Juburi Medical Center
2817 Duke Street
Alexandria VA 22314

Family Medcare
4225 Altamont Place, Suite 203
White Plains MD 2695

Intake Form

Date: _____/_____/________

Patient Information:

Last Name:______________________ First Name:______________________ MI:______

Date of Birth:__________________ Age:________ SSN:_______________________

Address: ____APT:______________

City:______________________________State:_____________Zip Code:___________

Home Phone___________________________ Cell Phone_____________________

Email Address: ____

Marital Status:_______________Gender:_________________

Preferred Language:____________________ Employer:_________________________

Pharmacy info:____

IN CASE OF EMERGENCY

Name of friend or relative:__________________________________

Relationship to patient:_________________________________

Home Phone #:____________________________Cell Phone #:__________________

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Primary Insurance Information:

Name of Insurance:____

Name of Policy Holder:______________________DOB:______________

SSN:______________________Relationship to the patient:__________________

Employer:_________________________

Policy #:_____________________ Group #:______________________

Secondary Insurance Information (Only if Applicable)

Secondary Insurance Name:____________________________

Name of Policy Holder:_____________________ DOB:_________________

SSN:__________________Relationship to the patient:_____________________

Employer:________________________

Policy #:_____________________________Group #:____________________

The 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 Juburi Medical Center. or insurance company to release any information required to process my claims.

Patient/Parent/Guardian Signature__________________________________

Today's Date_________________________________

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BILLING

Patients must pay co-pay before each visit. Any returned checks will be subject to a $30.00 charge. Pending balances will be billed to you. We are happy to make payment arrangements with you. Our office submits all claims to the insurance carrier you provide to us. We will continue to submit claims for all services we provide. Please understand that there are services your insurance carrier may consider "non-covered". Our patients will be responsible for payment of these charges should your insurance carrier deny coverage. Your insurance carrier defines an annual physical as "A routine evaluation and management service in the absence of patient complaints including history, physical examination, risk factor reduction intervention and the ordering of laboratory/diagnostic procedures". If an illness or injury is discovered during an annual physical examination, an additional office visit code is to be billed. Your insurance company established this billing system following their reduction (by more than 50%) in payment for annual examinations. Therefore, you may find that we have billed your insurance carrier for a preventive visit as well as an additional visit on the same date of service. INITIAL__________________

APPOINTMENTS

Once an appointment has been made, please respect the time that has been reserved in our office schedule for you. There will be a $25.00 charge for missed appointments and appointments not cancelled within 24 hours. If a message for appointment cancellation is left on the reception desk voicemail only, 24 hours prior to your appointment you will not incur a fee. We make every attempt to give our patient a courtesy call reminding you of your appointment time, but it is your responsibility to make sure you have this information so you do not miss your appointment. INITIAL__________________

REFERRALS

Your insurance company, not this office, establishes referral policies. Please note that referrals require up to 24 hours to process. When requesting a referral, please include your name, date of birth, insurance company name, insurance ID number, specialist name, specialty, and reason for visit. We will notify you when your referral is ready for pick up or we can send it to you via USPS Mail. We will automatically send it via facsimile. Same day referrals are limited to medical emergencies. **WE DO NOT BACK DATE REFERRALS**, per your insurance and our office policies. If you are unsure whether your insurance plan requires referrals, please ask the front desk or you may call your insurance company. INITIAL__________________

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PRESCRIPTION REFILLS In order to provide quality healthcare, please obtain an adequate supply of medication to last you until your next appointment. Your provider will give you enough refills to last until the next office visit. For example, blood pressure and cholesterol medication necessitate an office visit every 3 months. If you running out of medication, please inform our office so that we may arrange for a 30 day supply. In addition, we do not refill controlled substances without seeing the patient ever. For instance, Percocet, Vicodin, Tylenol #3, or the generics of any of those medications will not be refilled over the phone so please do not ask. Antibiotics are frequently over prescribed, we will only prescribe an antibiotic if we see you for your illness, and then only at the providers discretion. Coming in is not a guarantee you will receive antibiotics. INITIAL_________________

LAB SERVICES Our preferred laboratory is LabCorp, we are able to draw and collect specimens but you may be subject to a copayment and/or a deductible. Please note , that you are fully responsible for any and all charges. INITIAL_________________

LAB RESULTS

If your results are of concern due to abnormal, we will make every effort to promptly contact you. Please be sure this office has your correct telephone numbers. If you are contacted regarding abnormal results, you may be asked to schedule a follow up appointment with your provider. We understand that some patients may not have access to the web or may still want an actual copy. If you wish to obtain an actual copy of your report, you may do so by making prior arrangements with the office to pick up a copy, which we will leave at the front desk. If you do not hear from us within 10 days after completing the test, it is your responsibility to call and obtain these results. INITIAL__________________

PRIOR AUTHORIZATION

Your insurance company, not this office, sets medication formularies. We make every effort to adhere to these formularies, which frequently change. Effective January 1, 2006 if the medication prescribed to you is not covered by your insurance, we will be happy to change the medication to an alternative on your formulary-preferred list. INITIAL__________________

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Communication

I, ____ consent for JMC/BRMC staff and providers to use NON-HIPAA compliant bi-directional communication through my personal email and/or text. Email:_________________________
Cell phone#:____

I authorize the release of information including the diagnosis, records: examination rendered to me and claims information. This information may be released to:
Name and relation to patient:________________________________
This information may not be released to anyone__________initial

This release of information will remain in effect until terminated by me in writing.

PATIENT FORMS

There will be a $25.00 fee for all forms that are dropped off during unscheduled appointments. In order to be exempt from this charge you will need to schedule an appointment with a provider. If your forms are not available at the time of service you have 7 days to drop them off to avoid the fee. After 7 days the $25.00 form fee will apply. INITIAL________________

MEDICAL RECORDS To obtain medical records from our office please send in a signed request with the following information: Your full name, address, billing information, social security number, date of birth, and part of records you are requesting. For example, the entire chart or just lab results. You can mail or fax your request to this office. Under no circumstances will your original chart be given to you. INITIAL________________

PATIENT MEDICAL HISTORY

Name:______________________________ DOB:________________

Medications: List all prescription and over-the-counter drugs, their strength(mg), and no of tablets/day you are currently taking					
Drug	Strength (mg, mcg)	Number Taken Per Day	Drug	Strength (mg, mcg)	Number Taken Per Day

ALLERGIES: List all known allergies, including medication and reactions.	
Allergy:	Reaction:

Medical History: Indicate if you have ever had any of the following.								
Yes	No		Yes	No		Yes	No	
		High blood pressure			Yellow jaundice			Hepatitis
		Diabetes			Gallstones			Glaucoma
		Peptic ulcers			Kidney stones			Lung problems/asthma
		Heart attack			Diverticulosis			Stroke
		History of heart murmur			Thyroid problem	List Accidents & Broken bones		
		Cancer (type)			STD infections			

Females Only: Number of pregnancies: Number of live births: Number of miscarriages:
Birth Control Method: Have you experienced menopause? ☐ Yes ☐ No

SURGICAL HISTORY: List all operations and hospitalizations and any complications.		
Year	Type of operation / hospitalization	Complications

Family History: Indicate if you family has a history of these conditions by checking 'F' for father, 'M' for mother, and/or 'S' for Sibling. (may check more than one)

Heart Disease ☐ F ☐ M ☐ S	Kidney problems ☐ F ☐ M ☐ S	Diabetes ☐ F ☐ M ☐ S	Seizure disorder ☐ F ☐ M ☐ S
Cancer (type) ☐ F ☐ M ☐ S	Depression ☐ F ☐ M ☐ S	Schizophrenia ☐ F ☐ M ☐ S	Early senility ☐ F ☐ M ☐ S
Alcoholism ☐ F ☐ M ☐ S	Stroke ☐ F ☐ M ☐ S	Obesity ☐ F ☐ M ☐ S	
Manic-depressive disorder ☐ F ☐ M ☐ S	High blood pressure ☐ F ☐ M ☐ S	Other (specify) ☐ F ☐ M ☐ S	

SOCIAL HISTORY: Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

☐ Yes ☐ No Do you smoke? If Yes, how many packs per day:
If No, have you ever smoked in the past?

☐ Yes ☐ No Do you drink alcohol? If Yes, what kind and how much:
If No, have you drink alcohol in the past?

☐ Yes ☐ No Do you use street drugs?

☐ Yes ☐ No Have you ever had a blood transfusion? If Yes, specify when:

☐ Yes ☐ No Do you have any tattoos?

☐ Yes ☐ No Do you have any history of IV drug use?

HIPAA NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for hospital stay may require that your relevant protected health information by disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you: We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health Information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.
You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.
We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.
Signature below is only acknowledgement that you have received this Notice of Privacy Practices:

Print Name ____________________________

Signature ____________________________ *Date* __________________