Courthouse Family Medicine

Last:

First:

Middle Initial: DOB:

Today's Date:

## PATIENT INFORMATION FORM (Page 1 of 2)

SSN: Gender: Male Female

Mailing address: City: ST and Zip:

911 address: City: ST and Zip:

Marital status: Race: Ethnicity:

Preferred language: Religion:

Home phone: Cell phone:

Email address:

Student status: ☐ N/A ☐ Full Time ☐ Part Time

## HOW WOULD YOU LIKE TO BE CONTACTED FOR FUTURE APPOINTMENT REMINDERS?

☐ Email ☐ Text ☐ Cell phone ☐ Home phone

## PATIENT EMPLOYER INFORMATION

Employer name: Phone:

Address: City: ST and Zip:

## RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM ABOVE)

Last: First:

SSN: DOB:

Mailing address: City: ST and Zip:

Gender: Male Female Contact Phone Number:

Relationship to patient:

## PHARMACY

Local pharmacy: Phone:

Address: Fax:

Mail order pharmacy: Phone:

Address: Fax:

## EMERGENCY CONTACT

Name: Phone: Relationship:

Name: Phone: Relationship:

Courthouse Family Medicine

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## PRIMARY HEALTH INSURANCE INFORMATION (Page 2 of 2)

Insurance: Subscriber ID: Group#:

Subscriber last name: First: M. I.:

DOB: SSN: Marital status:

Gender: ☐ M ☐ F Relationship to patient:

## SECONDARY HEALTH INSURANCE INFORMATION

Insurance: Subscriber ID: Group#:

Subscriber last name: First: M. I.:

DOB: SSN: Marital status:

Gender: ☐ M ☐ F Relationship to patient:

## TERTIARY HEALTH INSURANCE INFORMATION

Insurance: Subscriber ID: Group#

Subscriber last name: First: M. I.:

DOB: SSN: Marital status:

Gender: ☐ M ☐ F Relationship to patient:

## HOW DID YOU HEAR ABOUT US?

☐ Who referred you? ☐ Hospital referral ☐ CFM website

☐ Internet ☐ Facebook ☐ Other/print ad

## RELEASE

I assign payment to and authorize Courthouse Family Medicine to file a claim with my insurance company(s) for payment of services or to accept assignment of any government benefits due to me. I authorize the release of all of information necessary to process these claims. I understand that if it is later determined that I am not eligible to receive benefits for the services, or there is a remaining balance not covered by my policy(s) I am financially responsible for payment to Courthouse Family Medicine.

## SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

Signature: Date:

Printed name: Date:

Courthouse Family Medicine

Last:

First:

Middle Initial: DOB:

Today's Date:

**RELEASE OF HEATLHCARE INFORMATION FORM** PLEASE PRINT ALL INFORMATION (Page 1 of 1)

Patient's name: DOB:

Previous name: SSN:

**I REQUEST AND AUTHORIZE**

Facility/ Doctor's name:

Phone number:

Fax number:

To release healthcare information of the patient named above to:

COURTHOUSE FAMILY MEDICINE

Dr. Joseph Leming, MD, Vickie Bell Leming, NP-C
Elise K. Meadows, NP-C, Amanda R. Wingfield, NP-C
P.O. Box 857
Gloucester, VA 23061-0857

Fax: (804) 693-3503

**THIS REQUEST AND AUTHORIZATION APPLIES TO:**

I authorize Courthouse Family Medicine to access any health related information from Virginia Commonwealth University Health Systems, Riverside Health System, Sentara Health System, Bon Secours Health System, Hospital Corporation of America and all electronic pharmacy records.

☐ Yes ☐ No ☐ N/A

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 ☐ N/A

I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

☐ Yes ☐ No ☐ N/A

All healthcare information.

☐ Yes ☐ No

Other (please list):

☐ Yes ☐ No

Signature of Patient or responsible party: Date:

By signing and requesting for your health records you may be charged a fee associated with this request from your previous doctor's office or a 3rd party.

**THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.**

Courthouse Family Medicine

Last:

First:

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Today's Date:

## PATIENT RIGHTS AND RESPONSIBILITIES FORM 

This bill of rights services as notice to you of Courthouse Family Medicine's responsibilities. Likewise, patient responsibilities are included to promote an understanding of expectations of patients for the benefit of caregivers, fellow patients, and our staff.

## PATIENT RIGHTS (YOU HAVE THE RIGHT TO):

- Receive considerate, respectful and compassionate care in a safe setting regardless of your age, gender, race, national origin, religion, language, culture, sexual orientation, gender identity, disabilities or source of payment.
- Receive care in a safe environment, free from all forms of abuse, neglect, harassment or mistreatment.
- A complete and understandable explanation of your illness, treatment, pain, alternatives and expected outcomes of treatment, including unexpected outcomes.
- Communication that you can understand. Information given will be appropriate to your age, understanding and language.
- Access, request and obtain information on disclosures of your health information. Additionally, you can expect that your health record is maintained confidentially to the extent permitted by law. You have the right to obtain a copy of your health record by signing a record request form.
- Make decisions about your care, including the right to refuse care and the right to be informed of potential health risks related to care refusal. You DO NOT have the right to demand treatment or services deemed medically unnecessary or inappropriate.
- Have your pain assessed and to be involved in decisions regarding treatment of your pain.
- Full consideration of your privacy and confidentiality in care discussions, examinations and treatments.
- Voice a complaint in a mindful, calm manner without fear of being subjected to coercion, discrimination, reprisal or unreasonable interruption of care.

## PATIENT RESPONSIBILITIES (YOU ARE RESPONSIBLE FOR):

- Providing complete and accurate information about your health, medical history and personal data, including address, telephone number, date of birth, Social Security number, insurance and employer. You must also present your photo ID and most recent insurance card at each visit.
- Asking questions when you do not understand your treatment plan. If you are unable or unwilling to follow the plan of care, you are responsible for informing your care provider who will explain the potential medical risks of not doing so. You are responsible for the outcomes of not following your plan of care.
- Meeting your financial obligation to Courthouse Family Medicine in a timely manner and if you are unable to do so, this may be grounds for dismissal from the practice.
- Keeping appointments and if unable to do so, you will notify us within a minimum of 24 hours prior to your appointment. If less than 24 hours' notice is given, then a cancellation fee of $200 for new patient appointments, $100 for a physical or $50 for an established patient visit will be applied. Additionally, if there are more than 3 NO-SHOWS in a 1 year period, this may be grounds for dismissal from the practice.
- Committing to arriving to the office 15 minutes before my scheduled appointment time.
- Understanding that if I arrive to my appointment 10 or more minutes late that I may be asked to reschedule.
- Understanding that in order to remain a "current" patient of our practice you must be seen at least one time every three years or you will be required to reestablish care in order to see you for any reason.
- Extending courtesy and respect to all Courthouse Family Medicine staff, fellow patients and visitors. You are responsible for following all of Courthouse Family Medicine's rules and safety regulations.
- Accepting that we may end our patient-provider relationship if you do not follow your plan of care.
- Accepting that inappropriate language and/or behavior is not tolerated and may be grounds for dismissal.

Signature of patient or responsible party: Date:

Courthouse
Family Medicine

Last:

First:

Middle Initial: DOB:

Today's Date:

## FINANCIAL AGREEMENT FORM (Page 1 of 1)

Thank you for choosing us as your practice family! We are committed to providing you with quality and affordable health care. We ask all patients to review and sign this policy, asking questions as necessary.

### INSURANCE:

We accept assignment and participate in many insurance plans. If your insurance is not a plan we participate in, payment in full is expected at each visit. Knowing your insurance benefits are your responsibility. Please contact your insurer with any questions you may have regarding your coverage to receive the maximum benefit.

### PATIENT PAYMENT:

All copayments and deductibles are to be paid at the time of service. This arrangement is part of your contract with your insurance company as well as part of your patient-provider relationship. A $50 fee will be charged for any returned check.

### FORMS:

There is a $25 fee for completing FMLA, sick leave, AFLAC and disability forms. This fee must be paid before the forms are completed. Please allow 48 business hours for them to be completed.

### REGISTRATION:

All patients must complete our patient information form, which will be entered into our computer to maintain accurate information for proper billing. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of the claim. Most insurance companies have time filing restrictions; if a claim is not received within 30 days of the date of service, it can be rendered ineligible for payment and you will be responsible for the balance that remains.

### CLAIMS:

We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may not accept information from our office and may need information from you. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance pays or not. Your insurance benefit is a contract between you and the insurance company; we are not party to that contract.

### UNINSURED PATIENTS:

We do offer self-pay rates if you do not have insurance. All services are estimated and the estimate is expected to be paid in full before services are rendered. Please be aware that the final balance due will not be available until **after** the provider has seen you and completed your visit. You may receive a bill for additional charges.

### CREDIT AND COLLECTIONS:

All bills are due upon receipt. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance has remained unpaid, it may be sent to an outside collection agency. If an account is sent to collections, it is the policy of this office to discharge the patient and possibly immediate family members from the practice. You will at the time be notified by mail that you have 30 days to find alternative medical care. During that 30-day period our physicians will be able to treat you **only** on an emergency basis.

### MISSED APPOINTMENTS:

Our policy is to charge $200 for a missed new patient appointment, $100 for a missed physical and $50 for missed established patient appointments if not canceled within 24 hours prior to the appointment time. Please note that you may call and leave a message after business hours to cancel and you will not be charged. However, if you fail to do so these charges will be your responsibility and billed directly to you.

By signing below, I indicate that I have read and understand the financial policy and agree to abide by its guidelines. A copy will be provided to each patient upon request.

Signature of patient or responsible party: Date:

Courthouse Family Medicine

Last:

First:

Middle Initial: DOB:

Today's Date:

## PATIENT CONSENT AND ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES FOR PURPOSES OF PAYMENT AND HEALTHCARE OPERATIONS 

- I consent to the use or disclosure of my protected health information by Courthouse Family Medicine, PLLC. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Courthouse Family Medicine, PLLC.

- I have the right to revoke this consent, in writing, at any time, except to the extent that Courthouse Family Medicine, PLLC. has taken action in reliance on this consent.

- My "protected health information" (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

- I understand I have the right to review Courthouse Family Medicine, PLLC. Notice of Privacy Practices (NPP) prior to signing this document. The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Courthouse Family Medicine, PLLC. The Notice of Privacy Practices for Courthouse Family Medicine, PLLC. is also provided in the lobby and on the group website at www.courthousefamilymedicine.com. The Notice of Privacy Practices also describes my rights and Courthouse Family Medicine, PLLC. duties with respect to my protected health information.

- **Electronic Format:** I acknowledge that my records are stored in an electronic format. I understand that Courthouse Family Medicine, PLLC maintains their patient records in electronic format. Original documents are destroyed after being converted to an electronic format.

- Courthouse Family Medicine, PLLC. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by accessing the group's website, calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment. I acknowledge I have received a copy of the Notice of Privacy Practices.

- **Release of Information:** I hereby give Courthouse Family Medicine, PLLC. permission to release information on my medical condition to the following people:

- **I understand the areas discussed with the below people could include treatment options, side effects, prescriptions, financial information, lab results, etc.**

Name: Relationship:

Name: Relationship:

Name: Relationship:

Signature of patient or responsible party: Date:

Printed name: Date:

Relationship if other than patient:

Patient or Personal Representative refused to sign acknowledgement.

_____ Staff Initials _____ Date

Courthouse Family Medicine

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Today's Date:

## MEDICAL HISTORY FORM (Page 1 of 3)

Provider: Reason for visit:

**MEDICATIONS:** Please list all prescription and over the counter medications that you take and why

| | |
|---|---|
| 1. | 11. |
| 2. | 12. |
| 3. | 13. |
| 4. | 14. |
| 5. | 15. |
| 6. | 16. |
| 7. | 17. |
| 8. | 18. |
| 9. | 19. |
| 10. | 20. |

**ALLERGIES:** Please list any allergies to medication and the reaction you have

| | |
|---|---|
| 1. | 6. |
| 2. | 7. |
| 3. | 8. |
| 4. | 9. |
| 5. | 10. |

Are you allergic to latex? No Yes Reaction?

Food allergies? No Yes Reaction?

## HEALTH HABITS:

Have you ever smoked or used tobacco?

☐ No, never ☐ Yes, quit If quit, how long ago?

☐ Yes, currently Number of years? Amount each day?

Do you drink alcohol? ☐ No, never

☐ No, never ☐ Yes, quit If quit, how long ago?

☐ Yes, currently If yes, how much and how often?

Have you ever felt that you should cut down on your drinking? No Yes

Do you drink caffeine? No Yes If yes, how much and how often?

**With whom do you live?** Please list below

| | |
|---|---|
| 1. | 3. |
| 2. | 4. |

Courthouse Family Medicine

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**PATIENT:** Please select the most appropriate box and make any additional comments as needed (Page 2 of 3)

| Condition | Current | Past | Comment |
|---|---|---|---|
| Alcohol/drug abuse | | | |
| Allergy (hay fever) | | | |
| Anemia | | | |
| Anxiety | | | |
| Arthritis | | | |
| Asthma | | | |
| Bipolar | | | |
| Bladder/kidney problems | | | |
| Bleeding problems | | | |
| Cancer | | | |
| Coronary artery disease | | | |
| Depression | | | |
| Diabetes | | | |
| Diverticulitis | | | |
| Emphysema (copd) | | | |
| Gerd (acid reflux) | | | |
| Glaucoma | | | |
| Heart disease | | | |
| Heart attack | | | |
| Hepatitis | | | |
| High blood pressure | | | |
| High cholesterol | | | |
| Irritable bowel syndrome | | | |
| Kidney stones | | | |
| Kidney disease | | | |
| Liver disease | | | |
| Osteoporosis | | | |
| Pneumonia | | | |
| Reproductive issues | | | |
| Seizure/epilepsy | | | |
| Sleep apnea | | | |
| Stroke | | | |
| Thyroid disorder | | | |
| Other | | | |
| Other | | | |
| Other | | | |

Courthouse Family Medicine

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First:

Middle Initial: DOB:

Today's Date:

**SURGICAL HISTORY:** Please list any prior surgeries you've had, the year and surgeon 

| | |
|---|---|
| 1. | 6. |
| 2. | 7. |
| 3. | 8. |
| 4. | 9. |
| 5. | 10. |

| **Vaccines** | **Date Received** |
|---|---|
| Tdap (tetanus with pertussis) | |
| Tetanus with diphtheria | |
| Prevnar 13 (pneumonia) | |
| Pneumovax 23 (pneumonia) | |
| Zostavax (shingles) | |
| Shingrix (shingles) | |
| Hep A | |
| Hep B | |
| Meningitis | |
| Hpv | |
| Flu | |
| **Other Procedures** | **Date Received** |
| Last dexa (bone density scan) | |
| Last digital rectal exam | |
| Last psa (prostate lab work) | |
| Last colonoscopy | |
| Lung cancer screening (low dose CT scan) | |
| AAA (abdominal aortic aneurysm ultrasound) | |
| Last diabetic eye exam | |
| Last diabetic foot exam | |

| **Menstrual and Pregnancy History** |
|---|
| Include Abortions and Tubal Pregnancies |
| Age at first period: |
| Last menstrual cycle: |
| Last mammogram: |
| Last pap exam: |
| Number of pregnancies: |
| Number of miscarriages: |
| Number or premature births: |
| Currently trying to conceive |
| **Notes:** |

**FAMILY MEDICAL HISTORY** (check the box that most appropriately represents your family history)

| Medical Condition | Mom | Dad | Sibling | Child | Mom's mom | Mom's dad | Dad's mom | Dad's dad |
|---|---|---|---|---|---|---|---|---|
| Alcohol or Drug Abuse | | | | | | | | |
| Cancer (type) | | | | | | | | |
| Diabetes | | | | | | | | |
| Heart Disease | | | | | | | | |
| High Blood Pressure | | | | | | | | |
| High Cholesterol | | | | | | | | |
| Osteoporosis | | | | | | | | |
| Mental Illness | | | | | | | | |
| Stroke | | | | | | | | |
| Thyroid Disease | | | | | | | | |

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## CARE TEAM FORM (Page 1 of 1)

Courthouse family medicine is committed to providing our patients with the highest quality and most comprehensive care plans for all medical needs. In order to ensure we are meeting this level of care, please complete the form below so we know who to collaborate with on your behalf.

**Previous primary care:** Phone:

Address:

Date and reason of last appointment:

**Obgyn:** Phone:

Address:

Date and reason of last appointment:

**Dentist name:** Phone:

Address:

Date and reason of last appointment:

**Optometrist name:** Phone:

Address:

Date and reason of last appointment:

**Specialist name:** Phone:

Address:

Date and reason of last appointment:

**Specialist name:** Phone:

Address:

Date and reason of last appointment:

**Specialist name:** Phone:

Address:

Date and reason of last appointment:

**Specialist name:** Phone:

Address:

Date and reason of last appointment:

**Specialist name:** Phone:

Address:

Date and reason of last appointment: