Virginia Integrated Primary Care & Weight Loss Center
Patient Demographic Profile

PATIENT INFORMATION

Name: _____

Address: _____

_____

City, State: _____ ZIP: _____

Phone: _____ [ ] Home [ ] Work [ ] Cell

Phone: _____ [ ] Home [ ] Work [ ] Cell

Email Address: _____

Ethnicity: _____ Preferred Language: _____

Patient ID #: _____ Sex: [ ] M [ ] F

Date of Birth: _____

Social Security #: _____

Race: [ ] African American [ ] American Indian [ ] Caucasian
[ ] Hispanic [ ] Asian [ ] Other

Marital Status: [ ] Married [ ] Single [ ] Divorced

Referring Physician: _____

Primary Physician: _____

Living Will [ ] Yes [ ] No DNR [ ] Yes [ ] No

Durable Medical Power of Attorney [ ] Yes [ ] No

RESPONSIBLE PARTY

[ ] Same as Patient

Name: _____

Address: _____

_____

City, State: _____

EMPLOYMENT

Employer: _____

Phone: _____

Phone: _____

Social Security #: _____

Date of Birth: _____

PRIMARY INSURANCE

[ ] Same as Patient [ ] Same as Guarantor [ ] Other

Insured Party: _____

Insured Phone: _____

Insurance Company: _____

Date of Birth: _____

Relationship to Patient: _____

Social Security #: _____

Insured ID: _____

Policy Group: _____

SECONDARY INSURANCE

[ ] Same as Patient [ ] Same as Guarantor [ ] Other

Insured Party: _____

Insured Phone: _____

Insurance Company: _____

Relationship to Patient: _____

Social Security #: _____

Insured ID: _____

Policy Group: _____

Policy Group: _____

I authorize Virginia Integrated Primary Care & Weight Loss Center to provide medical treatment to me. I understand that I am financially responsible for charges incurred by me and that in the event that my account is turned over to an attorney for collection, I shall be responsible for attorney fees and court costs. I further authorize Virginia Integrated Primary Care & Weight Loss Center to release medical information necessary to process my claims. In the event that any employee is exposed to my blood and/or body fluids, I consent to laboratory testing for Hepatitis B, Hepatitis C and AIDS antibody and that the results of those tests be shared with the exposed party. A photocopy of this information shall be considered as valid as the original.

Signature of Patient/Responsible Party _____ Date _____

CONSENT TO RELEASE OF
CONFIDENTIAL HEALTH INFORMATION

We frequently have phone calls from family members inquiring about the health status or treatment of a patient. To protect confidentiality, we ask that you notify us of any family members or others to whom you may wish to have your medical information disclosed. If a family member is not listed below, they will NOT be given information regarding your medical care and treatment.

PATIENT NAME: _____

PHYSICIAN NAME: _____

RELEASE INFORMATION TO:

NAME: _____
RELATION: _____
ADDRESS: _____
_____
PHONE: _____

NAME: _____
RELATION: _____
ADDRESS: _____
_____
PHONE: _____

NAME: _____
RELATION: _____
ADDRESS: _____
_____
PHONE: _____

NAME: _____
RELATION: _____
ADDRESS: _____
_____
PHONE: _____

As the person signing this consent, I understand that I am giving my permission to Virginia Integrated Primary Care & Weight Loss Center Cancer, llc. to release my confidential medical information to the individual(s) named above. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to Virginia Integrated Primary Care & Weight Loss Center, llc. A copy of this consent shall be included with my original records.

I authorize Virginia Integrated Primary Care & Weight Loss Center, llc. to disclose any and all information regarding my medical treatment to the individuals named above unless such release is otherwise limited as follows: _____

_____

Virginia Integrated Primary Care & Weight Loss Center, llc. is _____ is not _____ authorized to leave messages on my home answering machine regarding _____ appointment notification _____ please call office. This consent shall not expire unless I notify Virginia Integrated Primary Care & Weight Loss Center,llc. that this release is revoked.

Signed: _____ Date: _____

PATIENT RESPONSIBILITY FOR PAYMENT

You are responsible for any services rendered by the physicians or staff of Virginia Integrated Primary Care & Weight Loss Center,llc. Your health insurance will be billed for you to whenever possible when the information is supplied at the time of your service, however, the contract with your carrier is between you and the company. We cannot intervene to change the type or amount of coverage that you have. You are responsible for being aware of any deductibles, copayments, and non-covered services. You will be expected to pay these amounts at the time of service, unless other arrangements have been made in advance. Some insurance companies require a referral or pre-authorization before you can be treated by a specialist. It is your responsibility to bring this information with you at the time of your visit. We reserve the right not to see you if the referral is not here at the time of your visit.

YOU ARE RESPONSIBLE FOR ANY SERVICES RENDERED BY THIS PRACTICE THAT ARE NOT PAID BY YOUR INSURANCE CARRIER. YOU ARE RESPONSIBLE FOR ANY COLLECTION AGENCY COSTS, COURT COSTS, OR ATTORNEY'S FEES INCURRED BY THE PRACTICE IN COLLECTING ANY OUTSTANDING BALANCE FOR SERVICES RENDERED TO YOU.

AUTHORIZATION STATEMENTS:

1) Medicare Patients Lifetime Agreement

I authorize any holder of medical or other information about me to release such information necessary for the processing of Medicare claims to Social Security Administration and the Health Care Financing Administration or its intermediaries, carriers, billing agents or successors. I further permit a copy of this authorization to be used in place of the original and I request payment under Medicare to be made to either me or to the physicians, providers, or suppliers identified for service and/or supplies furnished by those physicians, providers, or suppliers.

2) I authorize Virginia Integrated Primary Care & Weight Loss Center,llc., Inc. to release or obtain any information necessary in the course of my treatment for billing or medical requirements.

3) I authorize my health insurance carrier(s) to pay Virginia Integrated Primary Care & Weight Loss Center,llc. directly for the medical, laboratory, surgical procedures, and/or other services rendered to me under the benefits/terms of my policy.

4) I further permit a copy of this authorization to be used in place of the original and request payment under Medicare to be made to Virginia Integrated Primary Care & Weight Loss Center,llc. for services and/or supplies furnished during my treatment.

I understand that I am directly responsible for all services rendered.

I have read and understand all of the above and agree with the terms of this document.

Signature _____ Date _____

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.

If you have any questions about this Notice, please contact the Privacy Officer.

804-537-8472

Effective Date: 01/02/2025

Revised: 2/20/2025

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

• Posting the new Notice in our office.
• If requested, making copies of the new Notice available in our office or by mail.
• Posting the revised Notice on our website: WWW.VIPCARE4U.COM

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office 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.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

• Billing companies
• Insurance companies, health plans
• Government agencies in order to assist with qualification of benefits
• Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

• Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
• Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
• Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

• If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
• Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.

Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and
inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other
government regulatory programs and civil rights laws.
Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
Coroner, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for
the coroner or medical examiner to perform other duties authorized by law
Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has
reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited
circumstances.
Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other
individuals.
Worker’s Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally established
programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI
necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of
business associates include billing companies or transcription services.
Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.
Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.
Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of
services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the
information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the
information.
We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for
your care of your location, general condition or death.
We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

Marketing
• Disclosures of for any purposes which require the sale of your information
• Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private

The following uses and disclosures of PHI require your written authorization:
Marketing
• Disclosures of for any purposes which require the sale of your information
• Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private
session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.
All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative. Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your
doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights;
You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. You may request an Authorization for Disclosure of
Health Care Information form verbally or by written request. Once you have completed and signed this document, you must return the original to the Privacy Officer for processing.

You have the right to see and obtain a copy of your protected health information.
This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected
health information. If requested, we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request
may be denied. We may charge you a reasonable cost-based fee for a copy of the records.

You have the right to request a restriction of your protected health information.
You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are
not required to agree with these requests. If we agree to a restriction request, we will honor the restriction request unless the information is needed to provide emergency
treatment.
There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it
is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.
We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for
an explanation from you about the request,

You may have the right to request an amendment of your health information.
You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases,
we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.
This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred
after JAN 2, 2025. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights
You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an
emergency situation we will give you this Notice as soon as possible,
You have a right to receive notification of any breach of your protected health information.

Complaints
If you think we have violated your rights, or you have a complaint about our privacy practices you can contact: Privacy Officer 804-537-8472.
You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.
If you file a complaint, we will not retaliate against you for filing a complaint.
This notice was published and becomes effective on JAN 02, 2025.

Virginia Integrated Primary Care

And Weight Loss Center

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:

_____

- ❑ Other: _____

_____

Prepared By _____

Signature _____

Date _____

Name:_____ **DOB:**_____ **SS#:**_____ **Date:**_____

Please fill out this form as completely as you can. It provides vital information to help your physician and staff care for you. All of your medical information is held in strictest confidence, and is only released to others in accordance with your wishes and federal privacy guidelines.

Preferred Pharmacy, including address and phone # _____

Please list all physicians involved in your care, including your previous primary care physician, the physician who referred you here, your GI , cardiologist, and any other physician involved in your care

Physician that referred you to this practice:	
Last Primary Care Physician	Other
OBGYN	Other
GASTRO	Other

Drug Allergies	Type of Reaction

Current Medications (Attach Additional Sheet if Needed)

Name of Medication	Dosage	How Often	Year Started

Are you currently taking blood thinners? ___ Yes ___No

***If yes*, how long? _____ Who manages your blood thinner prescription? _____**

Current Symptoms:

☐ fatigue ☐ fever ☐ chills ☐ night sweats ☐ lethargy ☐ loss of appetite ☐ weight change
☐ ear pain ☐ hearing loss ☐ trouble seeing ☐ sensitivity to light ☐ excessive tears ☐ significant pain
☐ mouth sores ☐ mouth dryness ☐ difficulty swallowing ☐ cough ☐ shortness of breath ☐ swelling
☐ palpitations ☐ rash ☐ dry skin ☐ decreased range of motion ☐ sensory problems ☐ disorientation
☐ breast pain ☐ breast masses ☐ new lumps ☐ hot flashes ☐ nipple discharge ☐ bleeding
☐ nausea ☐ vomiting ☐ heartburn ☐ diarrhea ☐ constipation ☐ incontinence ☐ weakness
☐ difficulty urinating ☐ frequent urinating ☐ blood in urine ☐ problems with sexual function
☐ anxiety ☐ depression ☐ insomnia ☐ dizziness ☐ memory loss ☐ seizures ☐ poor balance

Medical History (Please check any conditions that apply to you)

	For MD / MA Use
☐ Allergies / Hayfever	
☐ Anemia	
☐ Angioplasty / Stent Placement	
☐ Asthma	
☐ Irregular Heartbeat ☐ Bleeding Tendency	
☐ Chronic Anxiety ☐ Chronic Obstructive Pulmonary Disease (COPD) ☐ Congestive Heart Failure (CHF) ☐ Depression	
☐ Diabetes	
☐ Emphysema or Chronic Bronchitis ☐ GERD ☐ Glaucoma	
☐ Hearing Loss ☐ Hepatitis ☐ High Cholesterol	
☐ High Blood Pressure ☐ Thyroid Disorder	
☐ Kidney Stones	
☐ Heart Attack (MI) ☐ Migraine Headaches	
☐ Neuropathy ☐ Osteoarthritis ☐ Peptic Ulcer Disease ☐ Peripheral Vascular Disease (Arterial Obstruction)	
☐ Pneumonia ☐ Reflux / Heartburn	
☐ Renal Insufficiency (Decreased Kidney Function)	
☐ Rheumatoid Arthritis	
☐ Seizure	
☐ Stroke	
☐ Urinary Difficulty ☐ Urinary Incontinence	
☐ Venous Thrombosis (Blood Clots) ☐ Visual Loss	
☐ Cancer Type: _____ Age at Diagnosis: _____ Where were you treated? _____ ☐ Other Medical Problems (Please list) _____ _____ _____	

Surgical History	M / D /Y	*For MD / MA Use Only*
__ Appendix Removed		
__ Blood Transfusion		
__ Breast Biopsy		
__ Cataract Removal		
__ Colonoscopy		
__ Coronary Artery Bypass		
__ Gall Bladder Removed		
__ Hernia Repair		
__ Hip Replacement		
__ Knee Replacement		
__ Mastectomy		
__ Mastectomy, partial (lumpectomy)		
__ Other Joint Surgery		
__ Other Surgery		
__ Pacemaker Placement		
__ Prostate Surgery		
__ Tonsils Removed		
__ Tubal Ligation		
__ Uterus or Ovaries Removed		
__ Vasectomy		

GYN History (Women Only)

# of pregnancies ___ # of live births ___	Menopausal Status ___ Pre- ___ Post- ___ Peri- ___ Unknown	Age at Menopause ___
Hormone Use # Years Used __Birth Control Pills ____ __Post-Menopausal ____ __Other ____	_____Date of Last PAP Smear _____Date of Last Mammogram	Other GYN History:

Family History

	Alive?	History of MEDICAL PROBLEM	Age at Death	Age Diagnosed	Cancer	Cardiac Disorder	Diabetes
Mother	Y / N				☐	☐	☐
Father	Y / N				☐	☐	☐
Brother / Sister	Y / N				☐	☐	☐
Brother / Sister	Y / N				☐	☐	☐
Brother / Sister	Y / N				☐	☐	☐
Other	Y / N				☐	☐	☐
Other	Y / N				☐	☐	☐

Other Important Family History:

Personal History:

Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐	
___ I live alone ___ I live with spouse, significant other, family / friend ___ I live in assisted living / nursing home ___ I have religious objections to blood transfusions ___ I have a living will or advanced directives ___ In the event of cardiopulmonary arrest, I do not wish to be resuscitated ___ I have oxygen at home	
Smoking ___ Never ___ Yes, but quit ___ Yes, active	Smoking ___ # years ___ # packs per day ___ Years quit
Drinking ___ Never ___ Yes - Occasional ___ Yes, but quit ___ Yes, active	Drinking ___ # drinks per week ___ # drinks per day ___ Years quit

I have _____ children (Comments:)

Current occupation: _____

Previous occupations: _____

_____ _____ _____.