3038 Valley Ave Winchester,VA 22601

.

P: 540-508-0651 F: 540-508-0841

REGISTRATION FORM

Today's Date:	PCP:

PATIENT INFORMATION

Patient's name: Last: First: M:

Street Address: City: State: Zip Code:

Home Phone:	Cell Phone:

DOB:	Sex: Male/Female

Employer:	Occupation:

How did you hear about us: Insurance/Family/Friend/Social Media/Other

IN CASE OF EMERGENCY

Name:	Relationship:	Phone #:

Insurance Information

Primary Insurance: Policy ID # Group # Co-Pay amount:

The above information is true to the best of my knowledge. I authorize my insurance benefits to 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 will be made on my behalf to Boden Health for any services furnished to me by physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent's information to determine benefits payable for services rendered.

Patient/Guardian Signature:_____ Date:_____

VIRGINIA INTEGRATIVE MEDICAL PRACTICE FINANCIAL POLICY STATEMENT

Thank you for choosing our physicians for your 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 the 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/ MasterCard.

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, receiving 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 service 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 service 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 at 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:_____

MEDICAL HISTORY FORM

Name:_____ DOB:_____

Reason for visit today:

IMMUNIZATIONS

Last Tetanus:	Last TB:	Positive Y/N	Hep A Series:
Hep B Series:	Flu:	Covid 19:	

Please circle if you have any of have/had any of the following:

Asthma/Hepatitis B/Hepatitis C/Ulcers/UrinatingDifficulties/Hypertension/Seizures/Heartburn

Hay Fever/Depression/Blood Clots/Diabetes/Migraines/Psychiatric Disorder/Bleeding Disorder

Elevated Cholesterol/Cancer/Thyroid Disease/Other

Date of last Preventative

Colonoscopy: Year	Normal?	Y/N
PAP: Year	Normal?	Y/N
Mammograms: Year	Normal?	Y/N
Dexascan: Year	Normal?	Y/N

Social History:

Tobacco User Y/N Date Quit:

Vape User Y/N Date Quit:

Alcohol USer Y/N Date Quit:

Recreational Drugs Y/N Type:

Exercise Y/N

MEDICATIONS

List medications and dose you are currently taking. Include vitamins and herbal supplements:

1._____

2:_____

3._____

4._____

5._____

Allergies:

Preferred Pharmacy:_____

Please check medical problems Immediate Family Members have or have had in the past:

Heart Attack/Diabetes/Glaucoma/Cancer/Osteoporosis/Stroke/High Blood Pressure/Kidney Disease/Brain Aneurysm/Blood Clots/Colon Polyps/High Cholesterol/Thyroid Disease/Depression

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?
Sister: Alive/Deceased	Present Health or cause of death:	Age?

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

Back___ Sinus___ Tonsils___ Bones___ Hernia___ Appendix___ Vasectomy___ Gall

Bladder___ Tubal Ligation___ Hysterectomy___ Ovaries Removed Y/N

Others_____

Females Only:

Current method of birth control:_____

Total # of pregnancies:_____

Live births:_____

Miscarriages/Abortions:_____

Last menstrual period:_____

Review of Systems: To help us better 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/Obesity Medication change/Night sweats/Tiredness/Weight gain>10lbs/Weight loss>10lbs/Left handed Right handed

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

Heent:Headaches/Head injury/Blurred vision/Double vision/Visual disturbance/Visual loss/ Hearing loss/Deafness/Ear pain/Ringing ears/Spinning/Vertigo/Seasonal allergies/Sleep apnea/Snoring/Facial numbness

Neck: Neck mass/Neck pain/Neck stiffness/Swollen glands

Respiratory:Cough/Difficulty breathing/Wheezing/Fall asleep driving/Shortness of breath

Cardiovascular: Abnormal blood pressure/Chest pain/Edema/Elevated blood pressure/Fainting/black out/Irregular heartbeat/Leg pain/swelling/Palpitations/Rapid heart rate

Musculoskeletal: Back pain/Calf pain/Joint pain/Joint redness/Joint stiffness/Joint swelling/Muscle atrophy/Muscle cramps/Muscle pain/Muscle weakness/Neck pain/Leg pain/Arm pain

Neurological:Auras/Decreased memory/Difficulty speaking/Dizziness/Dysesthesia/Fainting/Focal neurological/Headaches/Hyperactivity/Seizure Stroke/Tremors/Weakness

Behavioral/Other: Irritability/Loss of energy/Decreased libido/Change of sleep pattern/Crying outburst/Mood changes/Panic attacks/Suicidal thoughts/

Endocrine: Appetite change/Cold/hot intolereance/Excessive thirst/hair change/Seual dysfunction/Thyroid problem

Hematology: Abnormal bleeding/Anemia/Blood clots/Easy bruising/Enlarged lymph nodes/Nose bleeds/Pinpoint hemorrhages/Prolong bleeding