PATIENT INFORMATION

LAST NAME:	FIRST:	MIDDLE INITIAL:
PHONE# H:	C:	DATE OF BIRTH:
MAILING ADDRESS:	CITY:	STATE AND ZIP:
911 ADDRESS:	CITY:	STATE AND ZIP:
GENDER: ☐ M ☐ F	SSN:	MARITAL STATUS:
PREFERRED LANGUAGE:	ETHNICITY:	RACE:
EMAIL ADDRESS:		

HOW WOULD YOU LIKE TO BE CONTACTED FOR FUTURE APPOINTMENT REMINDERS?

☐ HOME PHONE ☐ CELL PHONE ☐ EMAIL ☐ TEXT

PATIENT EMPLOYER INFORMATION

EMPLOYER NAME:		PHONE#:
ADDRESS:	CITY:	STATE AND ZIP:
STUDENT STATUS: ☐ N/A	☐ FULL TIME	☐ PART TIME

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM ABOVE)

LAST NAME:	FIRST:	MIDDLE INITIAL:
PHONE# H:	C:	DATE OF BIRTH:
MAILING ADDRESS:	CITY:	STATE AND ZIP:
GENDER: ☐ M ☐ F	SSN:	MARITAL STATUS:
RELATIONSHIP TO PATIENT:		

PHARMACY INFORMATION

LOCAL PHARMACY NAME:	PHONE#:
ADDRESS:	FAX#:
MAIL ORDER PHARMACY NAME:	PHONE#:
ADDRESS:	FAX#:

EMERGENCY CONTACT INFORMATION

NAME:	PHONE#:	RELATIONSHIP:
NAME:	PHONE#:	RELATIONSHIP:

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PRIMARY HEALTH INSURANCE INFORMATION

INSURANCE NAME:	SUBSCRIBER ID#	GROUP#
SUBSCRIBER LAST NAME:	FIRST:	MIDDLE INITIAL:
DATE OF BIRTH:	SSN:	MARITAL STATUS:
GENDER: ☐ M ☐ F	RELATIONSHIP TO PATIENT:	

SECONDARY HEALTH INSURANCE INFORMATION

INSURANCE NAME:	SUBSCRIBER ID#	GROUP#
SUBSCRIBER LAST NAME:	FIRST:	MIDDLE INITIAL:
DATE OF BIRTH:	SSN:	MARITAL STATUS:
GENDER: ☐ M ☐ F	RELATIONSHIP TO PATIENT:	

TERTIARY HEALTH INSURANCE INFORMATION

INSURANCE NAME:	SUBSCRIBER ID#	GROUP#
SUBSCRIBER LAST NAME:	FIRST:	MIDDLE INITIAL:
DATE OF BIRTH:	SSN:	MARITAL STATUS:
GENDER: ☐ M ☐ F	RELATIONSHIP TO PATIENT:	

HOW DID YOU HEAR ABOUT US?

☐ WHO REFERRED YOU? _____ ☐ FACEBOOK ☐ INTERNET

☐ CFM WEBSITE ☐ HOSPITAL REFERRAL ☐ OTHER/PRINT AD_____

RELEASE:

I ASSIGN PAYMENT TO AND AUTHORIZE COURTHOUSE FAMILY MEDICINE TO FILE A CLAIM WITH MY INSURANCE COMPANY(S) FOR PAYMENT OF SERVICES OR TO ACCEPT ASSIGNMENT OF ANY GOVERNMENT BENEFITS DUE TO ME. I AUTHORIZE THE RELEASE OF ALL OF INFORMATION NECESSARY TO PROCESS THESE CLAIMS. I UNDERSTAND THAT IF IT IS LATER DETERMINED THAT I AM NOT ELIGIBLE TO RECEIVE BENEFITS FOR THE SERVICES, OR THERE IS A REMAINING BALANCE NOT COVERED BY MY POLICY(S) I AM FINANCIALLY RESPONSIBLE FOR PAYMENT TO COURTHOUSE FAMILY MEDICINE.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

SIGNATURE: DATE:

PRINTED NAME OF PATIENT OR REPSPONSIBLE PARTY

PRINTED NAME: DATE:

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AUTHORIZATION TO RELEASE HEATLHCARE INFORMATION

PLEASE PRINT ALL INFORMATION

PATIENT'S NAME:	**DATE OF BIRTH:**
PREVIOUS NAME:	**SSN:**

I REQUEST AND AUTHORIZE

PREVIOUS DOCTOR'S NAME:

PHONE NUMBER:

FAX NUMBER:

TO RELEASE HEALTHCARE INFORMATION OF THE PATIENT NAMED BELOW TO:

COURTHOUSE FAMILY MEDICINE

Dr. Joseph Leming, MD, Vickie Bell Leming, NP-C
Elise K. Meadows, NP-C, Amanda R. Wingfield, NP-C
P.O. Box 857
Gloucester, VA 23061-0857

Fax: (804) 693-3503

THIS REQUEST AND AUTHORIZATION APPLIES TO:

I authorize Courthouse Family Medicine to access any health related information from Virginia Commonwealth University Health Systems, Riverside Health System, Sentara Health System, Bon Secours Health System, Hospital Corporation of America and electronic pharmacy records.

☐ YES ☐ NO ☐ N/A

I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ YES ☐ NO ☐ N/A

I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

☐ YES ☐ NO ☐ N/A

All healthcare information.

☐ YES ☐ NO

Other:

☐ YES ☐ NO

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

PATIENT SIGNATURE: **DATE:**

BY SIGNING AND REQUESTING FOR YOUR HEALTH RECORDS YOU MAY BE CHARGED A FEE ASSOCIATED WITH THIS REQUEST FROM YOUR PREVIOUS DOCTOR'S OFFICE OR A 3RD PARTY.

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.

Courthouse Family Medicine

Courthouse Family Medicine is committed to improving access to quality patient care in the Middle Peninsula and its surrounding areas by providing superior and compassionate patient care to improve the health of all members of the communities we serve. We do this by collaborating with patients and families along with their support networks to promote open communications, safety and participation in healthcare planning. This bill of rights services as notice to you of Courthouse Family Medicine's responsibilities. Likewise, patient responsibilities are included to promote an understanding of expectations of patients for the benefit of caregivers, fellow patients, and our staff.

PATIENT RIGHTS (YOU HAVE THE RIGHT TO):
❖ Receive considerate, respectful and compassionate care in a safe setting regardless of your age, gender, race, national origin, religion, language, culture, sexual orientation, gender identity, disabilities or source of payment.
❖ Receive care in a safe environment, free from all forms of abuse, neglect, harassment or mistreatment.
❖ A complete and understandable explanation of your illness, treatment, pain, alternatives and expected outcomes of treatment, including unexpected outcomes.
❖ Communication that you can understand. Information given will be appropriate to your age, understanding and language.
❖ Access, request and obtain information on disclosures of your health information. Additionally, you can expect that your health record is maintained confidentially to the extent permitted by law. You have the right to obtain a copy of your health record by signing a record request form.
❖ Make decisions about your care, including the right to refuse care and the right to be informed of potential health risks related to care refusal. You DO NOT have the right to demand treatment or services deemed medically unnecessary or inappropriate.
❖ Have your pain assessed and to be involved in decisions regarding treatment of your pain.
❖ Full consideration of your privacy and confidentiality in care discussions, examinations and treatments.
❖ Voice a complaint in a mindful, calm manner without fear of being subjected to coercion, discrimination, reprisal or unreasonable interruption of care.
PATIENT RESPONSIBILITIES (YOU ARE RESPONSIBLE FOR):
❖ Providing complete and accurate information about your health, medical history and personal data, including address, telephone number, date of birth, Social Security number, insurance and employer. You must also present your photo ID and most recent insurance card at each visit.
❖ Asking questions when you do not understand your treatment plan. If you are unable or unwilling to follow the plan of care, you are responsible for informing your care provider who will explain the potential medical risks of not doing so. You are responsible for the outcomes of not following your plan of care.
❖ Meeting your financial obligation to Courthouse Family Medicine in a timely manner and if you are unable to do so, this may be grounds for dismissal from the practice.
❖ Keeping appointments and if unable to do so, you will notify us within a minimum of 24 hours prior to your appointment. If less than 24 hours' notice is given, then a cancellation fee of $200 for new patient appointments, $100 for a physical or $50 for an established patient visit will be applied. Additionally, if there are more than 3 NO-SHOWS in a 1 year period, this may be grounds for dismissal from the practice.
❖ Understanding that in order to remain a "current" patient of our practice you must be seen at least one time every three years or you will be required to reestablish care in order to see you for any reason.
❖ Extending courtesy and respect to all Courthouse Family Medicine staff, fellow patients and visitors. You are responsible for following all of Courthouse Family Medicine's rules and safety regulations.
❖ Accepting that we may end our patient-provider relationship if you do not follow your plan of care.
❖ Accepting that inappropriate language and/or behavior is not tolerated and may be grounds for dismissal.
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY
SIGNATURE: DATE:

Courthouse
Family Medicine

Thank you for choosing us as your practice family! We are committed to providing you with quality and affordable health care. We ask all patients to review and sign this policy, asking questions as necessary. A copy will be provided to each patient upon request.

INSURANCE:	We accept assignment and participate in many insurance plans. If your insurance is not a plan we participate in, payment in full is expected at each visit. Knowing your insurance benefits are your responsibility. Please contact your insurer with any questions you may have regarding your coverage to receive the maximum benefit.
PATIENT PAYMENT:	All copayments and deductibles are to be paid at the time of service. This arrangement is part of your contract with your insurance company as well as part of your patient-provider relationship. A $50 fee will be charged for any returned check.
FORMS:	There is a $20 fee for completing FMLA, sick leave, AFLAC and disability forms. This fee must be paid before the forms are completed. Please allow 48 business hours for them to be completed.
REGISTRATION:	All patients must complete our patient information form, which will be entered into our computer to maintain accurate information for proper billing. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of the claim. Most insurance companies have time filing restrictions; **if a claim is not received within 30 days of the date of service, it can be rendered ineligible for payment and you will be responsible for the balance that remains.**
CLAIMS:	**We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may not accept information from our office and may need information from you. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance pays or not. Your insurance benefit is a contract between you and the insurance company; we are not party to that contract.**
UNINSURED PATIENTS:	Please be advised that we do offer self-pay rates if you do not have insurance. All services are estimated and the estimate is expected to be paid in full before services are rendered. Please be aware that the final balance due will not be available until after the provider has seen you and completed your visit. You may receive a bill for additional charges.
CREDIT AND COLLECTIONS:	All bills are due upon receipt. If unpaid you can expect to receive a pre-collections notice at 30, 60, and 90 days requesting that you pay your account in full to remain current and in good standing with the practice. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance has remained unpaid, it may be sent to a collection agency. If an account is sent to collections, it is the policy of this office to discharge the patient and possibly immediate family members from the practice. You will at the time be notified by mail that you have 30 days to find alternative medical care. During that 30-day period our physicians will be able to treat you only on an emergency basis. For any questions please contact Megan Wilt at (804) 832-8290.
MISSED APPOINTMENTS:	Our policy is to charge $200 for a missed new patient appointment, $100 for a missed physical and $50 for missed established patient appointments if not canceled within 24 hours prior to the appointment time. Please note that you can call and leave a message after business hours to cancel your appointment and you will not be charged. However, if you fail to do so these charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment.

By signing below, I indicate that I have read and understand the financial policy and agree to abide by its guidelines.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

SIGNATURE: **DATE:**

PRINTED NAME OF PATIENT OR RESPONSIBLE PARTY

SIGNATURE: **DATE:**

PATIENT CONSENT AND ACKNOWLEDGEMENT OF NOITCE OF PRIVACY PRACTICES FOR PURPOSES OF PAYMENT AND HEALTHCARE OPERATIONS

❖	I consent to the use or disclosure of my protected health information by Courthouse Family Medicine, PLLC. For the purpose of

	diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Courthouse Family Medicine, PLLC.
❖	I have the right to revoke this consent, in writing, at any time, except to the extent that Courthouse Family Medicine, PLLC. Has taken action in reliance on this consent.
❖	My "protected health information" (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.
❖	I understand I have the right to review Courthouse Family Medicine, PLLC. Notice of Privacy Practices (NPP) prior to signing this document. The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Courthouse Family Medicine, PLLC. The Notice of Privacy Practices for Courthouse Family Medicine, PLLC. Is also provided in the lobby and on the group website at www.courthousefamilymedicine.com. The Notice of Privacy Practices also describes my rights and Courthouse Family Medicine, PLLC. Duties with respect to my protected health information.
❖	**Electronic Format:** I acknowledge that my records are stored in an electronic format. I understand that Courthouse Family Medicine, PLLC maintains their patient records in electronic format. Original documents are destroyed after being converted to an electronic format.
❖	Courthouse Family Medicine, PLLC. Reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by accessing the group's website, calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment. I acknowledge I have received a copy of the Notice of Privacy Practices.
❖	**Release of Information:** I hereby give Courthouse Family Medicine, PLLC. Permission to release information on my medical condition to the following people:

NAME:	RELATIONSHIP:
NAME:	RELATIONSHIP:
NAME:	RELATIONSHIP:

❖	I understand the areas discussed with these people could include treatment options, side effects, prescriptions, financial information, lab results, etc.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

SIGNATURE:	DATE:

PRINTED NAME OF PATIENT OR REPSPONSIBLE PARTY

PRINTED NAME:	DATE:
DESCRIPTION OF PERSONAL REP'S AUTHORITY:	

Patient or Personal Representative refused to sign acknowledgement.

_____ Staff Initials _____ Date

MEDICAL HISTORY

PATIENT NAME:	**TODAY'S DATE:**
DATE OF BIRTH:	**PROVIDER:**
REASON FOR VISIT:	

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MEDICATIONS

PLEASE LIST ALL PRESCRIPTION AND OVER THE COUNTER MEDICATIONS THAT YOU TAKE AND WHY

1.		11.	
2.		12.	
3.		13.	
4.		14.	
5.		15.	
6.		16.	
7.		17.	
8.		18.	
9.		19.	
10.		20.	

ALLERGIES

PLEASE LIST ANY ALLERGIES TO MEDICATION AND THE REACTION YOU HAVE

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

ARE YOU ALLERGIC TO LATEX?

☐ NO ☐ YES

IF YES, WHAT REACTION DO YOU HAVE?

ARE YOU ALLERGIC TO ANY FOODS?

☐ NO ☐ YES

IF YES, WHAT AND WHAT REACTION DO YOU HAVE?

HEALTH HABITS

HAVE YOU EVER SMOKED OR USED TOBACCO?

☐ NO, NEVER ☐ YES, QUIT ☐ YES, CURRENTLY

NUMBER OF CIGARETTES EACH DAY?

FOR HOW MANY YEARS?

IF QUIT, HOW LONG AGO?

OTHER TOBACCO PRODUCTS USED?

DO YOU DRINK ALCOHOL?

☐ NO, NEVER ☐ YES, QUIT ☐ YES, CURRENTLY

IF YES, HOW MUCH?

HOW OFTEN?

IF QUIT, HOW LONG AGO?

HAVE YOU EVER FELT THAT YOU SHOULD CUT DOWN ON YOUR DRINKING? ☐ NO ☐ YES

DO YOU DRINK CAFFEINE?

☐ NO ☐ YES

F YES, HOW MUCH?

WITH WHOM DO YOU LIVE? PLEASE LIST BELOW:

1.		3.	
2.		4.	

PATIENT: PLEASE SELECT THE MOST APPROPRIATE BOX AND MAKE ANY ADDITIONAL COMMENTS AS NEEDED

CONDITION	NOW	PAST	COMMENT

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ALCOHOL/DRUG ABUSE			
ALLERGY (HAY FEVER)			
ANEMIA			
ANXIETY			
ARTHRITIS			
ASTHMA			
BIPOLAR			
BLADDER/KIDNEY PROBLEMS			
BLEEDING PROBLEMS			
CANCER			
CORONARY ARTERY DISEASE			
DEPRESSION			
DIABETES			
DIVERTICULITIS			
EMPHYSEMA (COPD)			
GERD (ACID REFLUX)			
GLAUCOMA			
HEART DISEASE			
HEART ATTACK			
HEPATITIS			
HIGH BLOOD PRESSURE			
HIGH CHOLESTEROL			
IRRITABLE BOWEL SYNDROME			
KIDNEY STONES			
KIDNEY DISEASE			
LIVER DISEASE			
OSTEOPOROSIS			
PNEMONIA			
REPRODUCTIVE ISSUES			
SEIZURE/EPILEPSY			
SLEEP APNEA			
STROKE			
THYROID DISORDER			
OTHER			
OTHER			
OTHER			

ADDITIONAL HISTORY	
SURGICAL HISTORY: PLEASE LIST ANY PRIOR SURGERIES YOU'VE HAD, THE YEAR AND SURGEON	
1.	
2.	
3.	
4.	
5.	

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6.	
7.	
8.	
9.	
10.	

VACCINES	DATE RECIEVED	VACCINES	DATE RECIEVED
TDAP (TETANUS WITH PERTUSIS)		HEP A	
TETANUS WITH DIPTHERIA		HEP B	
PREVNAR 13 (PNEUMONIA)		MENINGITIS	
PNEUMOVAX 23 (PNEUMONIA)		HPV	
ZOSTAVAX (SHINGLES)		FLU	
SHINGRIX (SHINGLES)		OTHER, PLEASE LIST:	
OTHER PROCEDURES	**DATE RECIEVED**	**OTHER PROCEDURES**	**DATE RECIEVED**
LAST DEXA (BONE DENSITY SCAN)		LUNG CANCER SCREENING (LOW DOES CT SCAN)	
LAST DIGITAL RECTAL EXAM		AAA (ABDOMINAL AORTIC ANEURYSM ULTRASOUND)	
LAST PSA (PROSTATE LAB WORK)		LAST DIABETIC EYE EXAM	
LAST COLONOSCOPY		LAST DIABETIC FOOT EXAM	
MENSTRUAL HISTORY		**PREGNANCY HISTORY (INCLUDE ABORTIONS AND TUBAL PREGNANCIES)**	
AGE AT FIRST PERIOD		NUMBER OF PREGNANCIES	
LAST MENSTRUAL CYCLE		NUMBER OF MISCARRIGES	
LAST MAMMOGRAM		NUMBER OR PREMATURE BIRTHS	
LAST PAP EXAM		CURRENTLY TRYING TO CONCEIVE	☐ NO ☐ YES

FAMILY MEDICAL HISTORY

CHECK THE BOX THAT MOST APPOPRIATLEY REPRESENTS YOUR FAMILY HISTORY

	NONE	MOTHER	FATHER	SIBLING	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER	CHILD
ALCOHOL OR DRUG ABUSE									
CANCER (TYPE)									
DIABETES									
HEART DISEASE									
HIGH BLOOD PRESSURE									
HIGH CHOLESTEROL									
OSTEOPOROSIS									
MENTAL ILLNESS									
STROKE									
THYROID DISEASE									

COURTHOUSE FAMILY MEDICINE IS COMMITED TO PROVIDING OUR PATIENTS WITH THE HIGHEST QUALITY AND MOST COMPREHENSIVE CARE PLANS FOR ALL MEDICAL NEEDS. IN ORDER TO ENSURE WE ARE MEETING THIS LEVEL OF CARE, PLEASE COMPLETE THE FORM BELOW SO WE KNOW WHO TO COLLABORATE WITH ON YOUR BEHALF.

FORMER PCP
NAME:

Courthouse
Family Medicine

PHONE #:
DATE OF LAST APPOINTMENT:
OBGYN (IF OTHER THAN CFM)
NAME:
PHONE #:
DATE OF LAST APPOINTMENT:
DENTIST
NAME:
PHONE #:
DATE OF LAST APPOINTMENT
OPTOMETRIST
NAME:
PHONE #:
DATE OF LAST APPOINTMENT:
SPECIALIST 1
NAME:
PHONE #:
DATE OF LAST APPOINTMENT:
SPECIALIST 2
NAME:
PHONE #:
DATE AND REASON FOR LAST APPOINTMENT:
SPECIALIST 3
NAME:
PHONE #:
DATE AND REASON FOR LAST APPOINTMENT:
SPECIALIST 4
NAME:
PHONE #:
DATE AND REASON FOR LAST APPOINTMENT:
SPECIALIST 5
NAME:
PHONE #:
DATE AND REASON FOR LAST APPOINTMENT: