Name: ___________________ DOB: ___________

Email: _________________________________ Date: _______________

MEDICAL HISTORY

Why are you coming in today? ____

Are there any problems you would like to discuss with the Doctor today? ______________________________

____

If you have any problems, have you tried treating them yourself? IF YES, PLEASE EXPLAIN: _____________

____

List any Medical Conditions you have: _________________________ ________________________________

____

____

____

List all Prescription and over the counter medications you are taking: ________________________________

____

____

____

List allergies to medication, (food, latex, etc): ____

____

Insurance Information:

Who is your Primary Insurance ______________________________ Secondary Insurance ____________________

SHARING YOUR INFORMATION:

With whom may we discuss your medical/financial information with? (i.e Spouse, mother, father, son, POA, etc.):

__________________________________ ____

Name / Phone# Relationship to you

3200 Peoples Drive, Suite 210, Harrisonburg, VA 22801
Office: 540-217-0911 | Fax: 877-758-4943
Office@FowlerFamilyMedicine.com | www.FowlerFamilyMedicine.com

Leaving you a message:

Do we have permission to leave a message on your phone? (circle) YES or NO

Which phone number should we use to contact you and/or leave a message at? __________________

HIPPA Compliance Assurance Notification

The misuse of Personal Health Information (PHI) has been identified as a national problem causing inconvenience, aggravation and money. It is our priority to properly determine appropriate uses of personal health information. We strive to achieve the very highest standards of ethics and integrity in performing services for our regulations regarding the Health Information Portability and Accountability Act (HIPPA) with particular emphasis on the Privacy Rule. We also know that we are not perfect and because of this fact, our policy is the listen to our patients if they feel an event in any way compromises our policy of integrity. We welcome your input regarding any issues so that we may address the situation promptly.

TREATMENT AUTHORIZATION

The Patient and/or the Patient's responsible decision maker consent to all examinations and treatments directed by the physician and rendered by staff.

Release of Information, Assignment of Benefits and Payments

Release of Information:

I authorize my healthcare provider to release and exchange information with other healthcare providers, insurance companies, collection agencies, courts, etc.. to provide continuity of care, to secure payment, or to meet requests relative to medical and financial necessity. I understand that I have the right to request restrictions on how my health information is used and disclosed, but my healthcare provider is not required by law to agree to these requested restrictions. My healthcare provider also reserves the right to change the terms of this notice, at which time I will be asked to review and sign the amended version.

Assignment of Insurance Benefits:

I assign all health insurance benefits to be paid directly to my healthcare provider for services rendered.

Responsibility for Payment of Bill:

I understand that I, or the person listed as my guarantor, remain financially responsible to my healthcare provider for any and all charges not covered by my health insurance or not paid by my health insurance company within a reasonable amount of time. I also understand I am responsible for co-payments, co-insurance, deductibles and all other charges not covered by my health insurance company. I authorize providers to pursue a 25% collection fee of all unpaid debt, directly or through a collection agency. I agree to pay all costs associated with such collection, including attorney fees incurred.

Billing Consent and Acknowledgement of Privacy Practices Notice:

I have read and understand this form and any questions that I had, were explained to my satisfaction. I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under the Health Information Portability and Accountability Act (HIPPA).

Office Policy

If I am prescribed a controlled substance, I agree to be polite and compliant with the doctor and staff at all times. I understand that if I am non-complaint, rude to anyone at this office, excessively call the office that I can be discharged from the practice at any time. I understand that if I am discharged, I will receive a letter from the doctor and 30 days' worth of Emergency Medicine and Refills only.

It is **your** responsibility to notify us of your medication refills needs. We ask that you give us 7 days **prior** notice for your medication refills.

NO SHOW POLICY

Fowler Family Medicine Doctor's will need at least 24 hours' notice of your cancellation. If we do not receive the notification that you are going to be late or you do not show up for your scheduled appointment, this will be considered a NO SHOW and you will be charged $50 for the first occurrence, $100 for the second occurrence and $150 for each additional occurrence that this occurs.

Notice of Discharge

A patient may be discharged from the practice for the following reasons:

Nonpayment: If your account is continuously delinquent or has to be written off due to bankruptcy.

Nonadherence of Treatment or Follow-Up Care: The patient does not or will not follow the treatment plan or repeatedly cancels follow-up or is a no-show.

Misconduct: Verbal or physical abuse from the patient and/or a family member. Rude improper language with office personnel, exhibits violent behavior, makes threats of physical harm, or uses anger to jeopardize the safety and well-being of office personnel with threats of violent actions.

________________________________ _________________________

Signature of Patient/Guardian Date

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