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Patient Information

Last Name: _____First Name: _____M.I: _____

Street Address: _____Apt #_____

City: _____State: _____Zip Code: _____

Home Phone: _____Cell:_____

Work Phone: _____EXT:_____ Email Address: _____

Birth Date: _____Social Security #:_____

Gender: □ Male □ Female □ Transgender

Marital Status: □Married □ Single □ Divorced □ Widowed

Student? : □ Not a student □ Full-time student □ Part-Time Student

Employer Name: _____

Employer Address: _____

Emergency Contact

Name: _____Relation:_____

Home Phone: _____Cell:_____Work:_____

**********If the person resides with you please give us a second contact person*******

2nd Name: _____Relation:_____

Home Phone: _____Cell: _____Work:_____

Insurance

Guarantor:

Last Name: _____First Name _____MI:_____

Date of Birth: _____Social Security: _____

Telephone: _____

Primary Insurance Name: _____

Address: _____

Effective Date: _____Subscriber Number: _____

Group Number: _____

Secondary Insurance Name: _____

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Address: _____

Effective Date: _____Subscriber Number: _____

Group Number: _____

Preferred Pharmacy

Name: _____Address:_____

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FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our ***Financial Policy***, which we require you to read and sign prior to any treatment:

1. All patients must complete our information and insurance form before seeing the doctor.
2. For your convenience we accept cash, check, Visa, MasterCard, American Express and Discover.

We have contracts with most commonly used insurance companies. Please check to see if we accept your insurance. If we do not accept your insurance policy, as a courtesy, we will bill your company. Your insurance policy is a contract between you and your insurance company. We are not a party of that contract. If we bill your insurance company and they have not paid your account in full within 45 days, the balance may be automatically transferred to your credit card or billed directly to you. Any subsequent visits must be paid in full at the time the services are rendered. Please be aware that some insurance companies, including Medicare, may determine treatment to be non-covered or find it not to be reasonable or necessary. If such a determination is made, you will be responsible for such services. Such services will be billed and payment is due upon receipt of bill.

Regarding insurance plans where we are a participating provider: All co-pays and deductibles are due at the time of treatment. If there are any additional procedures performed, they may be subject to an additional **Co-Payment, Deductible or Co-Insurance.** Please refer to your HealthCare Plan for additional information. In the event that your insurance coverage changes to a plan where we are not a participating provider, refer to the above paragraph.

Usual and customary rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of what constitutes a usual and customary rate.

Minor patients: The adults accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless

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charges have been pre-authorized to an approved credit plan, Visa, MasterCard, Discover or payment by cash or check at the time of service has been verified.

Missed appointment: Unless canceled at least 24 hours in advance, you may be subject to $25.00 no-show fee at the physician's discretion. Please help us serve you by keeping scheduled appointments.

Co-pays and Balances: Co-pays are due at the time of service. If we need to bill you for the co-pay, there will be an additional $5.00 processing fee. You will also be asked to pay any outstanding patient balance.

Insufficient Fund Fee: Checks that are returned will be charged a $45.00 insufficient funds fee.

Collection Fee: Unpaid balances may be turned over to an outside collection agency. In the event your account is turned over for collections, you as the patient will be responsible for all fees and costs associated with collecting the balance.

Thank you for understanding our ***Financial Policy***. Please let us know if you have any questions or concerns.

I have read the *Financial Policy* and I understand and agree to its provisions.

_____ Date_____

Signature of patient or responsible party

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E-PRESCRIBING/MEDICATION HISTORY CONSENT FORM e-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e- Prescribe program. These include:

- **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Victory Medical Clinic, PA can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. Understanding all of the above, I hereby provide informed consent to Victory Medical Clinic, PA to enroll me in the e-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name: _____ Patient DOB: _____

Signature of Patient or Guardian: _____ Date: _____

Relationship to Patient: _____

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Authorization of Use and Disclosure of Protected Health Information

Patient Name: _____

Date of Birth: _____ SSN: _____

I. My Authorization

You, Victory Medical Clinic may use or disclose the following health care information:

ALL my health information maintained by you.

My health information relating to the following treatment or condition: _____

My health information for the date(s):_____

Other: _____

You may disclose this health information to:

Name (or title) and organization: _____

Relationship: (parent, child, sibling, legal guardian, etc,):

_____

Name (or title) and organization: _____

Relationship: (parent, child, sibling, legal guardian, etc,):

_____

Name (or title) and organization: _____

Relationship: (parent, child, sibling, legal guardian, etc,):

_____

This Authorization ends: on (date) _____

When the following event occurs _____

II. My Rights

I understand I do not have to sign this authorization in order to receive treatment. However, I may be required to sign this authorization form:

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☐ To take part in a research study; or

☐ To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization at any time, in writing, sent to Victory Medical Clinic at the address provided below. If I do, it will not affect any actions already taken by Victory Medical Clinic based upon this authorization; uses and disclosures already made cannot be taken back. I may not be able to revoke this authorization if its purpose was to obtain insurance.

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Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____

Patient or legally authorized signature Date

Patient is unable to sign because of (minor, disability, etc) _____

Please check the appropriate box if you or any of your blood relatives have ever had any of the listed conditions:

CONDITION	YOU	RELATIVE	CONDITION	YOU	RELATIVE
DIABETES			ANEMIA		
HIGH BLOOD PRESSURE			LEUKEMIA		
STROKE			SICKLE CELL		
HEART ATTACK			BLEEDING PROBLEMS		
ASTHMA			STOMACH ULCER		
MIGRAINE HEADACHES			GALLSTONES		
CANCER			SEIZURES		
EMPHYSEMA			TUBERCULOSIS		
KIDNEY PROBLEMS			ALCOHOLISM		
ARTHRITIS			SUICIDE		
GLAUCOMA / EYE PROBLEMS			DEPRESSION		
SKIN RASH			MENTAL ILLNESS		
OTHER			OTHER		

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OPERATIONS / SURGERIES:

_____
_____
_____

Please check the appropriate box if you or any of your blood relatives have ever had any of the listed condit
OPERATIONS / SURGERIES:

_____
_____
_____

Last Colonoscopy:_____
OTHER HOSPITALIZATIONS:

_____
_____

BLOOD TRANSFUSIONS:

_____

MEDICATIONS: _____ _____

Last Pneumonia Vaccine(Pneumovax or Prevnar):_____

Last Flu Vaccine:_____

ALLERGIES: (Any reaction to any medication of any kind?)

_____

OCCUPATION / WORK HISTORY:

_____

Any exposure to pesticides, chemicals, or other hazards? YES _____ NO _____
If yes, What kind?

_____

Family / Household: (Who lives at home with

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you?)_____
_____

HABITS: Cigarettes: _____ PPD ____ X _____ years Quit in _____ (year)
Other Tobacco Products? _____ Alcohol
_____
Drug Use _____ Caffeine
(coffee/colas)_____
Seat Belt Use: Yes: _____ No _____ Exercise: _____

FOR WOMEN ONLY

Age of first menstrual period _____ How many days between periods?
_____
How many days does it last? _____ Is bleeding heavy or light?
_____
Date of last menstrual period _____ Was it normal?
_____
If menstrual periods have stopped, have you had any bleeding since?
_____
Any Vaginal Discharge? Yes _____ No _____
Method of Preventing Pregnancy
_____
Pregnancies _____ Births _____ Abortions/Miscarriages
_____
Last Mammogram:_____Last Bone Density:_____
Last Pap Smear: _____
Any other concerns?
_____
_____
_____

Name: _____
Social Security: _____
Birth Date: _____

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Private Practices describes how e may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. I t also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

 Treatment: We will use and disclose your protected health information to provided, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care for you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

 Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

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 Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities included, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration area desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations **without** your authorization. These situations include:
As Required By Law Military Activity and National Security
Public Health issues as required by law Workers' Compensation
Communicable Diseases Inmates
Health Oversight Required Uses and Disclosures
Abuse or Neglect Criminal Activity
Food and Drug Administration requirements Research
Law Enforcement Legal Proceedings
Coroners, Funeral Directors, and Organ Donation
Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

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2. Your Rights

Following is a statement of your rights with respect to your protected health information and how you may exercise these rights.

 Inspect and Copy your protected health information: Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action proceeding, and protected health information that is subject to law that prohibits access to protected health information.

 Request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If your provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

 Request to receive confidential communications from us by alternate means or at an alternate location: upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

 Have a physician amend your protected health information: If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such a rebuttal.

 Receive an accounting of certain disclosures we have made, if any.

 Obtain a copy of this notice from us.

3. Complaints:

VICTORY MEDICAL CLINIC LLC.

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You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Practice Manager, telephone 862-254-2299. **We will not retaliate against you for filing a complaint.**
Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity unless required by law.

You may revoke this authorization, at any time, in writing, except that your physician or physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdrawal as provided in this notice.

This notice was published and becomes effective on/or before **August 08, 2016.**

Signature below is only acknowledgement that you have received this notice of our Privacy Practices:

Print Name: _____
Signature: _____
Date: _____