TYSONS INTERNAL MEDICINE & WELLNESS CENTER

First name _____ Last Name: _____ Sex: M ( ) F ( )

Address_____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ Email _____

DOB: Month_____ Day___Year _____ Race: _____ Marital Status: _____

Employer _____ Address _____

Phone _____ Occupation _____ Education _ _____

IN CASE OF EMERGENCY NOTIFY:

First Name: _____ Last Name: _____ Relationship to patient: _____

Home phone: _____ Cell phone: _____

INSURANCE:

Insurance Name: _____ Policy Holder: _____

Member ID: _____ Group number: _____

1. Tysons Internal Medicine and Wellness Center does not guarantee insurance coverage as payment.
2. If your insurance company does not settle your claim within 90 days of claim submission, then you will be billed for the services.
3. All non-covered services need to be paid at time of visit.
4. All co-payments need to be paid at the time of the visit.
5. There will be **a $50 charge** for any missed appointment without **24 hour cancellation notice.**

Signature _____ Date _____

PAST MEDICAL HISTORY (Please check all that apply)

( ) Abnormal Mammogram	( ) Cancer	( ) Heart Disease	( ) Mental Illness _____
( ) Abnormal Menstruation	( ) Chronic Headache	( ) Hernia	( ) Prostate Disease
( ) Abnormal Pap Smear	( ) Circulation Problem	( ) High Blood Pressure	( ) Rheumatoid Arthritis
( ) Abnormal T.B. test	( ) Colon Polyp	( ) High Cholesterol	( ) Seizure or Epilepsy
( ) Acid reflux	( ) Depression	( ) Hemorrhoids	( ) Sexually Transmitted Disease
( ) Active Tuberculosis (T.B.	( ) Diabetes	( ) HIV or AIDS	( ) Skin disease _____
( ) Allergies/Hay Fever	( ) Diverticulosis	( ) Intravenous Drug Use	( ) Stomach Ulcer
( ) Anemia	( ) Dialysis	( ) Liver Disease/Hepatitis	( ) Stroke
( ) Asthma	( ) Eating Disorder	( ) Lung Disease	( ) Thyroid Disease
( ) Blood Product Transfusion	( ) Gall Bladder Disease	( ) Lupus	( )Other_____

FAMILY HISTORY: (Please check all that apply and indicate relationship to family member)

( ) Asthma	( ) Depression	( ) High Cholesterol	( ) Prostate Cancer	( ) Tuberculosis
( ) Bleeding Disorder	( ) Diabetes	( ) Mental Illness	( ) Skin Cancer	( ) Thyroid Disease
( ) Breast Cancer	( ) Heart Attack	( ) Osteoporosis	( ) Stroke	( ) Other _____
( ) Colon/Rectal Cancer		( ) High Blood Pressure		( ) Ovarian Cancer

MEDICATIONS: List current medications and doses (incl. birth control or shots, non- prescription drugs, vitamins, supplements, ointments, creams, nasal sprays, inhalers and eye drops_____

_____

_____

HOSPITALIZATIONS/MAJOR EVENTS _____

_____

_____

ALLERGIES to any medications (please list): _____

Allergic to: ( ) Latex ( ) Iodine/Dye ( ) Metal ( ) Food Allergies _____

PREVENTIVE CARE: Check and date all that apply: ( ) Mammogram _____ ( ) Pap Smear _____

( ) DEXA Scan _____ ( ) Colonoscopy _____ ( ) Physical _____

( ) Last Dental Exam _____ ( ) Last Eye Exam _____

IMMUNIZATIONS: (Check if you had the disease or received the vaccine and list the year)

( ) Diptheria/Tetanus _____
( ) Hepatitis A _____
( ) Hepatitis B _____
( ) Gardisil (HPV Vaccine) _____
( ) Influenza _____
( ) Measles/Mumps German Measles _____
( ) Meningitis _____
( ) Pneumonia _____
( ) Polio _____
( ) Small Pox _____
( ) T.B.Skin Test _____
Result: Positive/negative
Treatment: _____
( ) Zostavax _____

Height _____ Weight _____

SOCIAL HISTORY

Marital Status: _____ Children: _____ Occupation _____

Smoking Status ( ) Never smoked ( ) Now smoking ( ) Used to smoke ( ) Chew Tobacco

If smoking _____ cigarettes/packs per day/week

Alcohol type _____ Amount _____ per day/week

Street drugs including marijuana, cocaine, heroin and other mood altering drugs or pills _____

Caffeinated beverages (coffee, tea, soda, etc.) _____ per day/week Guns in the home? ( ) Y ( ) N

Do you consistently wear seatbelts? ( ) Y ( ) N

Sexual orientation ( ) Heterosexual ( ) Homosexual ( ) Bisexual ( ) Other

Do you eat well? _____ How do you feel about your weight? _____

Exercise type _____ How often? _____

Are you an organ donor? ( ) Y ( ) N Do you have a living will? ( ) Y ( ) N

FEMALES ONLY

Menstruation: Age of onset _____ Flow: ( ) regular ( ) irregular ( )heavy ( ) moderate ( ) light

Number of pregnancies _____ Last Pap Smear ( ) normal ( ) abnormal

Number of live births _____ Last Mammogram ( ) normal ( ) abnormal

Number of abortions _____ Number of ectopic pregnancies _____

Number of miscarriages _____ Age at first pregnancy _____

Are you currently pregnant? ( ) Y ( ) N Are you breastfeeding? ( ) Y ( ) N

Any post-menopausal vaginal bleeding? ( ) Y ( ) N

MALES ONLY

Do you practice testicular self- exam? ( ) Y ( ) N Do you have urinary frequency? ( ) Y ( ) N

Is there a history of impotence? ( ) Y ( ) N Do you awaken at night to urinate? ( ) Y ( ) N

Do you have a urethral (penile) discharge? ( ) Y ( ) N Do you regularly use condoms? ( ) Y ( ) N

Concerns/ Comments:

Patient Signature: _____ **Date:** _____

☐ I acknowledge this history is correct and complete.

NOTICE OF PRIVACY PRACTICES

Our Promise!

Dear Patient,

This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA – Health Insurance Portability and Accountability Act) Laws written to protect the confidentially of your health information seriously. We do not ever want you to delay treatment because you're afraid your personal health history might be unnecessarily made available to others outside of your office.

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for those purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

How your HEALTH INFORMATION may be used

To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between physician assistant, nurse, physician and business office staff. In addition we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for the treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed may be reviewed during the routine process of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and curative care modern medicine can provide. They may include post cards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

Abuse or Neglect

Because we will notify government authorities if we believe a patient is a victim of abuse, neglect, or domestic violence. We will make this disclosure only when we are compelled by our ethical judgement, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete and investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects a drug treatment or medical device.

For Law Enforcement

As permitted or required by State of Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including , under certain limited circumstances, if you are the victim of a crime in order to report a crime

Family, Friends or Caregivers

We may share your health information with those you tell us will be healing you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In case of emergency, where you are unable to tell us what you want, we will use only our best judgement when sharing your health information only when it will be important to those participating in providing your care.

To Coroners, Funeral Directors and Medical Examiners

We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for a funeral.

Medical Research

Advancing medical knowledge often involves learning from the careful study of medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval of an Institutional Review Board.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Rights

The new law is careful to describe that you have the following rights related to your health information.

Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communication

You have the right to request that we communicate with you in a certain way. You may request that we on communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change. Your request may be denied if the health information record in question was not created by pour office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stoop by or give us a call and we will mail or email a copy to you. We are required by law to maintain the privacy of your health information and to provide to you and your represenatives this Notice of Privacy Practices.

We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices, we will be sure all of our patients receive a copy of the revised Notice. You have the right to express complaints to us or the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

PATIENT ACKNOWLEDGEMENT

PATIENT Name(s): _____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions, we want to hear from you. If not we would appreciate very much your acknowledging your receipt of your policy by signing and returning this card. We look forward to seeing you again soon!

Patient Signature: _____ Date: _____/_____/_____