PATIENT REGISTRATION FORM

Patient Information

Last Name:	First Name:	M.I.	Previous Name:
Mailing Address:		Apt #:	
City/State/Zip:			
Home Phone:	Cell Phone:	Work Phone:	
Date of Birth:	Sex: ☐ Male ☐ Female	Family Physician:	
Marital Status:	Social Security #:		
Employer Name:	Emergency Contact Name:		
Emergency Contact Phone #:	Relationship to Patient:		

Additional Information and Responsible Party

Person responsible for the bill (ONLY IF DIFFERENT THAN THE PATIENT):

Last Name:	First Name:	
Date of Birth:	SSN #:	Phone:
Address of Person Responsible (if different from patient):		
City/State/Zip:	Relationship to Patient:	

Additional Information (PLEASE FILL OUT ALL FIELDS BELOW):

Email Address:	**Can we leave a message regarding your medical care & test results?** ☐ **Yes** ☐ **No**
Race (please select): ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic ☐ Native Hawaiian or Pacific Islander ☐ Black or African American ☐ Other ☐ Decline	**Ethnicity (please select one):** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Preferred Language (please select one): ☐ English ☐ Bosnian ☐ Indian (including Hindi & Tamil) ☐ Russian ☐ Sign Language ☐ Spanish ☐ Other

Preferred Pharmacy Location:

Insurance Information

Primary Policy Holder Information (ONLY IF DIFFERENT THAN THE PATIENT OR RESPONSIBLE PARTY):

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name:	Ins. Co. Name:
Policy Holder Name:	Policy Holder Name:
Policy Holder DOB:	Policy Holder DOB:
Policy Holder Relationship to Patient:	Policy Holder Relationship to Patient:
Policy Holder Social Security #:	Policy Holder Social Security #:

I have read and agree to Family Medicine Healthcare's (FMHC) payment policy. I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to FMHC all money to which I am entitled for medical expenses related to the services performed from time to time by FMHC, but not to exceed my indebtedness to FMHC. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to FMHC. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of Family Medicine Healthcare's Privacy Notice. ☐ **(Initials)**

Signature of Responsible Party: _____ Date_____

Printed Name of Responsible Party:_____

PATIENT INFORMATION SHEET

NAME:_____ DOB:_____ DATE:_____

ALLERGIES:_____

SOCIAL HISTORY:

Recreational Drug Use: Current / Past / Never

Smoking: Currently Past Never Packs/day:_____

Alcohol: Currently Past Never Drinks/day:_____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

Medications	OTC and vitamins

PERSONAL MEDICAL HISTORY: (Please circle/fill in all that apply)

ADHD	COPD	High Cholesterol	Peptic Ulcer
Alcoholism	Dementia	HIV	Psoriasis
Allergies, Seasonal	Depression	Hepatitis	Pulmonary Embolism (PE)
Anemia	Diabetes: 1 or 2	Irritable Bowel Syndrome	Rheumatoid Arthritis
Anxiety	Diverticulitis	Kidney Stones	Sciatica
Arrhythmia (irregular heart beat)	DVT (Blood Clot)	Kidney Disease	Seizure Disorder
Arthritis	Eczema	Lupus	Sleep Apnea
Asthma	Emphysema	Liver Disease	Stroke
Bipolar	Gallstones	Macular Degeneration	Thyroid Disorder
Bladder problems/Incontinence	GERD (Acid Reflux)	Migraines	Ulcerative Colitis
Bleeding problems	Glaucoma	Nosebleeds	
Cancer:_____	Heart Disease	Neuropathy	
Carpal Tunnel	Heart Attack (MI)	Osteopenia/Osteoporosis	
Headaches	Hiatal Hernia	Parkinson's Disease	
Crohn's Disease	High Blood Pressure	Peripheral Vascular Disease	

Last Menstrual Period	Yes/No Date:____	Normal Abnormal
Colonoscopy	Yes/No Date:____	Normal Abnormal
Mammogram	Yes/No Date:____	Normal Abnormal
Dxa (Bone Density)	Yes/No Date:____	Normal Abnormal

Other medical problems not listed above:

_____

_____

Surgical History: Please list all prior surgeries and approximate dates performed.

_____ _____

_____ _____

_____ _____

FAMILY HISTORY:

FATHER: Living: Age_____ Deceased: Age_____

Alcoholism	Blood Cancer	Migraines	Bipolar	Osteoporosis
COPD/Emphysema	Skin Cancer	Colon Cancer	High Cholesterol	
Stroke	Heart Disease	Lymph Cancer	Thyroid disorder	
Anemia	Asthma	Breast Cancer	Dementia	
Blood Clot/DVT	Depression	Kidney Disease	Prostate Cancer	
Arthritis	High Blood Pressure	Diabetes 1 or 2	Thyroid Cancer	

Other:_____

MOTHER: Living: Age_____ Deceased: Age:_____

Alcoholism	Breast Cancer	Migraines	Bipolar	Osteoporosis
COPD/Emphysema	Blood Cancer	Colon Cancer	High Cholesterol	
Stroke	Heart Disease	Skin Cancer	Thyroid disorder	
Anemia	Asthma	Lymph Cancer	Dementia	
Blood Clot/DVT	Depression	Kidney Disease	Ovarian Cancer	
Arthritis	High Blood Pressure	Diabetes 1 or 2	Thyroid Cancer	

Other: _____

Siblings: _____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, etc.)

_____

_____

Previous PCP: _____

Patient signature:_____ Date:_____

Provider reviewed:_____ 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.

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. Uses And Disclosures We May Make Without Written Authorization. We may use or disclose your health information for certain purposes without your written authorization, including the following:

Treatment. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.

Payment. We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain payment for treatment.

Healthcare Operations. We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.

Other Uses or Disclosures. We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:

- To avoid a serious threat to your health or safety or the health or safety of others.
- As required by state or federal law such as reporting abuse, neglect or certain other events.
- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the military or correctional institutions.
- For research purposes if certain conditions are satisfied.
- In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.
- To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

2. Disclosures We May Make Unless You Object. Unless you instruct us otherwise, we may disclose your information as described below.

- To a member of your family, relative, friend, or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment.

3. Uses and Disclosures With Your Written Authorization. Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. Your Rights Concerning Your Protected Health Information. You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below**.**

- You may request additional restrictions on the use or disclosure of information for treatment, payment or

healthcare operations. We are *not* required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.

- We normally contact you by telephone, mail at your home address and possibly by e-mail if you have given

your e-mail address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.

- You may inspect and obtain a copy of records that are used to make decisions about your care or payment

for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others.

- You may request that your protected health information be amended. We may deny your request for certain

reasons, e.g., if we did not create the record of if we determine that the record is accurate and complete.

- You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period.

- You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. Changes To This Notice. We reserve the right to change the terms of this Notice at anytime, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or Privacy Officer.

6. Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.

7. Contact Information. If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact:

Privacy Officer:	Graisse Abdelshaheed
Phone:	757-488-3333
Address:	6111 Portsmouth Blvd. Portsmouth, VA 23701
E-mail:	graisse@familymedicinehealthcare.com

8. Effective Date. This Notice is effective September 15, 2013.

AUTHORIZATION TO RELEASE & PAY BENEFITS

Patient's Full Name _____ Date of Birth _____

I hereby consent to treatment by Dr. Abdelshaheed and / or assistant and accept responsibility for fees for such medical services. I understand that treatment may include medical appliances and / or such other procedures deemed necessary.

I understand that payment (or co-payment) is expected at time of services, and my insurance is filed as courtesy to me. I understand that I am financially responsible for charges not paid by my insurance. I further understand that if a balance results on my account at the time of any litigation settlement relating to my account with this practice this will be the first bill paid and paid in full at the time of settlement. Should collections actions become necessary, I understand that I will be liable for any and all costs, including all attorney fees associated in collecting the unpaid balance owing on my account.

I hereby authorize the release of any information necessary for filing of insurance and direct payment to Dr. Abdelshaheed or **FAMILY MEDICINE HEALTH CARE** for any amount due under my present policy or any policy that I may at a later date ask to be filed.

This authorization is valid for current and subsequent treatment unless I submit a written revocation. A photo copy of this authorization shall be considered as valid as the original. I will advise **FAMILY MEDICINE HEALTH CARE** and / or medical staff, of any changes of my insurance coverage. The undersigned agrees to pay all costs of collections including attorneys fees of 331/3% of the amount of the account placed with the attorney.

If I fail to appear for scheduled appointments, it is my responsibility to reschedule, without any expectation from FAMILY MEDICINE HEALTH CARE to call me to determine my failure to appear. In the event that I am unable to give FAMILY MEDICINE HEALTH CARE 24 hours notice of my inability to appear to my appointment I may be charged a $20.00 fee.

If health care workers are exposed to my blood or body fluid in the course of providing health care to me, I agree to have my blood tested for any infectious disease which might be transmitted to them through this exposure, including HIV/AIDS and hepatitis.

Insurance is filed as a courtesy. Co-pays are expected at time of service.

Signature of Patient or Responsible Party _____

Relationship to Responsible Party _____ Date _____

Samir Abdelshaheed, MD • 6111 Portsmouth Boulevard • Portsmouth, VA 23701 • office 757-488-3333 • fax 757-488-0007

PATIENT CONSENT

Patient's Name: _____ Date of Birth _____

The Department of Health and Human Services has established a 'Privacy Rule' to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical information and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we will provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for the purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of you personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you chose to give consent in this document, at some future time you may request to refuse to disclose all or part of your (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our Privacy Notice.

EACH UNDERSIGNED REPRESENTS THAT HE/SHE HAS READ AND FULLY UNDERSTANDS THE MEANING AND EFFECTS OF THIS ENTIRE AGREEMENT.

_____ _____

Signature of patient or parent/guardian if minor Date

_____ _____

Printed name of patient or parent/guardian if minor Relationship to Patient