Family Health Clinic

600 Randolph St. Radford, VA 24141

P: 540-639-5300 F: 540-639-4653

CHARLES R. JUDY, M.D IDA SUTHERLAND, D.N.P JESSICA WINDLE MSN, RN, FNP-BC

Registration Form

Today's Date: ______________ Preferred Name: __________ Email: ________________

Patient's Last Name: First Name: Middle Name:

________________ ________________ _______________

Date of Birth: _____________ Gender: _________ Race: ____________

Mailing Address: ____

Physical Address: ____

Preferred Pharmacy & Location: ____

Home Phone no: ___________________________

Social Security No: ________________ Cell Phone no: ___________________________

Marital Status: _____ Spouse Name: ___________ Preferred phone no: _________________

Spouse DOB: ___________ Phone No: _____________ Work phone no: ________________

Insurance Information

(Please give your Insurance Card to the receptionist)

Primary Insurance: __________________

Subscriber's Name: ______________ DOB: ___________ Policy no: ________________

Patient's Relationship to Subscriber: _____________________

Name of Secondary Insurance: ________________________

Subscriber's Name: ________________ Policy No: _____________________

In Case of Emergency

Name of Emergency Contact: Relationship to Patient: DOB: Phone no:

______________________ __________________ ___________ _______________

To the best of my knowledge the above information is accurate. I understand that it is my responsibility to acquire any authorizations required by my insurance carrier prior to receiving services. If benefits are denied, I understand that I am responsible for the balances of services rendered.

(Initial) _______

FAMILY HEALTH CLINIC, INC
600 RANDOLPH ST RADFORD VA, 24141
PHONE: 540-639-5300 FAX: 540-639-4653

Ida E. Sutherland, DNP, RN-BC, FNP-BC ~ Charles R. Judy, M.D., F.A.A.F.P. ~ Jessica Windle,FNP-BC, MSN,RN.

Patient Consent to the Use and Disclose of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health care, FAMILY HEALTH CLINIC, INC. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

* A 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 following rights and privileges:

* The right to review the notice prior to signing the consent.
* The right to object to the use of my health information for directory purposes, and
* The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that FAMILY HEALTH CLINIC, INC. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that FAMILY HEALTH CLINIC, INC. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should FAMILY HEALTH CLINIC, INC. change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email.).

I wish to have the following restrictions to the use or disclosure of my health insurance:______________________________

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

______________________	__________________	__________________
Patient Signature	DOB	Date

To the best of my knowledge the above information is accurate. Family Health Clinic, IN participates in Virginia's Prescription Monitoring Program and has unlimited access to prescription history._____(Initial)

I understand that the laws of Virginia provide my physician, or any person employed or under direction of my physician(s), is directly exposed to bodily fluids in any manner which may, according to the 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 be deemed to have consented release of these test results to the person who is exposed to my body fluids.

______________________	__________________
Patient Signature	Date

********************************FOR OFFICE USE ONLY**********************************

[ ] Consent received by ________________________________ on ______________________

[ ] Consent refused by patient, and treatment refused as permitted.

Family Health Clinic, Inc.

Ida E. Sutherland, D.N.P. Charles R. Judy, M.D Jessica Windle, FNP-BC

FINANCIAL POLICY

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship.

ALL CO-PAYS ARE DUE AT TIME OF SERVICE

All NEW self-pay patients must pay fees at time of service. No exceptions made.

ESTABLISHED SELF-PAY PATIENT- All fees are due at the time services are rendered unless other arrangements are made prior to appointment date.

We participate with multiple insurance companies, and Medicaid and Medicare, and will balance bill for all unpaid services after those insurances have made their allowed determination. Balances must be paid by the due date listed on your bill. Call your insurance carrier if you question covered services.

If we are not participants in your carrier's network, or if your carrier misrepresents itself or our participation with its network, we do not accept responsibility for reducing fees. We care about our patients and would not wish hardship for them or their families. If circumstances exist that make payment in full impossible at the time of service, notify the receptionist that you wish to discuss payment arrangements.

There is a $35.00 service fee for any returned or cancelled check after services are rendered.

Billing and collections efforts add administrative cost to all patients' fees. Please do your part to keep costs down. Bills are mailed monthly and payment is due within 15 days of statement date. Please do not ignore billing and collection attempts. Out of fairness to our paying patients, and in compliance with our contractual obligations with your insurance carrier, we must actively pursue all past due accounts to include referring account to our selected collection agency.
Due to the decreased fees from insurance companies, Medicare and Medicaid, we have had to adopt this collection policy to ensure the same quality of medical care services to all our patients.

FAMILY HEALTH CLINIC FOLLOWS A STRICT FORMAL SECURITY AWARENESS POLICY REGARDING CREDIT CARD INFORMATION. AT NO TIME IS A PATIENT'S CREDIT CARD INFORMATION TRANSMITTED VIA EMAIL, INSTANT MESSAGING OR ANY OTHER INTERNET FORM. ALL CREDIT CARDS RECEIVED FROM PATIENTS ARE PROCESSED THROUGH A SAFE-PROTECTED CREDIT CARD MACHINE AND GIVEN TO THE BILLING DEPARTMENT TO BE STORED IN A SECURED LOCK BOX. FURTHERMORE, NO CREDIT CARD INFORMATION IS TO BE DISCUSSED WITH ANYONE BUT THE PATIENT OR THEIR LEGAL GUARDIAN.

I, ______________________________, understand and agree with the terms
(PRINT NAME)
of this financial agreement. I understand this financial agreement covers all dates of service at Family Health Clinic, Inc.

______________________________ ______________________
PATIENT (OR GUARDIAN) SIGNATURE DATE

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Charles R. Judy, M.D. **Ida Sutherland, D.N.P** **Jessica Windle MSN, RN, FNP-BC**

MEDICAL HISTORY

Today's Date: ______________ Former PCP: ____________________________

Patient Information

Patient's Last Name: ______________ First: ________________ Middle: ______________ DOB: ______________

Known Allergies: ____

Current Medications: ____

____

Previous Surgeries:

____

HAVE YOU HAD ANY PROBLEMS WITH THE FOLLOWING? (IF SO PLEASE EXPLAIN):

Eyes:
Ears, Nose, Throat:
Skin
Thyroid:
Heart:
Arteries/ Veins:
Lungs:
Stomach/Bowels:
Liver/Pancreas:
Legs/Feet:
Anxiety/ Depression:
Bones/Muscles:
Male/Female Problems:

FAMILY HEALTH: DESCRIBE ANY ILLNESS OR DISEASES THAT FAMILY MEMBERS HAVE BEEN DIAGNOSED WITH:

MOTHER: ____

Father: ____

Brothers/ Sisters: ____

Grandparents: ____

Spouse:

____

Children:

____

Any family members that are current patients: ____

SOCIAL HISTORY: (DESCRIBE WEEKLY USAGE):

Tobacco:
Caffeine:
Alcohol:
Illicit Drugs:

IMMUNIZATIONS: (TYPE OF VACCINE & DATE):

Tetanus:	Shingles:
Pneumonia:	Flu:

FAMILY HEALTH CLINIC

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Ida E. Sutherland, DNP   Charles R. Judy, M.D.   Jessica Windle, FNP-BC

HIPAA RELEASE

Patient Name ____

Social Security # ____________________ Birthdate ________________________________

The above patient or legal guardian has received the Notice of Privacy Practices and has been provided an opportunity to review it.

Patient and/or legal guardian understands that certain restrictions may require legal documentation.

Disclosure

We have agreed to disclose (discuss) the above named patient's PHI to the following persons or entities:

1.________________________________

2.________________________________

3.________________________________

4.________________________________

Signature of Patient or Guardian,

________________________________ Date ____________

Family Health Clinic, Inc.

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________

Previous Name: ______________________ Social Security #: ______________

I request and authorize ______________ to release healthcare information of the patient named above to:

Name: Family Health Clinic
Address: 600 Randolph Street
Radford, Va 24141
Phone: 540-639-5300 Fax: 540-639-4653

This request and authorization applies to:

○ Healthcare information relating to the following treatment, condition, or dates

______________.

○ All healthcare information ○ Other ______________

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

○ Yes ○ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

○ Yes ○ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ______________________ Date signed: ______

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.