Veritas Family Medicine

DEMOGRAPHIC INFORMATION

Last Name	First Name	Middle Name	suffix	Social Security #
Gender *(Please Circle)* M or F	Date of Birth	Marital Status *(Please Circle)* Single Married Divorced Widowed Other		
Preferred Language *(Please Circle)* English Spanish Other	*Race (Please Circle)* Asian - Black/African American White - Other	Ethnicity *(Please Circle)* Hispanic Not Hispanic Unknown		
Address		State	Zip Code	
Home Phone	Cell Phone	Work Phone		
Email Address	**Your preferred PHARMACY:**			
Emergency Contact				
Last Name	First Name	Gender M or F		
Home Phone	Cell Phone	Work Phone		
Relationship to Patient:				
PRIMARY INSURANCE:				
Subscriber/Member Last Name	First Name			
Gender M or F	Date of Birth:			
Subscriber/ Member #	*Group #*			
SECONDARY INSURANCE:				
Subscriber/Member Last Name	First Name			
Gender: M or F		Date of Birth:		

FINANCIAL POLICY, ASSIGNMENT, AND RELEASE OF INFORMATION

It is our policy to inform every patient of our payment procedures, please read and mark the section below that is applicable to you.

1. **PATIENT WITH INSURANCE**

You are responsible for deductibles, copayments, noncovered services or equipment, co-insurance, and items considered 'not medically necessary' by your insurance company. Plan/insurance co-pays and deductibles/co-insurance payments are required at the time services are rendered. If you or your insurance carrier make payments exceeding your balance, reimbursements will be remitted. If payment cannot be made at your time of service, a payment arrangement will need to be put in place before service is rendered. ***Initial:*** _____

2. **Patient without insurance**

If you do not have insurance coverage, The Veritas Physicians Group expects a complete payment at each time of service. At check-in you be required to pay your visit. Any additional services provided during your visit are not included in your visits cost and are collected at checkout. ***Initial:*** _____

3. **MEDICARE PATIENT**

Our office will submit your Medicare charges to Medicare and your secondary/supplemental insurance, but you are still responsible for all deductibles, co-pays and non-covered services. ***Initial:*** _____

4. **WORKER'S COMPENSATION PATIENT**

As a worker's compensation patient, you may be covered by insurance if your injury is reported at work and verified with your employer, be sure to inform the office personnel that your injury did occur during employment, so we can best suit your needs. Any balance discrepancies will still fall under the responsibility of the patient.

Initial: _____

5. **PERSONAL INJURY MOTOR VEHICLE ACCIDENT**

If you are a person injury (motor vehicle, etc.,) patient, our office policy states that *payment is due in full at the time of service as we **do not** participate in third party billing*. You are responsible for paying for each visit in full. We will not file your health insurance for MVA claims. ***Initial:*** _____

6. **REFUNDS**

To receive a payment refund, the following criteria must be met:
There must be no outstanding insurance claims on the account & there must be no outstanding balance(s) on the patient account. If such criteria cannot be met, a refund will not be issued until the above is met. If the refund denial reason is due to an outstanding balance that is owed to the clinic, the refund amount will be applied to that balance.

Initial: _____

7. **NO SHOW FEE INCREASE**

You will be charged **a $50 No Show Fee** for any missed or no appointments. You need to give 24hr notice for cancellations to avoid fee. This needs to be paid prior to your next appointment. ***Initial:*** _____

I HAVE READ AND AGREE TO THE FINANCIAL POLICY OF THIS MEDICAL PRACTICE AND AUTHORIZE VERITAS FAMILY MEDICINE TO RELEASE TO MY INSURANCE CARRIER(S) ANY INFORMATION NEEDED TO DETERMINE BENEFITS OR BENEFITS PAYABLE FOR RELATED SERVICES.

Signature of Patient: _____ **Date:** _____

RELEASE OF INFORMATION

HIPPA NOTICES OF PRIVACY PRACTICES

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

Original Effective Date: April 14, 2003

Last Revised Date: January 31, 2025

The Health Insurance Portability' & Accountability Act of 1196 (HIPPA) is a federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept property confidential. This Act gives you, the patient, the right to understand and control how personal health information (PHI) is used. HIPPA is provided for covered entities that misuse personal health information.

As required by HIPPA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may create and distribute health information (with shared Electronic Health Records) by removing all references to individually identifiable information.

We may use and disclose your medical records only for each of the following purposes, treatment, payments and health care operations.

- Treatments mean providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring to a different specialist.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing, or collections activities and utilizations review. An example of this would be to include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, public health and safety issues, health research, state and federal law compliance, organ and tissue donation requests with medical examiner or funeral director, worker's compensation, law enforcement, government request and lawsuit/legal actions. .

The following use and disclosures of PHI (Patient Health Information) will only be made pursuant to us receiving written authorization from you:

- Most uses and disclosures of Psychotherapy notes use and disclosure of your PHI (Protected Health Information) for marketing purposes, including subsidized treatment and health care operations.
- Disclosure that constitutes a sale of PHI (Patient Health Information) under HIPPA
- Other uses and disclosures not described in this notice

You may revoke such authorizations in writing, and we are required to honor and abide by that written request; except to the extent that we have already taken actions relying on your authorization.

NOTICE OF PRIVACY PRACTICES CONTINUED

You may have the following rights with respect to your Protected Health Information

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a restrictions request except to limited circumstances which we shall explain if you ask. If we do agree to the restrictions, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information.
- The right to inspect and copy your PHI
- The right to have your PHI amended
- The right to receive an accounting of disclosures of our PHI
- The right to obtain paper copy of the notices
- The right to be activated if your unprotested PHI is intentionally or unintentionally disclosed
- The right to be advised if your unprotected PHI intentionally or unintentionally disclosed

If you have paid for services "out of pocket" in full request that we do not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

This notice is effective as of January 1, 2025, and it is our intention to abide by the terms of those Notice of Privacy Practices and HIPPA Regulations currently in effect. We reserve the right to change the terms of Notice of Privacy Practices and to make the new notice provision effective for all PHI that we maintain.

HIPPA ADDITIONAL AUTHORIZED POINTS OF CONTACT

I GIVE PERMISSION TO Veritas Family Medicine to DISCLOSE AND DISCUSS ANY INFORMATION RELATED TO MY MEDICAL CONDITION(S) &/OR BILLING TO/WTTH THE FOLLOWING PEOPLE(S):

NAME: _____ **RELATIONSHIP:** _____ **PHONE:** _____

NAME: _____ **RELATIONSHIP:** _____ **PHONE:** _____

NAME: _____ **RELATIONSHIP:** _____ **PHONE:** _____

BLANK LINES MEANS I DO NOT WISH TO GIVE PERMISSION FOR MY HEALTH INFORMATION TO BE DISCLOSED AND DISCUSSED WITH ANY OTHER PEOPLE.

THE DURATION OF THIS AUTHORIZATION IS INDEFINITE UNLESS OTHERWISE REVOKED IN WRITING. I UNDERSTAND THAT REQUESTS FOR MEDICAL INFORMATION FROM PERSONS LISTED ABOVE IS AUTHORIZED BY ME SIGNING BELOW.

I ACKNOWLEDGE THAT I WAS PROVIDED NOTICE OF PRIVACY PRACTICES OF THIS MEDICAL PRACTICE.

PATIENT SIGNATURE: _____ **DATE:** _____

Patient History

NAME: _____ DOB: _____

ALLERGIES: _____

MEDICATIONS: *List all current medications prescription & non-prescription*

	Medication	Dose	Frequency	Start Date
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

HEALTH MANAGEMENT:

Please indicate when *YOU* last had each of the following exams and IF the results are *normal or abnormal.*

	YES	DATE	Abnormal		YES	DATE	Abnormal
Dental				Bone Density/DEXA			
Ophthalmology				Mammogram			
Stress Test				Pelvic/Pap Smear (female)			
Colonoscopy (over age 50)				Breast exam (female)			
Stool test for blood				PSA Exam (male)			
Chest X-ray				Rectal / Prostate			
Tuberculosis skin (PPD)				Tetanus Shot			
Pneumonia Shot				Flu Shot			
Hepatitis A & B				Shingles Shot			
Gardasil Shot(s) (female)				Other:			

Health History Questionnaire

Do you use Illegal Drugs? ___ YES ___ NO
What types of illegal drugs do you use? _____

Check one of the following about smoking tobacco:
___ Never Smoked ___ Exposed to secondhand smoke
___ Former Smoker ___ Smoke Some Days ___ Smoke Everyday
If you smoke or used to smoke, how many packs do/did you smoke per day? _____
How many years did you/have you smoked? _____
If you quit smoking, when did you quit? _____

Check the following about smokeless tobacco:
___ Never Used ___ Former User ___ Current User
If you quit smokeless tobacco, when did you quit? _____

Do you Vape or use e-cigarettes?
___ No ___ Used in past ___ Not presently ___ Occasionally ___ Daily

Do you drink Alcohol? ___ YES or ___ NO
Please indicate the quantity per week of each:
Glasses of wine ____ Can/bottles of Beer ____ Shots of Liquor ____ Mixed Drinks ____

Do you have daily bowel movements? ____ YES or ____NO

Do you have cold hands or feet? ____ YES or ____ NO

Do you have gas, bloating or abdominal pain after eating? ____ YES or ____ NO

Do you exercise: ____0-1 days weekly ____ 2-3 days weekly ____ 3+ days weekly

Your Past Medical History:

___ Abnormal Pap
___ Alcoholism
___Allergies
___ Anemia
___ Anxiety
___ Arthritis
___ Asthma
___ Blood Transfusion
___ Cancer: _____
___ Cataracts
___ Clotting Disorder
___ Congestive Heart Failure
___ COPD
___ Coronary Artery Disease
___ Depression
___ Diabetes
___ Diverticulitis
___ GERD (heartburn)
___ Glaucoma
___ Headaches
___ Heart Murmur
___ High Cholesterol
___ Irregular Periods
___ Kidney Disease
___ Liver Disease
___ Menorrhagia (painful periods)
___ Myocardial Infarction
___ Nerve/Muscle Disease
___ Osteoporosis
___ Prostate Enlargement
___ Seizures
___ Sickle Cell Anemia
___ Sleep Apnea

___ Concussion
___ Other: _____
___ High Blood Pressure
___ Hypo/Hyper Thyroid
___ Stroke
___ Tuberculosis

Your Past Surgical History: (check any surgeries you have had)

___ Appendectomy
___ Bariatric Surgery
___ Brain Surgery
___ Breast Surgery
___ CABG (bypass)
___ Cesarean Section
___ Colon Surgery
___ Cosmetic Surgery
___ Eye Surgery
___ Fracture Repair Surgery
___ Gallbladder Removal
___ Hernia Repair
___ Hysterectomy (Ovaries remain)
___ Hysterectomy (ovaries removed)
___ Prostate Surgery
___ Small Intestine Surgery
___ Spine Surgery
___Tonsillectomy
___ Tubal Ligation (tubes tied)
___ Valve Replacement
___ Vasectomy

Other Surgeries: _____
_____
_____
_____

Family History:

	Mother	Father	Sibling	Daughter	Son	Other
Alcohol Abuse	____	____	____	____	____	_____
Aneurysm:	____	____	____	____	____	_____
Asthma:	____	____	____	____	____	_____
Autoimmune Disease:	____	____	____	____	____	_____
Birth Defects:	____	____	____	____	____	_____
Breast Cancer:	____	____	____	____	____	_____
Cancer:	____	____	____	____	____	_____
Colon Cancer:	____	____	____	____	____	_____
Colon Polyps:	____	____	____	____	____	_____
COPD:	____	____	____	____	____	_____
DVT:	____	____	____	____	____	_____
Dementia:	____	____	____	____	____	_____
Depression:	____	____	____	____	____	_____
Diabetes:	____	____	____	____	____	_____
Heart Disease:	____	____	____	____	____	_____
High Cholesterol:	____	____	____	____	____	_____
Hypertension:	____	____	____	____	____	_____
Kidney Disease:	____	____	____	____	____	_____
Mental Illness:	____	____	____	____	____	_____
Osteoporosis:	____	____	____	____	____	_____
Prostate Cancer:	____	____	____	____	____	_____
Pulmonary Embolism:	____	____	____	____	____	_____
Stroke:	____	____	____	____	____	_____
Thyroid Disease:	____	____	____	____	____	_____
Alive (Yes or NO)	____	____	____	____	____	

Male & Female Hormone issues:	***None***	***Mild***	***Moderate***	***Severe***
Hot Flashes, episodes of sweating	____	____	____	____
Heart Discomfort, racing, tightness	____	____	____	____
Sleep Problems	____	____	____	____
Depressive mood, tears, sad	____	____	____	____
Irritability, nervous, tension aggressive	____	____	____	____
Anxiety, restlessness, panicky	____	____	____	____
Physical or mental exhaustion	____	____	____	____
Memory loss, forgetfulness	____	____	____	____
Sexual dysfunction, desire or satisfaction	____	____	____	____
Bladder problems, incontinence	____	____	____	____
Vagina dryness (females)	____	____	____	____
Decrease in morning erections (men)	____	____	____	____

For Female Patients Only:

Age when period started: _____ ***<u>If period has not started yet, skip this section</u>***

Period Cycle: ____ days *Period Duration: _____ days*

Period Pattern: ____ Regular or _____ Irregular

Menstrual Flow: ____ Light ____ Moderate ____ Heavy

Menstrual control method: ___ Tampon ___ Panty Liner ___Maxi Pad _____ Specify other

How often do you have to change your menstrual control method? Every _____ hours?

Dysmenorrhea (painful periods): ____ None ____ Mild ____ Moderate ____ Severe

Describe period symptoms: _____

Date of last Pap Smear: _____

History of abnormal pap smears: _____ YES ____ NO

The approximate date of last Mammogram if over 35 _____

Pregnancy History:

____ Never Pregnant ____ History of Pregnancy ____ Currently Pregnant

Number of Pregnancies: ____

# of Deliveries: ____ Preterm deliveries < 37 wks: _____ Full term deliveries: ____

Multiple birth deliveries: ____ Miscarriage/abortions: ____ Living Children: _____