MetroHealth Internal Medicine, PC

450 Garrisonville Road, Ste.215
Stafford, VA 22554
Phone: (540) 318-8167 Fax: (540) 318-8165

PATIENT INFORMATION				
Last Name:	First Name:	MI:	Date of Birth:	
Sex: ☐ M ☐ F	Race: ☐ Declined	Ethnicity: ☐ Declined	Preferred Language: ☐ Declined	
Home Address:			Social Security # :	
City:	State:	Zip Code:	Marital Status: (Circle One) Single/Married/Widowed/Separated/Divorced	
Home Phone: Preferred	Cell Phone: Preferred		Work phone:	
Email:			Employer:	
Previous Primary Care Physician (PCP):				

PRIMARY INSURANCE INFORMATION			
Insurance Name:			Effective Date
Subscriber Name:		ID #:	Group #:
Subscriber DOB:		Email:	
Relation to Patient:	Subscriber Employer:		Subscriber Work Phone:

SECONDARY INSURANCE INFORMATION			
Insurance Name:			Effective Date
Subscriber Name:		ID #:	Group #:
Subscriber DOB:		Email:	
Relation to Patient:	Subscriber Employer:		Subscriber Work Phone:

EMERGENCY CONTACT INFORMATION			
Name:	Relationship to Patient:	Home Phone:	Cell Phone:

I authorize my insurance benefits to be paid directly to the physician and I agree to be financially responsible for all charges incurred. I hereby consent to the release and re-disclosure of my financial records to enable or facilitate the collection, verification, or settlement of my account for any amounts due from me or any third party payer, Health maintenance organization, insurer or other health benefit plan. This consent applies to Metrohealth, P.C, (MHIM), any of its affiliates or agents, lenders, or any third party services acting on behalf of MHIM or any of its affiliates.

I understand that I am financially responsible for all amounts payable with regards to fees for healthcare services rendered now and in the future by this practice. In the event of non-payment of any amounts due by the responsible party to this practice I agree that in addition to the amount due, I am responsible to pay late fees of $55.00 on accounts over 60 days and collection fees of 33 and 1/3% of the amount due court costs and submit delinquent account over to our attorneys at which time any and all civil penalties as provided in section 8.01-27 of the code of Virginia (1950) will be imposed.

I, _____ (print full name) as the financially responsible party to the above named patient agree to the aforementioned statements and authorize payment of medical benefits to MetroHealth Internal Medicine, P.C for services rendered.

_____ _____

Signature of Responsible Party Date

MetroHealth Internal Medicine, PC

450 Garrisonville Road, Ste.215
Stafford, VA 22554
Phone: (540) 318-8167 Fax: (540) 318-8165

OFFICE POLICIES

Office Hours

- Monday-Thursday 9:00am-5:00pm
- Friday 9:00am- 12:00pm
- Closed for lunch 12:00pm-1:00pm

Appointments

- We will call the day before to confirm your appointment, if there is no answer we will Leave a message; please make every effort to return our call before 5:00pm that day.
- We require 24 hour notice to cancel all appointments.
- No Show fee is $50.00. This will be billed to you, not you're insurance.
- Not showing up to an appointment two times is grounds for termination of the doctor patient relationship.
- Patient is responsible for knowing insurance coverage before office visit.

Refills

- For all prescription refills **please contact your pharmacy first.**
- No refills will be given over the phone. You will be required an office visit for refill. Make sure you review your medication(s) before your visit and request refill during your office visit.
- We **DO** NOT prescribed any type of controlled substances including narcotic, pain medicine and/or benzodiazepine.

Self-Pay

- New patient visit are $165.00, due at time of visit.
- All appointments thereafter are $120.00, due at time of visit.
- All testing done, including, but not limited to EKGs, injections, and labs are at additional cost and due at time of visit. **Please ask for cost(s) before having any tests done.**

Print Name of Patient: _____

Patient Signature: _____ Date: _____

MetroHealth Internal Medicine, P.C.

HEALTH QUESTIONAIRE
Confidential Data

Name: _____ **D.O.B:**_____ **Date:** _____

Allergies to Medication, X-Ray Dyes, or other substance		
Allergen Name	Reaction	Start Date

Medications- List all prescription medications you currently take.		
Medication	Strength	How Often
Supplement- List all vitamins or over the counter medications you use.		

Preventive Care- List date of last test or screening	
Colonoscopy	
DEXA (bone density)	
Eye Exam	

MALE PATIENTS	**Date of last test**	**FEMALE PATIENTS**	**Date of last test**
PSA Laboratory		Mammogram	
Rectal/ Prostate Exam		Pap Smear	

Past Procedures/ Surgeries- List surgical procedures, reasons for hospitalizations and the year.			
Type	Approximate Date	Type	Approximate Date

Health History- Are you being treated for or have you ever had any of the following health conditions?
Please ☑ if applicable and the approximate date of when you were diagnosed.

	Illness	Date			Illness	Date
	Alcohol problems				High Blood Pressure	
	Anemia				High cholesterol	
	Anxiety				HIV/AIDS	
	Asthma				Hyperthyroidism	
	Bleeding problems				Hypothyroidism	
	Blood clots				Kidney Disease	
	Cancer Type:				Low Vitamin D	
	Convulsions				Osteoporosis/ Osteopenia	
	COPD				Peptic Ulcer	
	Depression				Prostate problems	
	Diabetes				Seizure Disorder	
	Emphysema				Sleep Apnea	
	GERD				Stroke	
	Glaucoma				Thyroid problems	
	Heart				Venereal Disease	
	Arrhythmia				**Any others please list below:**	
	Coronary Artery Disease					
	Defibrillator					
	Failure					
	Pacemaker					
	Palpitations					
	Stents					
	Valvular					
	Hepatitis A B C other:_____					

Family History- Has any of your family (including parent, grandparents, and siblings) ever had the following?

Illness	Which family member?
Stroke	
Cancer	
High Blood Pressure	
High Cholesterol	
Diabetes	
Heart problems	
Bleeding Disease	
Asthma	
Anemia	
Convulsions	
Kidney Disease	
Thyroid Disease	
Hereditary defects	
Anxiety/ Depression	
Drug or Alcohol addiction	
Glaucoma	

Social History

Marital Status:☐ Single ☐ Married ☐ Divorced I ☐ Widowed ☐ Separated

Use of Alcohol: ☐ Never ☐ Occasional ☐ Moderate ☐ Heavy (daily)

Use of Drugs: ☐ Never ☐ Past Use of _____ ☐ Current use of: _____

Use of Tobacco: ☐ Never ☐ Past ☐ Current ☐ If so how many packs a day?
_____

Start Date: _____ Quit Date: _____

Caffeine Intake: ☐ Never ☐ Past ☐ Current ☐ If so how many cups a day?
_____

Highest Degree of Education: _____

Current Work Status: _____

Occupation: _____

Sexually Active: ☐ Yes ☐ No

History of STDs: ☐ Never ☐ at age _____

Women's Health

Age of menarche: _____ Age of Menopause: _____ Hysterectomy Year: _____

Last Menstrual Period: _____ ☐ Regular ☐ Irregular

Pregnancies: _____ Full Term Pregnancies: ____ Abortion/Miscarriage: ____ Living children: _____

Vaginal Deliveries: _____ Cesarean Deliveries: _____

Birth Control Method: ☐ None ☐ Tubal Ligation ☐ BC Pills ☐ Depo Injection ☐ SQ Implant ☐ BC Ring
☐ BC Patch ☐ Partner's Vasectomy ☐ Other: _____

MetroHealth Internal Medicine, PC

450 Garrisonville Road, Ste.215
Stafford, VA 22554
Phone: (540) 318-8167 Fax: (540) 318-8165

PERMISSION TO DISCLOUSER AND RELEASE INFORMATION

(Protected Health Information)

I, _____ hereby request this practice to disclosure and release information of the following topics contained in my medical:

_____ History of injury, illness or condition for which I am being treated.

_____ Diagnosis.

_____ Test result.

_____ Medications.

_____ Medical Recommendations.

I give my permission to disclose the information to the person (s) listed below.

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
Signature of Patient, parent or Guardian Date

Note: In order to obtain information by telephone, the party calling must share the patient identity with the staff.
Patient information: Complete name. Date of birth, and SS#.

MetroHealth Internal Medicine, PC

450 Garrisonville Road, Ste.215
Stafford, VA 22554
Phone: (540) 318-8167 Fax: (540) 318-8165

COLLECTIONS CONTRACT

In the absence of prompt payment, the undersigned understands that medical, personal and financial records concerning these professional services will be released to the provider's attorney for collections. The attorney will act as the provider's "Business Associate" in compliance with the federal "Health Insurance Portability and Accountability Act."

In consideration for the professional services rendered now and in the future, for all account balances forwarded to collections, the undersigned hereby agrees to pay 18% interest per annum on all balances which are unpaid sixty (60) days after the services are rendered; plus attorney's fees which are hereby stipulated to be 33 1/3% of such outstanding balance whether suit is filed or not; plus court costs. If the undersigned fails to promptly pay for the services rendered, the undersigned authorizes the release by or to any credit reporting agencies of personal credit information on the undersigned and further agrees to pay all costs of obtaining such credit information and/or locating the undersigned, as may be necessary.

The undersigned understands that Medical Insurance claims may be billed by the provider, as a courtesy, if the provider participates in the patients insurance plan, and if the patient promptly furnishes the provider with all correct insurance information. The undersigned is fully responsible for all sums due whether or not insurance coverage is available.

I, the undersigned, certify that I

[ ] am an active duty member of the US Armed Forces.
[ ] am not an active duty member of the US Armed Forces.

_____ _____

Date Print name of Responsible Party

_____

Signature of Responsible Party

MetroHealth Internal Medicine, PC

450 Garrisonville Road, Ste.215
Stafford, VA 22554
Phone: (540) 318-8167 Fax: (540) 318-8165

NOTICE OF INFORMATION PRACTICES

MetroHealth Internal Medicine is dedicated to protecting your medical information. We are required by law to maintain the privacy of Protected Health Information (PHI) and to provide you with the Notice of our legal duties and privacy practices with respect to Protected Health Information (PHI). MetroHealth Internal Medicine is required by law to abide by the terms of this Notice.

****PHI-Protected Health Information****

1. MetroHealth may use and disclose PHI for treatment, payment and healthcare operations. Examples of these include but are not limited to: Requested schools or sports physicals, referral to nursing or foster care homes, home health agencies and/or insurers, collection agencies, internal quality control, and assurance including auditing of records.

2. MetroHealth is permitted or required to use or disclose PHI without the individual's written consent or authorization in certain circumstances. Examples of these are: for public health requirements or court orders.

3. MetroHealth will not make any other use or disclosure of a patient's PHI without the individual's written authorization; such authorization may be revoked at any time. Revocation must be written.

4. MetroHealth will abide by the terms of this Notice currently in effect at the time of the disclosure.

5. MetroHealth reserves the right to change the terms of its Notice and to make new notice provisions effective for all PHI that it maintains. MetroHealth will provide each patient with a copy of any revisions of its Notice of Information Practices at the time of their next visit, or at their last known address if there is a need to use or disclose and PHI of the patient. Copies may also be obtained at any time at our office.

6. Any patient, guardian or personal representative has the right to inspect and obtain copies of their medical records.

7. Any patient, guardian or personal representative has the right to request amendments be made to their medical records.

8. Any patient, guardian or personal representative has the right to request a six year accounting of all disclosures of their medical records. The history will be provided within 60 days of the request and reasonable charge may be assessed for any copies after the first requested in a 12 month period.

9. Any patient, guardian or personal representative has the right to request restrictions as to how their health information may be used or disclosed to carry out treatment, payment or healthcare operations. The Practice is not required to agree to the restrictions requested, but if the Practice does agree, the Practice must abide by those restrictions.

10. Any person/patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. All complaints will be addressed and the results will be reported to the Privacy Officer. To file a complaint with the Practice, please contact the Privacy Officer at the following address and or phone number:

MetroHealth Internal Medicine
450 Garrisonville Road- Ste. 215
Stafford, VA 22554
(540) 318-8167

Name of Patient (Please Print): _____

Signature of Patient or Legal Guardian: _____

Date: _____

'Disclaimer: Contents are informational and not intended as legal advice. MHIM, P.C. and its subsidiaries, its employees, agents and staff, make no representation, guarantee or warranty, express or implied, that these forms are error-free or that the use of this information will prevent differences of opinion or disputes with any other party, and will bear no responsibility or liability for the results or consequences of its use.

MetroHealth Internal Medicine, PC

450 Garrisonville Road, Ste.215
Stafford, VA 22554
Phone: (540) 318-8167 Fax: (540) 318-8165

GUARANTEE OF PAYMENT

I, _____ birth date_____ understand that I am financially responsible for all monetary charges not covered by my insurance carrier with regards to fees for healthcare services rendered now and in the future by MetroHealth Internal Medicine. I acknowledge that I personally responsible for all denied charges to MetroHealth Internal Medicine and further agree that in the event of default, I am responsible to pay collections fees, court costs and reasonable attorney fees.

Patient's Name (Print): _____

Signature: _____

Date: _____