Smyth County Family Physicians

A Division of Royal Oak Medical Associates P.C.

Emily B. Bralley, D.O. Paul G. Brown, M.D. Chelsea C. Hamman, M.D.

J. Ryan McGlothlin, D.O. Jennifer L. Quesinberry, M.D.

PATIENT INFORMATION

DATE_____ ACCT #_____

NAME OF PATIENT:

_____

LAST FIRST MIDDLE NICKNAME

ADDRESS_____

CITY _____STATE _____ ZIP _____

MARITAL STATUS: M S D W DATE OF BIRTH _____ SS#_____

PHONE (HOME) _____ WORK_____ CELL_____

EMAIL ADDRESS_____

EMPLOYER _____ ADDRESS _____

EMERGENCY CONTACT_____ADDRESS_____

RELATIONSHIP _____ PHONE _____

PHARMACY _____ PHONE _____

FAMILY INFORMATION

(PLEASE LIST IMMEDIATE FAMILY)

1. _____ 3. _____

RELATIONSHIP RELATIONSHIP

2. _____ 4._____

RELATIONSHIP RELATIONSHIP

HAVE YOU SEEN ANY OF THE PHYSICIANS IN OUR GROUP IN THE PAST THREE YEARS?

_____YES _____NO

OUR GROUP CONSISTS OF DRS. PAUL G. BROWN, R. VAN CLAMPITT, CHELSEA HAMMAN, KIM LACY, J. RYAN MCGLOTHLIN, EMILY B. BRALLEY, DAVID PARKER, JENNIFER QUESINBERRY AND BRIAN STIEFEL.

INSURANCE INFORMATION

PRIMARY INSURANCE _____

PLEASE GIVE ALL INSURANCE CARDS TO RECEPTIONISTS TO COPY

SECONDARY INSURANCE _____

** IF EITHER PRIMARY OR SECONDARY INSURANCE IS IN YOUR SPOUSE'S NAME, WE MUST HAVE THE SPOUSE'S BIRTH DATE: _____

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** WE DO NOT BILL INSURANCE COMPANIES FOR MVA ACCIDENTS. PATIENT IS RESPONSIBLE FOR PAYMENT AT TIME OF SERVICE.

**PARENT BRINGING CHILD TO OFFICE IS RESPONSIBLE FOR PAYMENT. WE DO NOT BILL PARENT AT ANOTHER ADDRESS.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES FOR SERVICES TO ME, INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURANCE BENEFITS. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO MYSELF OR THE NAMES PROVIDED FOR PROFESSIONAL SERVICES RENDERED. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

SIGNED _____ DATE _____
PATIENT OR PARENT IF MINOR

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ROYAL OAK MEDICAL ASSOCIATES, P.C.

I understand and agree that, regardless of my insurance coverage, I am ultimately responsible for payment of any charges for professional services rendered.

I certify that the information I have given is true and correct to the best of my knowledge.

I authorize Royal Oak Medical Associates, P.C. to release (or receive) any and all of my medical and billing information to any physician involved in my treatment, and to any health care facility at which I seek treatment, for the purposes of treatment, billing, collection, quality assurance or risk management activities, or defense of litigation or anticipated litigation and to any insurance company, health maintenance organization or other entity which is directly or indirectly responsible for payment or review of services provided by **ROYAL OAK MEDICAL ASSOCIATES, P.C.** A photocopy of this authorization shall be considered as valid as the original.

Also, I hereby agree to pay and accept responsibility for any collection fee, court costs and/or attorney fees incurred or imposed by ROYAL OAK MEDICAL ASSOCIATES, P.C.

I authorize the treatment by physicians or family nurse practitioner and request the payment for professional services rendered be made directly to **ROYAL OAK MEDICAL ASSOCIATES, P.C.,** Smyth County Family Physicians Division.

DEEMED CONSENT FORM

I understand that the laws of Virginia provide if my physician, or any person employed by or under the direction and control of my physician(s), is directly exposed by my body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the **human immunodeficiency virus (HIV) or hepatitis B or C viruses,** that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to consent to the release of these test results to the person who is exposed to my body fluids.

DATE:_____ **PATIENT SIGNATURE:**_____

WITNESS:_____ **AUTHORIZED PERSON:**_____

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FOR MEDICARE PATIENTS ONLY
LIFETIME AUTHORIZATION TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER/PHYSICIAN AND PATIENT

I certify that the information given me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorization benefits be made on my behalf. I assign the benefits payable for covered Medicare services to the physician.

PATIENT SIGNATURE_____

AUTHORIZED PERSON:_____

DATE:_____

WE RESERVE THE RIGHT TO ASK YOU TO SEEK MEDICAL CARE ELSEWHERE IF YOU REPETITIVELY MISS APPOINTMENTS.

Revised 2-2017

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I GIVE PERMISSION FOR SMYTH COUNTY FAMILY PHYSICIANS TO LEAVE NORMAL TEST RESULTS ON MY ANSWERING MACHINE OR VOICEMAIL.

PATIENT NAME

DATE

WITNESS

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PERMISSION TO DISCUSS PHI

PATIENT NAME_____ DATE OF BIRTH_____

ACCOUNT NUMBER_____

I HEREBY GIVE MY PERMISSION TO THE PERSON(S) LISTED BELOW TO RECEIVE INFORMATION ABOUT THE CARE OF THE ABOVE NAMED PATIENT.

NAME	RELATIONSHIP

_____
SIGNATURE OF PATIENT/GUARDIAN

_____
DATE

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PAYMENT POLICY

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patient have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-covered services.** Please be aware that some-and perhaps all- of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. You will be notified if reasonable to expect a charge.

4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

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6. **Coverage changes.** If our insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular certified mail that you have 30 days to find alternative medical care. During that 30-day period our physician will only be able to treat you on an emergency basis.

8. **Missed Appointments.** Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment.

9. It is the patient's responsibility to be familiar with your insurance carrier's requirements regarding preauthorizations and referrals.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
SMYTH COUNTY FAMILY PHYSICIANS

NOTICE TO PATIENT

We are required to advise you of you Notice of Privacy Practices, which states how we may use and/or disclose your health information. A copy will be provided upon request.

I acknowledge that I have been made aware of this office's Notice of Privacy Practices. I may refuse to sign this acknowledgment if I wish.

Patient's Name Date of Birth

Please print your name here (if different than above) Relationship to patient

---

Signature Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient, but it could not be obtained because-

Patient account number_____

____ The patient refused to sign.

____ Due to an emergency situation, it was not possible to obtain an acknowledgment

____ We were not able to communicate with the patient.

____ Other (Please provide specific details)

Employee Signature Date

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CONSENT FORM
(FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS (TPO)

I understand that as part of my healthcare, Royal Oak Medical Associates, P.C. originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I also understand this information serves as:

- As basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand the Practice reserves the right to change their notice and practices, and prior to implementation, will mail a copy of any revised notice to the address that I have provided if there is a need to use or disclose any protected health information. I also understand that I have the right to restrict as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested other than the exception noted in the Notice of Information Practices. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

With this consent, Royal Oak Medical Associates, P.C. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With this consent, Royal Oak Medical Associates, P.C. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and other correspondence as long as they are marked Personal and Confidential.

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With this consent, Royal Oak Medical Associates, P.C. may e-mail to me appointment reminders and patient statements. I have the right to request that Royal Oak Medical Associates, P.C. restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions except for a request for a restriction on a disclosure to a health plan where services have been paid in full, out-of-pocket, but if it does, it is bound by this agreement.

By signing this form, I am consenting for Royal Oak Medical Associates, P.C. to use and disclose my PHI to carry out my TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, Royal Oak Medical Associates, P.C. may decline to provide treatment to me.**

Print Patient Name: _____
Account Number: _____

Signature of Parent or Legal Guardian: _____
Date: _____

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NOTICE OF INFORMATION PRACTICES

1. Royal Oak Medical Associates, P.C. may use and disclose protected health information for treatment, payment and healthcare operations. Treatment examples include, but are not limited to, referrals to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers; collection agencies. Healthcare operations include, but are not limited to, internal quality control and assurance including auditing of records.

2. Royal Oak Medical Associates, P.C. is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. Two examples of such are for public health uses or court orders.

3. An authorization form the patient is required for uses or disclosures for marketing purposes and for any disclosure constituting the sale of protected health information. No other use or disclosure of a patient's protected health information will be made without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.

4. Patients have the right to opt out of any communication involving fundraising. In the event of a breach of unsecured protected health information, a notification will be provided.

5. Royal Oak Medical Associates, P.C. will abide by the terms of the notice currently in effect at the time of the disclosure.

6. Royal Oak Medical Associates, P.C., reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains. Royal Oak Medical Associates, P.C. will provide each patient with a copy of any revisions of its Notice of Information Practices at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our office.

7. Any patient, guardian or personal representative has the right to object to the use of their health information for directory purposes.

8. Any patient, guardian or personal representative has the right to inspect and obtain their medical record.

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9. Any patient, guardian or personal representative has the right to request amendments be made to their medical record.

10. Any patient, guardian or personal representative has the right to request a six-year accounting of all disclosures of their medical record. The history will be provided within 60 days of the request and a reasonable charge may be assessed for any copies after the first requested in a 12-month period.

11. Any patient, guardian or personal representative has the right to request restrictions as to how their health information may be used or disclosed to carry out treatment, payment or healthcare operations. The Practice is not required to agree to the restrictions requested except for a request for a restriction on a disclosure to a health plan where services have been paid in full, out-of-pocket; but if the Practice does agree, the Practice must abide by those restrictions.

12. Any person/patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, please contact the Privacy Officer at the address and/or phone number listed above. All complaints will be addressed and the results will be reported to the Privacy Officer.

13. It is the policy of Royal Oak Medical Associates, P.C. that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

Effective Date: _____
Name of Patient: _____

Signature of Patient or Legal Guardian: _____
Date: _____

Today's Date_____

Periodic History

Child's Name: _____ Birth Date :_____

Please complete the following. All information is confidential

Mother's Full Name:_____ **Father's Full Name:**_____

Legal Guardian/Custodial Parent:_____

List any **medical conditions** or **diseases** the child has or has had. Please include surgeries and hospitalizations:

_____ _____ _____

_____ _____ _____

_____ _____ _____

List ALL the **medicines** the child is taking, include any over the counter medicines and vitamins

_____ _____ _____

_____ _____ _____

_____ _____ _____

Drug allergies-_____

Family History Please check or list any **diseases** that child's **relatives** have now or have had:

	Age if Alive	Age at death	Diabetes	Breast Cancer	Colon (Gut) Cancer	Heart Disease	Other diseases
Mother							
Father							
Brother(s)							
Sister(s)							

Other diseases that run in the child's family:_____

_____

Please check if child has any of these:

Constitutional

Weight Loss _____

Fever or Chills _____

Respiratory

Frequent Cough _____

Spitting up of Blood _____

Shortness of Breath or Wheezing _____

Cardiovascular

Chest Pain _____

Intestines

Blood in your stools (BMs) _____

Black, tarry stools (BMs) _____

Any change in your Stools or Bowels _____

Lots of heartburn or indigestion _____

Eyes

Trouble seeing _____

Ears, Nose, Mouth, Throat

Sores that won't heal _____

Trouble hearing _____

Neurological

Passing Out or Fainting Spells _____

Skin

Change in Birth Marks or moles _____

Sores that won't heal _____

Breast Lumps _____

Emotions/Psychiatric

Feeling very down or depressed _____

"Nerves" or feeling anxious or on edge _____

Problems sleeping too much _____

Problems not sleeping (insomnia) _____

Hematologic/Lymphatic

Growing Glands, Nodes or Lumps _____

Genito-Urinary

Blood in Urine (Pee) _____

Can't Control Urine _____

Girls ONLY:

Vaginal Discharges or Sores? _____

Boys ONLY:

Lump on the testicle (ball) _____

Unable to feel both testicles _____

Swelling or discharge (drip) from Penis _____

Any other concerns (not listed above)

_____

_____

_____

_____

_____

_____

_____

_____

Social History - Who lives **with child**?

Name, First & Last	Age	Relation to child	Name, First & Last	Age	Relation to child
1.			4.		
2.			5.		
3.			6.		

Does anyone who **lives with** or is **related to** child come to **our practice?** (If yes, who?)

_____

Does anyone smoke in the house or around child? _____ yes _____no

What kind of water does the house have? _____ well _____ town _____ don't know

Are there any guns kept in the house? _____ yes _____ no

If Baby or less than two years old please give mom's History For This Pregnancy:

How was mom's **health overall during this pregnancy?** (Circle one) Excellent Very Good Good Fair Poor

If you circled Fair or Poor, please briefly explain why. (examples: High blood pressure, high blood sugar, ……..)

_____

What was your due date? _____ When was baby born? _____

Where was baby born? _____

Any problems while in hospital after delivery? No _____
Yes _____ (please explain:_____)

Did your baby receive his/her 1st Hep B vaccination before leaving the hospital? Yes_____ No _____

If not, please enter the name and address of the hospital in which your baby was born. _____

_____