Bon Secours
Medical Group

Place patient label inside box (if no patient label, complete below)

Name: _____

DOB: _____

MR #: _____

PRACTICE NAME: _____

PATIENT INFORMATION

PATIENT NAME: _____
Last First Middle

HOME ADDRESS: _____

ZIP CODE: _____ **CITY:** _____ **STATE:** _____

MAILING ADDRESS: (☐ same as above) _____

ZIP CODE: _____ **CITY:** _____ **STATE:** _____

HOME PHONE: (____)_____ **WORK PHONE:** (____)_____ **CELL PHONE:** (____)_____

DATE OF BIRTH: _____ **SOCIAL SECURITY NUMBER:** _____

MARITAL STATUS: _____ **CONTACT PREFERENCE:** _____

GENDER: _____ **RACE:** _____ **ETHNICITY:** _____

LANGUAGE: _____ **RELIGIOUS PREFERENCE:** _____

PRIMARY CARE PHYSICIAN: _____ **REFERRED BY:** _____

EMPLOYER: _____ **PHONE #:** (____)_____

EMAIL: _____ ☐ No E-Mail ☐ Declines to Provide

HOW DID YOU HEAR ABOUT US? _____

GUARANTOR INFORMATION *(name of person to whom financial statements are sent)*

GUARANTOR NAME: _____
Last First Middle

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

HOME PHONE: (____)_____ **DATE OF BIRTH:** _____ **SOCIAL SECURITY NUMBER:** _____

INSURANCE POLICY INFORMATION

PATIENT RELATIONSHIP TO POLICY HOLDER: (circle one) **SELF** **SPOUSE** CHILD OTHER

PRIMARY POLICY HOLDER DATE OF BIRTH: _____

SECONDARY PATIENT RELATIONSHIP TO POLICY HOLDER: (circle one) **SELF** **SPOUSE** **CHILD** **OTHER**

SECONDARY POLICY HOLDER DATE OF BIRTH: _____

EMERGENCY CONTACT INFORMATION

NAME: _____ **RELATIONSHIP:** _____

HOME PHONE: (_____)_____ **CELL PHONE:** (_____)_____

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE: _____ **DATE:** _____

Bon Secours
Medical Group

Place patient label inside box (if no patient label, complete below)
Name: _____
DOB: _____
MR #: _____

Practice Name: _____

Authorization for Treatment

- I hereby authorize medical treatment by the physician, the clinical staff and technical employees assigned to my care.
- I authorize my treating providers to order any ancillary services, such as laboratory or radiology tests, or any other services or treatments deemed necessary for my care and safety.
- I understand that I have the right and the opportunity to discuss alternative plans of treatment with my physician or other healthcare provider and to ask and have answered to my satisfaction any questions or concerns before treatment is provided.
- In the event that a healthcare worker is exposed to my blood or body fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus, or hepatitis C virus, I consent to the testing of my blood and/or body fluids for these infections and the reporting of my test results to the health care worker who has been exposed, as required by Virginia law.
- I understand that Bon Secours Health System utilizes an electronic medical record system.
- I understand that Bon Secours Health System utilizes an electronic prescribing mechanism for electronic transmission of prescriptions and that any medications my physician prescribes for me may be communicated electronically through any local or mail order pharmacy I have designated.
- I authorize the release of my prescription history to my Bon Secours Health System physician from any pharmacy or drug monitoring agency.

Payment Arrangements

- I agree to accept financial responsibility for the payment of the costs of health care services provided to me and my dependent(s) by or on behalf of Bon Secours Health System.
- By signing this document, I authorize the assignment to the Medical Practice of all payments under any insurance benefits otherwise payable to me for services provided under any insurance policy (hospitalization, major medical, workers' compensation, or any other insurance or benefit plan).
- I agree to pay, at the time of service, any required co-payments, co-insurance and deductibles, as well as charges for services provided by Bon Secours Health System which are not covered by my insurance.
- I understand that all unpaid balances will be billed to my address on file with this office and that I am responsible for updating my registration information as necessary.
- I understand that I am responsible for paying the balance of my bill in full unless other arrangements have been approved in advance.
- I understand that there is a $20 charge for any check returned by my bank.
- I understand that any past due amount owed on my account may be referred to a collection agency, and that I will be responsible for all collection charges and associated legal fees, in addition to the full balance on my account.
- By signing this document, I agree that photocopies of this document are as legally binding as the original.

This Authorization for Treatment is a legal document and no modifications may be made to it without the written approval of an authorized Bon Secours Health System employee. By signing below, I acknowledge that I have read, understand and agree to the above terms.

Patient or Guarantor Signature	Printed Name	Relationship to Patient	Date	Time

Bon Secours
Medical Group

Practice Name: _____

Place patient label inside box (if no patient label, complete below)

Name: _____

DOB: _____

MR #: _____

BON SECOURS HAMPTON ROADS HEALTH SYSTEM
NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the Bon Secours Hampton Roads Health System "Notice of Privacy Practices". Our "Notice of Privacy Practices" provides information about how we may use and disclose your protected health information, as well as your rights with respect to your protected health information. We encourage you to read it in full.

Our "Notice of Privacy Practices" is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing our website at http://www.bshr.com, or by asking for a copy of the Notice at your next visit to our facility.

_____ _____

[Signature of patient or legal representative] [Date of Receipt]

_____

[Printed Name of patient or legal representative]

If signed by someone other than the patient, indicate relationship to the patient: _____

For Office Use Only:
Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained.

Good faith efforts. Please describe:

Reasons why acknowledgement was not obtained:

- ☐ Patient/legal representative refused to sign this acknowledgement even though the patient/legal representative was asked to do so and the Notice of Privacy Practices was provided to the patient/legal representative.
- ☐ Signature not obtained due to patient incapacitation/emergency situation.
- ☐ Other. Please describe:

I personally delivered the Notice of Privacy Practices to the patient listed above. A written acknowledgement of receipt by the patient was not obtained as noted above.

_____ _____

[Signature of Staff Member] [Date of Receipt]

_____

[Printed Name of Staff Member]

Bon Secours

Patient Name: _____

DOB: _____

MR #: _____

Patient Email and Text Message Informed Consent

Bon Secours Health System, Inc. and its affiliates, agents, independent contractors and any "covered entity" or "business associate" (as those terms are defined in the HIPAA Privacy Rule) with which your information may be shared under HIPAA (collectively, "Bon Secours") may communicate with you by e-mail, text message, and/or other forms of unencrypted electronic communication (together, "Electronic Messaging") to the telephone number(s), email address(es) or other locations reflected on your account or as otherwise provided below. This form provides information about Bon Secours' use, risks, and conditions of Electronic Messaging. It also will be used to document your consent for Bon Secours' communication with you by Electronic Messaging.

How we will use Electronic Messaging: Bon Secours may use Electronic Messaging to communicate with you regarding a wide range of healthcare related issues, including:

- reminders of appointments or actions for you to take before an appointment, follow-ups from appointments, and notices about preventive services, treatment options, coordination of your care and other available health services;
- how to participate in patient satisfaction surveys or how to use our secure patient portal (MyChart); and
- information regarding insurance, billing, eligibility for programs/benefits, and account balances.

Bon Secours may use automatic dialers or pre-recorded voice messages when it communicates with you through Electronic Messaging. All Electronic Messaging may be made a part of your medical record.

Risk of using Electronic Messaging: Electronic Messaging has a number of risks that you should consider, including:

- Electronic Messaging can be circulated, forwarded, sent to unintended recipients, and stored electronically and/or on paper.
- Senders can easily misaddress Electronic Messaging and send the information to an unintended recipient.
- Backup copies of Electronic Messaging may exist even after deletion.
- Electronic Messaging may not be secure and can possibly be intercepted, altered, forwarded or used without authorization or detection.
- Electronic Messaging service providers may charge for calls or messages received.
- Employers and online providers have a right to inspect Electronic Messaging sent through their company systems.
- Electronic Messaging can be used as evidence in court.

Conditions for the use of Electronic Messaging: Bon Secours cannot guarantee, but will use reasonable means to maintain, the security and confidentiality of the messages we send. By signing where indicated below, you acknowledge your consent to the use of Electronic Messaging on the following conditions:

- **IN A MEDICAL EMERGENCY, DO NOT USE ELECTRONIC MESSAGING, CALL 911.** Urgent messages or needs should be relayed to us by using regular telephone communication. Non-urgent messages or needs should be relayed to us by using regular telephone communication or our secure patient portal, MyChart.
- Electronic Messaging may be filed into your medical record.
- Bon Secours is not liable for breaches of confidentiality caused by you or any third party.
- You are solely responsible for any charges incurred under your agreement with your Electronic Messaging service provider (for example, on a per minute, per message, per unit-of-data-received basis or otherwise).

Expiration and Withdrawal of Consent: Unless you earlier withdraw your consent, this consent will expire upon the end of your treatment relationship with Bon Secours. You may choose to stop participating in Electronic Messaging at any time by informing Bon Secours in writing as described herein. You further understand that withdrawing this consent will not cause you to lose any benefits or rights to which you are otherwise entitled, including continued treatment, payment or enrollment or eligibility for benefits. To withdraw consent and stop participating in Electronic Messaging, please contact the BSHSI Privacy Officer or your Local Privacy Officer as described in the Notice of Privacy Practices.

Patient Acknowledgement and Agreement: I have read and fully understand this consent form. I understand the risks associated with the use of Electronic Messaging between Bon Secours and me, and I consent to the conditions and instructions outlined, as well as any other instructions that Bon Secours may impose to communicate with me by Electronic Messaging.

I understand that Bon Secours will send Electronic Messaging to those telephone number(s) and email address(es) in my account:

☐ I request to receive **text messages**

☐ I request to receive **e-mail messages**

Release. In consideration of Bon Secours' services and my request to receive Electronic Messaging as described herein, I hereby release Bon Secours from any and all claims, causes of action, lawsuits, injuries, damages, losses, liabilities or other harms resulting from or relating to the calls or messages, including but not limited to any claims, causes of action, or lawsuits based on any asserted violations of the law (including without limitation the Telephone Consumer Protection Act, the Truth in Caller ID Act, the CAN-SPAM Act, the Fair Debt Collection Practices Act, the Fair Credit Reporting Act, the Health Insurance Portability and Accountability Act, any similar state and local acts or statutes, and any federal or state tort or consumer protection laws).

_____ _____ _____

Patient (or Authorized Representative) Signature **Patient's Printed Name** **Date**

BON SECOURS MEDICAL GROUP
Bon Secours Virginia Health System

Permission to Disclose Private Health Information (PHI)

Patient Name:_____DOB: _____

By signing this paper below, I give permission to the person(s) listed in the table documented to receive Private Health Information or other authorization as listed in the comments section. I understand this form is legally binding and that I may revoke my authorization at any time by submitting by request to change, add, or terminate such permission in writing.

Date of Permission	Name of Individual	Comments/Instructions (i.e.; may pick up meds)	Parent/ Guardian Initials	Date Permission Revoked	Parent/ Guardian Initials	Telephone Number

In order to obtain information by telephone, the party calling the practice must be able to share the patient identifier/password with the staff.

Patient Identifier/Password:_____

Signature of Patient or Legal Guardian_____Date _____ Time_____

Printed Name of Patient or Legal Guardian_____Relationship (if not self) _____

Southampton Orthopaedic & Sports Medicine Center

Manish A. Patel, MD, FAAOS

Board Certified – American Board of Orthopaedic Surgeons
Assistant Professor of Clinical Orthopaedic Surgery EVMS
Arthroscopic Surgery – Sports Medicine – Joint Replacement

Phone: 757-562-7301 www.SouthamptonOrtho.com **Fax: 757-562-7305**

New Patient Complaint / Injury

First Name:_____ Last Name:_____ Today's Date:_____

Date of Birth: _____ Age: ____ Height:_____ Weight: _____ Sex: M or F

Please **Circle** affected extremity: **Left** **Right** **Both**

Shoulder	Arm	Elbow	Forearm	Wrist	Hand	Finger	Back
Hip	Thigh	Knee	Leg	Ankle	Foot	Toes	Neck

Is Your pain (Circle): Sharp Dull Throbbing Stabbing Burning Numbness **NONE**

How and When did this injury / problem begin? (**Be specific**)

_____

Is your Pain? (Circle One) **Better** **Worse** **Same** compared to your initial pain.

What has helped? I What makes it worse?
I

Please rate your pain level Using 0 (None) to 10 (Severe) [**0 1 2 3 4 5 6 7 8 9 10**]

Review of Systems:

Musculoskeletal: **Circle** any that apply to you or **Circle NONE**

Fractures	Joint Swelling	Joint Infections	Locking
Stiffness	Night Time Pain	Instability	**NONE**

Constitutional: **Circle** any that apply to you or **Circle NONE**

Weight Gain	Weight Loss	Fever	Chills	Fatigue
Weakness	Night Sweats	Insomnia	**NONE**	

Is this a Work Related Injury? (Answer Must be Circled)	**YES**	**NO**
Was this related to a Motor Vehicle Accident?	**YES**	**NO**
Is there a LAWSUIT involved? (Answer Must be Circled)	**YES**	**NO**

Have you been treated previously for this problem? **YES** **NO**

Physician: _____ Hospital:_____ City:_____

Circle **ALL** previous testing for the **CURRENT** problem:

X-ray	Cat Scan	MRI	Physical Therapy	DVT Study
Injections	Surgery	EMG	Bone Scan	**NONE**

Have you received you COVID 19 vaccination? YES OR NO Date_____

(PLEASE SIGN) Patient or Guardian Signature _____

First Name: _____ Last Name: _____ Today's Date: _____

Who is your Family Doctor? _____

Please list the consulting Doctor? _____

Do you have any of the following medical conditions? (**Circle** all that apply or **NONE**)

High Blood Pressure	Kidney Disease	Hepatitis
Lung Disease	Asthma	Bleeding Disorder
Sickle Cell	Osteoporosis	Diabetes
Poor Healing	Reflux / Ulcers	Heart Disease / Problems
High Cholesterol	Thyroid Problems	HIV / AIDS
Rheumatoid Arthritis	Osteoarthritis	Gout
Cancer	**NONE**	Other: _____

Please indicate any major health conditions that your immediate family members have:

Relationship: _____ Medical Condition: _____ Died at age: ____
Relationship: _____ Medical Condition: _____ Died at age: ____
Relationship: _____ Medical Condition: _____ Died at age: ____
Relationship: _____ Medical Condition: _____ Died at age: ____

Please List **ALL** supplements / medications, dosages, and frequencies that you take or **NONE**:

_____
_____

Do you take any blood thinners? NO or YES (List if yes) _____
Please list **ALL** allergies: **NONE** or YES (if yes, list medication and type of reaction):

Please list any and all previous surgeries or **NONE**. (Include date and surgeon):

Smoking Status (Circle one): Never Former Smoker Current Smoker
If current smoker, how many packs a day: _____
Smokeless Tobacco: _____Yes _____No

Do you drink alcohol: _____Yes _____No
If yes, how often? _____

What Pharmacy do you use? _____Location: _____

DEPRESSION SCREENING: Mental Health
Do you have little interest or pleasure in doing things? 0=Not at all, 1=Several Days, 2=More than half the days, or 3=Nearly everyday

Are you feeling down, depressed, irritable, or hopeless? 0=Not at all, 1=Several Days 2=More than half the days, or 3=Nearly everyday

(PLEASE SIGN) Patient or Guardian Signature: _____

Patient Name: _____ DOB: _____

BSHSI LEARNING ASSESSMENT

Who is the primary learner? (Responsible for your care) _____

What is the preferred language for health care of the primary learner? _____

How does the primary learner prefer to learn new concepts? Ex: demonstration, listening, pictures, reading, videos - _____

Answered by: _____

Relationship to learner - _____

Highest level of education completed by primary learner? _____

Are there any special topics the patient would like to review?

_____