VIRGINIA
INTEGRATIVE MEDICAL

REGISTRATION FORM

Today's Date: [Date]	PCP: [PCP]

PATIENT INFORMATION

Patient's last name:	First:	Marital status:		
Street Address:	P.O. Box	Birth date: / /	Age:	Sex: ☐ M ☐ F
Address: City, State, ZIP Code				
Home Phone:	Cell Phone:	Employer:		
Occupation:	Employer Address:	Employer phone no.:		

How did you hear about us: ☐ Doctor ☐ Insurance plan ☐ Family ☐ Friend ☐ Close to home/work ☐ Social media ☐ Other

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill if not the patient:		Address (if different):	Home phone no.:
Primary Insurance:	Subscribers Name:	Address: (If Different)	Home Phone:
Subscribers Date of Birth / /	Group #:	Policy #:	Co-payment $

Subscribers Occupation:	Employers Address:	City"	State, Zip	Phone #:

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize VIRGINIA INTEGRATIVE MEDICAL or insurance company to release any information required to process my claims. Medicare Beneficiary Lifetime "Signature on File": I request that payment of authorized Medicare benefits be made on my behalf to BoDen Health for any services furnished me by physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents information todetermine benefits payable for services rendered.

Patient/Guardian signature **Date**

Privacy Notice/ Billing Waiver/ Patient Portal/ Release of Medical Information

Privacy Notice

I ____ (Patient/Guarantor) have been provided with a copy of the Notice of Privacy Practices for Virginia Integrative Medical.

Due to the **HIPAA Privacy Act,** we are not permitted to release information regarding your care. If you wish to grant your permission, please list below the person(s) that we may speak with on your behalf. Please be aware that these persons designated by you will have full access to your Private Health Information (PHI).

NAME:	RELATIONSHIP:
__________________________	__________________________
__________________________	__________________________
__________________________	__________________________
__________________________	__________________________

YOUR NAME: ____
SIGNATURE: ____
DATE: ______________________

Do you authorize Virginia Integrative Medical to leave a confidential voice-mail?
Authorized Secured Phone # : _______________________________________

VIRGINIA INTEGRATIVE MEDICAL PRACTICE FINANCIAL POLICY STATEMENT

Thank you for choosing our physicians for your Neurological health care needs. We are committed to providing the very best medical care and treatment. The following is a statement of our Financial Policy, which you ***must*** read, agree to and sign, prior to treatment.

Practice Payment Policy Guidelines:

- Patients/ (guardians) are financially responsible for all charges, regardless of third-party involvement.
- Full payment is due at time of services, unless prior insurance billing arrangements have been made.
- Patients with insurance will be required to pay all “out-of-pocket” financial obligations at time of service.
- We accept: Cash, Check, and debit/credit cards: Visa/ Master Card.

Patient Responsibilities and Financial Policies: Provide Accurate Information: You have a responsibility to provide accurate and complete information about your health history, mailing address, health insurance and other billing information. If any information changes – name, address, phone, insurance coverage, etc. – you must inform this practice immediately. Insurance denials or billing errors due to patient supplied information will result in the transfer of the account balance to the patient’s immediate financial responsibility.

Know Your Insurance Coverage, Benefits and Referral Requirements: Your health insurance is a contract between you and your health insurance plan(s). Patients are responsible for understanding their health insurance coverage(s), benefits and referral requirements per-authorizations or pre-certifications from their primary care physicians. Patients are responsible for securing the necessary written referrals, received the necessary per-authorizations or per-certifications from your primary care physician or health plan prior-to service rendered. If you have not received the necessary authorizations prior to your appointment, the appointment will be rescheduled. Please present your Insurance ID card to our staff upon registration for ***each office visit***.

Self-Pay Patients: Patients without insurance coverage are expected to pay for service received in full at time of service.

Patient with Private Insurance / Medicare / Medicaid Coverage: Our physicians participate with the Medicare and Medicaid Programs, and with most major insurance companies. We will file claim(s) to your insurance provided you authorize the “assignment of benefits” below for payment directly to our practice. For participating insurance plans, the practice will accept payment based on contractual agreements. For plans that we don’t participate in (i.e., there is no contractual agreement), the practice will expect full payment from the patient at time of service. Any coverage or payment dispute is a matter between the insurance policyholder and the insurance company.

Patient Payment Agreement: I understand that I am financially responsible for all charges, regardless of third-party involvement. I agree to pay any deductible coinsurance, co-payment, or serviced deemed as “non-covered” by my insurance carrier at the time of service. If my insurance has not paid on my account in 60 days, the outstanding serviced will become my responsibility for immediate payment (unless Medicare and Medicaid). Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, non-payment at time of service and/or any other reason, I agree to pay all charges within 30 days of notice. I understand that if I fail to pay outstanding balances or make payment arrangements within 75 days, the amount due will be considered delinquent and subject to legal action. I further understand that delinquent accounts will be assessed a 1.5% interest charge per month (18% APR), and will be subject to the possible dismissal of the patient from our care. If my account is forced to collection I agree to pay all collection costs, including, but not limited to, court costs, attorney’s fees equal to 33.33% of the amount owed, and accrued interest charges to date. I agree to pay a $25.00 returned check fee. Copies of my medical records can be obtained with advance notice in accordance with §8.01-413 of the Code of Virginia, with charges not to exceed $0.50 per page for the first 50 pages and $0.25 per page thereafter, in addition to a $10.00 handling fee plus postage expense. The completion of special forms or reports has a minimum charge of$25.00 for each form.

Authorization & Assignment of Insurance Benefits: I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of specific medical or other protected health information, whether manual, electronic or telephonic. I authorize the Practice to apply for benefits for services rendered to myself or minor child under any health insurance policies providing benefits and do hereby also assign and authorize payment of benefits from my insurance company to the Practice (including benefits payable under Title XVIII of the Social Security Act and/or any other governmental agency.) I irrevocably authorize all such payments to the Practice. I authorize the Practice to contact the employer or insurance company regarding insurance information, existence of insurance and coverage of my benefits.

In consideration for medical service rendered, I acknowledge receiving notice of the financial policy and agree to pay for said medical services according to the above terms. My signature below indicates that I have read and agree to the above policy.

____ ____________________

Patient / Responsible Party / Guardian Signature Date

RELEASE OF MEDICAL RECORDS

Name of Hospital / Doctor: ______________________________

Address: ______________________________

Attention: Medical Records Department

[ ] X-Rays

[ ] Medical Records & Office Notes

[ ] Insurance Information

[ ] Other: ______________________________

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS REGARDING THE BELOW NAMED INDIVIDUAL DURING HIS/HER TREATMENT AT YOUR FACILITY HAS BEEN OBTAINED BELOW.

Today's Date: ____________________

X ______________________________
Patient's Signature (Guardian if Minor)

X ____________________
Patients Date of Birth

X ____________________
Print Name

Please Forward Medical Records to:

Virginia Integrative Medical, LLC

Fax: 540-508-0841

MEDICAL HISTORY FORM

Name: ______________________________

DOB: ____________________

Date: ____________________

Reason for visit today:

____

____

____

Please check if you currently have or have had any of the following:

☐ Asthma ☐ Hypertension ☐ Depression ☐ Psychiatric Disorder
☐ Hepatitis B ☐ Seizures ☐ Blood Clots ☐ Bleeding Disorder
☐ Hepatitis C ☐ Heartburn ☐ Diabetes ☐ Heart Disease
☐ Ulcers ☐ Hayfever ☐ Migraines ☐ Elevated Cholesterol
☐ Urinating Difficulties ☐Thyroid Disease ☐ Cancer
☐ Other Please specify: ________________
Comments: ____

Immunizations:

Last Tetanus: __________

Last TB: __________ Positive: Y N

Hepatitis A Series: __________

Hepatitis B Series: __________

Flu: ______________________

Date of Last Preventative:

Colonoscopy: Year _______ Normal?: ☐ Y ☐ N
Pap: Year _______ Normal?: ☐ Y ☐ N
Mammograms: Year _______ Normal?: ☐ Y ☐ N
Dexascan: Year _______ Normal?: ☐ Y ☐ N

Please mark any past surgeries and/or hospitalizations, indicate which by marking an S or H.

Back___(S/H) Sinus___(S/H) Tonsils___(S/H) Bones___(S/H)
Hernia___(S/H) Appendix___(S/H) Vasectomy___(S/H)
Gall Bladder___(S/H) Tubal Ligation___(S/H)
Hysterectomy ___(S/H) Ovaries Removed? (Y/N)
Other/Comments: ______________________________

Medications:

List medications and dose you are currently taking.
Include vitamins and herbal supplements.
Check if no medications. ☐

1. ________________Dose__________
2. ________________Dose__________
3. ________________Dose__________
4. ________________Dose__________
5. ________________Dose__________
6. ________________Dose__________
7. ________________Dose__________
8. ________________Dose__________
9. ________________Dose__________
10. ________________Dose__________

Allergies:

Family History: (Blood Relatives Only)

Father: ☐ Alive ☐ Deceased	Present Health or Cause of Death	Age?
Mother: ☐ Alive ☐ Deceased	Present Health or Cause of Death	Age?
Brothers: ___# Alive ___# Deceased	Present Health or Cause of Death	Age?
Sisters: ___# Alive ___# Deceased	Present Health or Cause of Death	Age?

Please check medical problems ***immediate family members*** have or have had in the past.

Medical Complaints	Mother	Father	Siblings	Comments - **Age?**
Heart Attack	☐	☐	☐	
Diabetes	☐	☐	☐	
Glaucoma	☐	☐	☐	
Cancer (list type)	☐	☐	☐	
Osteoporosis	☐	☐	☐	
Stroke	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Kidney Disease	☐	☐	☐	
Brain Aneurysm	☐	☐	☐	
Blood Clots	☐	☐	☐	
Colon Polyps	☐	☐	☐	
High Cholesterol	☐	☐	☐	
Thyroid Disease	☐	☐	☐	
Depression	☐	☐	☐	

Preferred Pharmacy?

____

Social History:

Tobacco User ______________ (date quit)
Alcohol __________________ (drinks/week)
Recreational Drugs ______________ (type)
Exercise __________________ (times/week)

Females Only:

Current method of Birth Control: ________
Total # of Pregnancies: ________
Live Births: ________
Miscarriages/Abortions: ________
Last Menstrual Period: ______________

Review of Systems: To help us best evaluate you, please check any symptoms which you have recently experienced, and add note, if applicable.

General: □ Appetite loss □ Chills □ Dietary changes □ Excessive crying □ Fatigue □ Fever □ Medication change □ Night sweats □ Obesity □ Tiredness □ Weight gain >10 lbs □ Weight loss >10 lbs □ Left-handed □ Right-handed

Skin: □ Bruising □ Clamminess □ Excessive sweating □ Hair growth □ Hair loss □ Hives □ Itching □ Nail changes □ New lesions □ Rash □ Skin color changes

HEENT: □ Headache □ Head injury □ Blurred vision □ Double vision □ Visual disturbances □ Visual loss □ Hearing loss/Deafness □ Ear pain □ Ringing in the ears □ Spinning sensation □ Vertigo □ Seasonal allergies □ Sleep apnea □ Snoring □ Facial numbness/tingling

Neck: □ Neck mass □ Neck pain □ Neck stiffness □ Swollen glands

Respiratory: □ Cough □ Decreased exercise tolerance □ Difficulty breathing □ Snoring □ Wheezing □ Fallen asleep driving vehicle □ Shortness of breath

Cardiovascular: □ Abnormal blood pressure □ Chest pain □ Difficulty breathing lying down □ Difficulty breathing on exertion □ Edema □ Elevated blood pressure □ Fainting/Blacking out □ Irregular heart beat □ Leg pain and/or swelling □ Palpitations □ Rapid heart rate □ Shortness of breath

Musculoskeletal: □ Back pain □ Calf pain □ Joint pain □ Joint redness □ Joint stiffness □ Joint swelling □ Muscle atrophy □ Muscle cramps □ Muscle pain □ Muscle weakness □ Neck pain □ Left leg pain □ Left arm pain □ Right leg pain □ Right arm pain □ Muscle spasms

Neurological: □ Auras □ Decreased memory □ Difficulty speaking □ Dizziness □ Dysesthesia □ Fainting □ Focal neurological symptoms □ Headaches □ Hyperactivity □ Incontinence stool □ Incontinence urine □ Incoordination □ Loss of consciousness □ Numbness □ Seizures □ Syncope □ Spinning sensation □ Stroke □ Tremor □ Unsteadiness □ Visual changes □ Weakness □ Muscle twitching □ Tingling

Behavioral/Other: □ Irritability □ Loss of energy □ Decreased libido □ Loss of interest □ Spontaneous crying □ Anxiety □ Change in sleep pattern □ Delusions □ Depression □ Early awakening □ Fearful □ Frequent crying □ Mood changes □ Panic attacks □ Suicidal ideation □ Suicidal planning Hallucinations □ Hypersomnolence □ Impaired cognitive function □ Inability to concentrate □ Insomnia/poor sleep □ Memory loss

Endocrine: □ Appetite changes □ Cold intolerance □ Excessive thirst □ Excessive urination □ Hair changes □ Heat intolerance □ Hot flashes □ Sexual dysfunction □ Thyroid problems

Hematology: □ Abnormal bleeding □ Anemia □ Blood clots □ Easy bruising □ Enlarged lymph nodes □ Nose bleed □ Pinpoint hemorrhages □ Prolonged bleeding