Front Royal Family Practice, PC
140 West 11th Street
Front Royal, VA 22630

CONSENT FORM

(For Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations)

I understand that as part of my healthcare Front Royal Family Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I also understand 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 right to review the notice prior to signing this consent. I understand the practice reserves the right to change their notice and practices, and prior to implementation, will mail a copy of any revised notice to the address that I have provided if there is a need to use or disclose any protected health information. I also understand that I have the right to restrict as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the practice is not required to agree to the restrictions requested, other than the exception noted in the **Notice of Information Practices**. I understand that I may revoke this consent in writing, except to the extent that the practice has already taken action in reliance thereon. Any patient, guardian or personal representative has the right to receive confidential communications of protected health information by alternative means or at alternative locations. Such request must be in writing and the practice must accommodate reasonable request.

With this consent, Front Royal Family Practice may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With this consent, Front Royal Family Practice may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and other correspondence as long as they are marked Personal and Confidential.

With this consent, Front Royal Family Practice may e-mail to me appointment reminders and patient statements. I have the right to request that Front Royal Family Practice restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions except for a request for a restriction on a disclosure to a health plan where services have been paid in full, out-of-pocket, but if it does, it is bound by this agreement.

By signing this form, I am consenting for Front Royal Family Practice to use and disclose my PHI to carry out my TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, Front Royal Family Practice may decline to provide treatment to me.**

Print Patient Name:_____
Account Number:_____
Signature of Patient or Legal Guardian:_____
Date:_____

Permission to Discuss Personal Health Information

Patient Name _____ D.O.B _____

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____

Signature of Patient, Parent, Guardian

_____

Date

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

Patient Identifier: _____

Authorization for Release of Health Information

Front Royal Family Practice
140 W. 11th Street
Front Royal, VA 22630

_____FRFP to Send Records
_____FRFP to Request Records

Patient's Name: _____ **Requested Date**: _____

Date of Birth: _____ **Medical Record Number**: _____

1. I authorize the use and/or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to disclose and to receive my health information:

Doctors Name: _____

Address: _____

City, State and Zip Code: _____

Phone Number: _____ **Fax**: _____

3. The type and amount of information to be used or disclosed is as follows: (Include dates where appropriate)

_____ Problem List/Core Data Sheet
_____ Medication List
_____ List of Allergies
_____ Immunization Record
_____ Most Recent History and Physical
_____ Most Recent Progress Note
_____ Consultation Reports

Other Physician/Hospital Records from:
_____ Laboratory Results Dated: _____ to _____
_____ X-Ray/Imaging Reports Dated _____ to_____
_____ Other _____

4. I understand that the information in my health record may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about Behavioral or Mental Health services, and treatment for alcohol and drug abuse.

5. The information may be disclosed to or from the following individual or organization:

Front Royal Family Practice
140 W. 11th Street
Front Royal, VA 22630
Phone: 540-631-3700
Fax: 540-635-1673

For the purpose of: Continuity of Care/Coordination of Services

Are you transferring care? _____ If yes, Why: _____

6. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke the authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in 1 (one) year.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules.

If I have questions about the disclosure of my health information, I can contact the practice privacy office.

Signature of Patient or Guardian: _____

Relationship to Patient _____ Date: _____

Front Royal Family Practice Registration Form

Patient's Name (Last, First, MI):_____

Date of Birth:_____ Age:_____ SSN #:_____ Gender:_____

Marital Status (Circle One): Married Single Separated Divorced Widowed

Employment Status (Circle One): Full Time Part Time Student Retired Unemployed Other

Home #:_____ Cell #:_____ Work #:_____

Email Address:_____

Physical Address:_____

Mailing Address:_____

Emergency Contact:_____

Relationship to Patient:_____ Home #:_____ Cell #:_____

Primary Insurance Name:_____ ID #:_____ Patient is Subscriber: Y/N

Secondary Insurance Name:_____ ID #:_____ Patient is Subscriber: Y/N

Tertiary Insurance Name:_____ ID #:_____ Patient is Subscriber: Y/N

Please complete if patient is not the Subscriber(s):

Insurance Name:_____ Subscriber Name:_____ Date of Birth:_____

Employer:_____ Relationship to Patient:_____ Phone #:_____

Please complete the following information to assist in Front Royal Family Practice providing diversified care to the community.

Primary Preferred Language **(Required)**:_____

Please **CIRCLE** the option that applies to you

Race: Asian American Indian or Alaska Native African American Native Hawaiian White

Other Pacific Islander More than One Race Unreported/Refuse to Report

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unreported/Refuse to Report

How did you hear about our Practice:_____

(Please turn form over to complete additional information)

Front Royal Family Practice Financial Policy

I certify that all information reported above is correct including my insurance information. I authorize the release of any medical and financial information relating to services rendered be released to my insurance carrier(s) by Front Royal Family Practice to obtain payment. I further authorize payment of all medical insurance benefits for my services be made payable to Front Royal Family Practice.

I understand it is my responsibility to know my insurance benefits prior to seeking services and that I agree to render payment in which I am financially responsible. I understand that payment is due at time of service unless prior arrangements have been made with the billing department. I understand that Front Royal Family Practice will add a 35% collection fee along with interest for delinquent balances. I understand delinquent balances may result in discharge from the practice. A copy of this authorization may be used in place of the original in submitting claims for rendered services. This authorization can be revoked in writing by me and/or my insurance carrier.

I understand if I am a self-pay patient that payment is due at time of service and that I may receive additional bills from other entities (ex. Lab Company), which are separately payable from the services paid to Front Royal Family Practice.

I understand any returned checks will be subject to a service charge for which I am responsible. And I understand Front Royal Family Practice reserves the right to charge a fee for any scheduled visits that are:

1. **Missed without calling to cancel (No Show)**
2. **Arrive half past the appointment duration**
3. **Call to cancel less than 24 hours before appointment time**

My signature certifies agreement of the above policy and that Front Royal Family Practice has provided me a copy of the consent form.

Print Patient Name:_____ Account Number:_____

Signature of Patient/Guarantor/Legal Guardian:_____ Date:_____

HEALTH HISTORY QUESTIONAIRE

Demographic Information

Patient Name (Last, First, M.I.):_____

Date of Birth:_____ Place of Birth:_____

Sex:_____ Marital Status_____

If married, spouse's name:_____

Pharmacy Name and Location: _____

Current Medications: Please list or attach a list of medications

CURRENT MEDICATIONS	
Drug allergies: ❑ No ❑ Yes	
Medication	**Reaction**
1.	
2.	
3.	

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	**Dose (include strength & number of pills per day)**	**How long have you been taking this?**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Please complete back of form

Patient Name (Last, First, M.I.):_____ Date of Birth:_____

Past Medical/Social History (Cont'd)

PAST MEDICAL HISTORY

Do you now or have you ever had:

❑ Diabetes	❑ Heart murmur	❑ Crohn's disease
❑ High blood pressure	❑ Pneumonia	❑ Colitis
❑ High cholesterol	❑ Pulmonary embolism	❑ Anemia
❑ Hypothyroidism	❑ Asthma	❑ Jaundice
❑ Goiter	❑ Emphysema	❑ Hepatitis
❑ Cancer (type) _____	❑ Stroke	❑ Stomach or peptic ulcer
❑ Leukemia	❑ Epilepsy (seizures)	❑ Rheumatic fever
❑ Psoriasis	❑ Cataracts	❑ Tuberculosis
❑ Angina	❑ Kidney disease	❑ HIV/AIDS
❑ Heart problems	❑ Kidney stones	

Other medical conditions (please list):

_____

_____

_____

_____

WOMENS REPRODUCTIVE HISTORY:

Age of first period:

Pregnancies:

Miscarriages:

Abortions:

Have you reached menopause? Y / N At what age?

Do you have regular periods? Y / N

Patient Name (Last, First, M.I.):_____ Date of Birth:_____

Family History

FAMILY HISTORY				
	IF LIVING		**IF DECEASED**	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings: Brother's Sister's				
Children: Daughter's Son's				
EXTENDED FAMILY HEALTH & PSYCHIATRIC PROBLEMS PAST & PRESENT: Maternal Relatives: Paternal Relatives:				

Immunizations *(check if Yes and indicate year of last injection)*

___ Influenza	___ Pneumonia	___ MMR	___ Zostavax
___ Tetanus	___ Hepatitis A or B	___ Other	___ Shingrix

Please complete back of form

Patient Name (Last, First, M.I.):_____ Date of Birth:_____

Social History

Tobacco Use:
Do you smoke? _____ If so, how many cigarettes/cigars per day? _____
Number of years smoking? _____ Do you chew tobacco_____ Have you thought about quitting? _____ Have you quit before?_____ How long?_____

Alcohol Use:
Do you drink alcohol? _____If, so what type(s)? _____
How many drinks do you have in 1 week? _____

Drug Use:
Any history of recreational (illegal, pain medication) drug use? _____
If so, what type(s)?_____
When? _____

Disease Exposure:
Have you been exposed or currently (circle all that apply): AIDS, HIV, Herpes, Syphillis, Tuberculosis, SARS, and/or Other(s)_____

Exercise/Nutrition:
Are you currently following a dietary lifestyle and/or regular exercise regimen? _____
How much caffeine do you consume on a daily basis?_____

Employment:
Are you currently employed? _____How many jobs are you currently working?_____
Occupation_____

The information listed above is true to the best of my knowledge.

_____ _____

Signature Date