



PATIENT NAME _____ Last _____ First _____ M.I. _____ HOME PHONE (____) _____ - _____
 ADDRESS _____ APT _____ WORK PHONE (____) _____ - _____
 CITY _____ STATE _____ ZIP _____ DATE OF BIRTH _____ - _____ - _____
 CELL PHONE (____) _____ - _____ FAX (____) _____ - _____ EMAIL: _____
 AGE _____ SEX (M/F) _____ EMPLOYED(Y/N) _____ SSN _____ - _____ - _____ MARITAL STATUS _____

GUARDIAN'S INFORMATION (IF UNDER 18)

LEGAL GUARDIAN'S NAME _____
 LEGAL GUARDIAN'S WORK PHONE (____) _____ - _____

EXTENDED INFORMATION

EMERGENCY CONTACT: _____
 RELATIONSHIP _____ PHONE (____) _____ - _____
 IS THIS A WORK RELATED CLAIM? _____ IS THIS AN ACCIDENT RELATED CLAIM? _____

PHARMACY INFORMATION

PHARMACY NAME _____ PHONE (____) _____ - _____ LOCATION: _____

INSURANCE INFORMATION/WORKERS COMPENSATION INFORMATION

PRIMARY INSURANCE POLICY HOLDER INFORMATION

NAME _____ DATE OF BIRTH _____ - _____ - _____ SEX (M/F) _____
 PHONE (____) _____ - _____ SSN _____ - _____ - _____ RELATIONSHIP TO PATIENT: _____
 INSURANCE CARRIER _____ POLICY NUMBER _____ GROUP _____

SECONDARY INSURANCE POLICY HOLDER INFORMATION

NAME _____ DATE OF BIRTH _____ - _____ - _____ SEX (M/F) _____
 PHONE (____) _____ - _____ SSN _____ - _____ - _____ RELATIONSHIP TO PATIENT: _____
 INSURANCE CARRIER _____ POLICY NUMBER _____ GROUP _____

I hereby give permission to my physician or a designee to provide medical care for me or minor child. I also authorize the release of medical information to my physician or a designee if needed and as necessary to process insurance claims, applications & prescriptions. I authorize payment of medical benefits to the physician. For those patients, applicable co-payment and deductibles will be collected. We accept payment in the form of cash, check or credit card. Our office will file with the appropriate insurance company. However, before such claims are filed, coverage will be verified and you will be asked to pay any deductible, non-covered services and co-payments. Please note that it is a courtesy to bill to your insurance company. In the event that your account must be turned over to collections, a 35% collection fee, court and attorney fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Please note there will be a \$25.00 charge for all missed appointments if not cancelled 24 hours in advance. I am aware that my health insurance company may not cover the services that I receive today from Medics USA, Inc and that payment is my personal responsibility. I understand that it's my responsibility to obtain the necessary referral/ authorization from my primary care physician or from my health Insurance company if needed. I have been informed that a copy of that referral must be given at the time of the service. I know that without a referral/authorization, if required, I will be held financially responsible for any charges not paid by my health Insurance company. I will make Medics USA aware of any changes to the above information and take full responsibility for this information given. I understand and agree to the above policy.

To ensure continuity of care and proper utilization of prescription medication, we participate in the Virginia Board of Pharmacy Prescription Monitoring program, and by signing below you give us permission to access your prescription history.

By signing below, I agree that I have reviewed and/or received a copy of Medics USA, Inc. Privacy Notice.

Signature: _____ Date: _____

Patient was provided a copy of our Privacy Notice, but did not wish to sign verification of receipt.

Patient Name: _____ Date: _____

Staff Member Signature: _____

MEDICAL HISTORY

Patient: _____

DOB: _____ / _____ / _____

Primary Care Physician (if not Medics USA): _____

Date of Last Physical: _____

Reason for today's visit: _____

Are you allergic to any medications? YES NO **If YES, please list below**

1. _____ 2. _____

Have you ever had any anesthesia (Novocain)? YES NO Any bad reaction? YES NO

List all medication's name(s)/dosage(s) you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

PAST HISTORY AND REVIEW OF SYSTEMIC: (PLEASE CHECK YES OR NO)

Systemic	YES	NO	Other Systemic:	YES	NO	Other Systemic:	YES	NO
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Urination	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Lower Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Lightheadedness	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Persistent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Stool	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
TB	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	STD	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Head/Neck Radiation	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>			

List any other diseases or conditions: _____

List surgical procedures you have had in last 6 months: _____

Family History (Please include which family member and the age at which they were diagnosed.)

Cancer _____ Mental Disease _____ Glaucoma _____ Stroke _____

Diabetes _____ High Blood Pressure _____ Heart Disease _____

Please supply most recent dates for:

HEP B. _____ Pneumovax _____ FLU _____ Tetanus _____ Pap Smear _____

Mammogram _____ Prostate Exam _____ Cholesterol Check _____ Stool for Blood _____

Have you ever had blood transfusion? YES NO If yes please include dates: _____

Social History:

Do you drink alcohol? YES NO If yes, how many per day? _____

Do you use IV Drugs? YES NO If yes, what & how often? _____

Do you smoke? YES NO If yes how much? _____

Have you ever had or been exposed to HIV (AIDS)? YES NO

Please answer the following questions:

(Women) Are you pregnant? YES NO Due Date: _____ / _____ / _____

Marital Status _____ Children (How many) _____

What is your occupation? _____ Hobbies? _____ Pets _____

How did you hear about us? Family/Friend Newspaper Television Ad Digital Signage Ad Drive-by Website

Signature: _____

Date: _____

Billing Waiver

I _____, hereby give permission to my physician or a designee to provide medical care for me or my minor children. I authorize the release of medical information to my physician or a designee if needed and as necessary to process insurance claims, applications and prescriptions. I authorize payment of medical benefits to the physician.

Patients with Insurance:

For patients with insurance, applicable co-payments and deductibles will be collected at the time of service. We accept payment in the form of cash, check or credit card. I am aware my health insurance company requires me to provide a current insurance card at the time of service. **Medics USA will not accept the insurance information after the date of service.** Medics USA will file with the appropriate insurance company, but I am aware my health insurance company may not cover the services that I receive today from Medics USA Medical Center and I will be held financially responsible.

Patients Needing Referral/Authorization:

I understand it is my responsibility to obtain the necessary referral/authorization from my primary care physician or from my health insurance company if needed. I have been informed that a copy of the referral must be presented at the time of service; for after hour services we will allow 24 hours. I understand without a referral/authorization, if required, I will be held financially responsible for any charges not paid by my health insurance company.

Patients without Insurance:

For patients without insurance or are covering their own medical treatment, all payments are due at the time of service. We will charge a venipuncture fee along with a specimen handling fee when applicable. You will receive a separate bill from the lab for the lab work.

All Patients:

1. There will be a \$25.00 charge for all missed appointments unless cancelled 24 hours in advance. If your appointment is made within less than 24 hours and you cancel, you will be charged the cancellation fee.
2. Please allow 48 hours for prescription refills and/or referrals to be completed by our office
3. **All Lab results will be disclosed through secure email**
4. In the event that your account must be turned over to a collection agency, a 35% collection fee, court and attorney fees will be added to your account.

Your signature below signifies your understanding and willingness to comply with this policy.

Patient / Authorized person Signature

Date

Address: _____

Witness Signature

Date

Consent to Email Notification

I authorize Medics USA to e-mail any information pertaining to my office visits, laboratory results, radiology results and payment receipts to myself or to the third party listed below.

Patient Name

Patient's Signature

Patient's E-mail Address

Date

Third Party Email (If applicable)

Third Party Contact Name (If applicable)

MEDICS USA, INC.

Notice of Privacy

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.

Introduction

At MEDICS USA, INC, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit MEDICS USA, INC, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment, and a means of communication with other health care professionals, your Health Insurance Company, legal entities, and public health officials in order to promote your general health and that of the general public.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of MEDICS USA, INC, the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of information practices upon request.
- Inspect and copy your health record by written request.
- Request an Amendment to your health record.
- Obtain an accounting of disclosures of your health information.
- Request communications of your health information by alternative means or at alternative locations.
- Request a restriction on certain uses and disclosures of your information.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

MEDICS USA, INC is required to:

- Maintain the privacy of your health information,
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this Notice
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post, and if you request, mail you a revised notice.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer:

Privacy Officer, MEDICS USA, INC:

Kyle Hottinger, Privacy Officer

17336 Pickwick Drive, Suite 110

Purcellville, VA 20132

Telephone: (540)338-3360 Fax: (540) 338-1975

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights

U.S. Department of Health and Human Services

200 Independence Avenue, S.W.

Room 509F, HHH Building

Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include certain laboratory tests and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. This includes appointment reminders, and lab or other test results.

Research: We may disclose 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 health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law provides for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

As always, it is a pleasure to provide your healthcare needs. Thank you.