast fed until age _____ **but stopped because** _____

Bottle Feeding _____ Ounces every _____hrs

Solid foods: I have / have not started solids

Describe any difficulties with eating solids: _____

VCOM Sports & Osteopathic Medicine

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:_____

1691 Innovation Dr, Ste 2100 • Blacksburg, Virginia 24060 • Phone: (540) 232-8405 • Fax: (540) 232-8429

VCOM Sports & Osteopathic Medicine

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:_____

VCOM Sports & Osteopathic Medicine

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:_____

VCOM Sports & Osteopathic Medicine

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.

VCOM Sports & Osteopathic Medicine

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:_____

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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:_____

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VCOM Sports & Osteopathic Medicine

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