

Change of Information _____

PATIENT REGISTRATION FORM
PHYSICIANS OF FAMILY MEDICINE

New Patient _____

PATIENT INFORMATION

Patient's Name (Last) _____ (First) _____ (Middle) _____

Address _____ City _____

State, Zip Code _____ Sex: M / F Social Sec. # _____

Birthdate _____ Home Phone _____ Work Phone _____ Marital Status _____

Email _____

EMERGENCY CONTACT _____ PHONE NUMBER _____

RESPONSIBLE PARTY

Guarantor's Name _____

Address _____ City, State, Zip _____

Patient Relation to Guarantor _____ Guarantor Employer _____

Employer's Address _____ City, State, Zip _____

Guarantor's SS # _____ Guarantor's Birthdate _____ Sex _____

PRIMARY INSURANCE

Name of Insurance Company _____ Policyholder _____

Pt. Relationship to Policyholder _____ Policy Number _____ Group Number _____

Insurance Co. Address _____

Insurance Co. Phone Number _____ Policyholder Birthday _____ Sex _____

SECONDARY INSURANCE

Name of Insurance Company _____ Policyholder _____

Pt. Relationship to Policyholder _____ Policy Number _____ Group Number _____

Insurance Co. Address _____

Insurance Co. Phone Number _____ Policyholder Birthday _____ Sex _____

I, the undersigned, hereby consent to and authorize the administration and performance so all treatments, the administration of any needed anesthetics; the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, the use of prescribed medication; the performance of diagnostic procedures; the taking and utilization of cultures and performance of other medically accepted laboratory test, all of which in the judgment of the attending physician on their assigned designees, may be considered medically necessary or advisable.

I fully understand that this consent is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full until revoked in writing.

I hereby authorize Physicians of Family Medicine to release medical information to any of my physicians or insurance companies that may be pertinent to my cause. I hereby authorize payment directly to Physicians of Family Medicine of benefits otherwise payable to me. I hereby authorize the release of my medical records to third party insurers, or other authorized person to whom disclosure is necessary to establish or collect a fee for the services provided. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize Physicians of Family Medicine to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Physicians of Family Medicine.

In accordance with the provisions of Section 32. 1/45.1 of the Code of Virginia (whenever any health care provider, or any person employed by or under the direction and control of a health care provider, is directly exposed to body fluids of a patient in a manner which may, according to the current guidelines of the Centers of Disease Control, transmit human immunodeficiency virus, the patient whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus.

If there is an exposure, and the patient's test is positive, the attending physicians will notify the patient, any person exposed, and the Virginia Health Department and appropriate counseling will be offered.

I have reviewed and understand my PATIENT RIGHTS AND RESPONSIBILITIES. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient's Signature (or responsible party) _____ Date _____

HCA Physician Services
Physicians of Family Medicine

Patient Consent Form

(Please Read and Sign)

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that Physicians of Family Medicine may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that Physicians of Family Medicine will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize release of medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Physicians of Family Medicine.

I acknowledge that I have been given the Physicians of Family Medicine Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. Patient Initial: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient (or Responsible Party) Signature

Date

Original - Practice

HIM.PRI.001, HIM.PRI.007

Revision Date: May 22, 2003

FORM 037

Kevin M.J. Harvey, M.D.
 Robert D. Cross, M.D.
 C. Randolph Hinson, M.D.
 Atiya Atique, M.D.

PHYSICIANS OF FAMILY MEDICINE

Oxbridge 10130 Hull Street Road Midlothian, VA 23112
 Clover Hill 13861 Hull Street Road Midlothian, VA 23112

Lorena L. Harvey, M.D.
 James Bampton, M.D.
 Bogale Jima, M.D.

Name: _____ Referred by: _____ Chart #: _____

Address: _____ Social Security #: _____

Date of Birth: _____ Male - Female _____ Race: _____ Marital Status: Single Married Widowed Divorced Remarried

Highest grade completed in School: _____ Number of Children: _____ Current Occupation: _____

Who else lives with you in your home: _____

Medical History: _____ Please list any significant medical illness or illnesses for which you are currently under care:

List all past Hospitalizations - include name of hospital, date, reason for hospitalization, and surgeries:

List any specialist doctors whom you see and the reason for the visits:

Date of last Tetanus shot: _____ Are all Childhood immunizations up to date? YES NO

List any current medications that you take and the dosage of each:

List any allergies, include medications, foods, environmental:

Do you smoke: Cigarettes Cigars Pipes Chew Tobacco Yes No How much per day?

Do you drink: Beer Wine Liquor Yes No If yes, how much do you consume in an average week?

Have you used any illegal drugs in the past year? Yes No If yes, which drugs?

Do you do any regular exercise? Yes No If yes, what do you do?

FAMILY HISTORY

Please list any medical illnesses and/or cancers in your family:

Relationship	Alive		Current Age	Age at Death	Medical Illness Cause of death	FOR WOMEN ONLY	
	Deceased					Age when periods began	
Mother						Age when periods began	
Father						Last PAP	
Brother / Sister						Last Mammogram	
Brother / Sister						Number of Pregnancies	
Child						Number of Miscarriages	
Child						Number of abortions	
How did you hear about our practice?						Do you perform self Breast Exams	
NAME OF PRIMARY PHYSICIAN:						Do you have regular menses	
Use this area to list anything else you would like us to know about you.						Age when periods stopped	
						Current method of contraception	
						Number of living children	

Kevin M.J. Harvey, M.D., FAAFP
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10130 Hull Street Road
Midlothian, VA 23112
Phone: (804) 276-6900
Fax: (804) 276-1366

13861 Hull Street Road
Midlothian, VA 23112
Phone: (804) 739-0910
Fax: (804) 739-2763

Release of Medical Information

May Physicians of Family Medicine and/or members of the office staff release medical information to specified persons other than you? Yes _____ No _____

If yes, please specify to whom this information may be released.

Authorized Person

Relationship to you

What information may be released?

Lab results	Yes _____	No _____
X-ray reports	Yes _____	No _____
Medications	Yes _____	No _____
Medical status	Yes _____	No _____
Appointments	Yes _____	No _____

I understand that as part of my continuing healthcare, my physician maintains medical records in his/her office, which contain my health history, symptoms, examinations, test results, diagnoses, and treatment plans, to be used as a basis for planning my care and treatment, and that this information may be released to my other physicians/healthcare providers.

I understand that I have the right to request restrictions as to how my medical record may be used or disclosed.

I understand that my physician keeps on premises a copy of the "Notice of Privacy Practices for Protected Health Information" which provides a more complete description of the uses and disclosures of my medical record, and that I have been provided the opportunity to review this document prior to signing this consent, and that a written copy will be provided to me on request.

I understand that my physician has the right to change this policy and that I will be notified in writing prior to any changes taking effect.

I understand that this document is a part of my permanent medical record, and that I may make changes regarding the disclosure of my health information at any time and that I need to notify my physician in writing of these changes.

X
Patient Signature

Date



Kevin M.J. Harvey, M.D., FAAFP
 Lorena L. Harvey, M.D., FAAFP
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 C. Randolph Hinson, Jr., M.D.
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We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policies.

PAYMENTS FOR SERVICES IS DUE AT THE TIME SERVICES ARE PROVIDED.

We accept cash, checks, Visa, MasterCard, Discover, and American Express. We will be happy to process claims for those PPO's and HMO's with which we participate, but you will be expected to pay any co-payment, coinsurance amount (generally 20% of the visit), or deductible amount (determined by your insurance policy) at the time of service. Also of note, is HCA has partnered with a firm called Cash Flow Management, who will aid us in collecting any outstanding balances after you have received your second statement. They will be making phone calls on our behalf and also send out statements. You, of course may continue to make any payments to us here at the practice.

We must emphasize that as medical care providers, our relationship is with you and not your insurance company. All charges are your responsibility from the date the services are rendered. If someone else is presumed liable for a bill, such as a divorced spouse or parent, we will look to the patient, or if minor, the guardian, for payment of services. We will gladly provide you with a receipt for payment. We realize that temporary financial problems may effect timely payment of your account. If such problems do arise, we encourage you to contact us promptly, and prior to your office visit, for assistance in the management of your account.

Returned checks and balances older than thirty days may be subject to additional collection fees. We will gladly discuss your charges prior to your office visits and any questions relating to your insurance. You must realize, however, that:

- 1) Your insurance is a contract between you, your employer, and the insurance company
- 2) Not all services are a covered benefit in all contracts. You may wish to contact your insurance carrier for information regarding coverage. For example: Many insurance companies do not cover routine exams or supplies such as crutches, or lab tests performed in the office such as strep and flu tests, and EKG's.

You can always help us by updating your registration sheet with the receptionist when changes occur such as a new employer or new home address. If you have any questions about our office, please do not hesitate to ask us. We are here to help you.

Initials _____

Date _____

10130 HULL STREET RD.
 MIDLOTHIAN, VA 23112
 804-276-6900
 FAX: 804-276-1366

Thank you.

13861 HULL STREET RD.
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