ACCESSIBLE PHYSICIAN HOME CARE
2121 Eisenhower Ave, Suite # 200
Alexancria, VA 20901
P: 703-249-5084
www.accessiblephysicianhomecareva.com

Patient Registration

Date _____ For Internal Use Only Patient Number _____

Patient Information

First Name _____ Middle _____ Last Name _____ Social Security # _____

Home Address _____ City _____ State _____ Zip _____

Phone _____ Secondary Phone _____ E-mail _____

Date of Birth _____ Sex _____ Marital Status (circle one) Married Single Divorced Widowed

Employment Status (circle one) Employed Unemployed Retired Full Time Student Other (explain) _____

Employer _____

Address _____ City _____ State _____ Zip _____

Referring Physician _____ Phone _____

Insurance Information

Please provide your insurance card

(circle one) Employer Self Medicaid Medicare Worker's Compensation Other (explain) _____

Insurance Company _____ Insured/Card Holder's Name _____ Relationship to patient _____

Policy # _____ Group# _____ Insured's Phone _____

Secondary Insurance Information

(circle one) Employer Self Medicaid Medicare Worker's Compensation Other (explain) _____

Insurance Company _____ Insured/Card Holder's Name _____ Relationship to patient _____

Policy # _____ Group# _____ Insured's Phone _____

Worker's Compensation Information

Company Name _____ Company Phone _____

Supervisor's Name _____ Supervisor's Phone _____

Emergency Contact

First Name _____ Middle _____ Last Name _____ Relationship _____

Phone _____ Secondary Phone _____ E-mail _____

Spouse/Parent/Responsible Party (if not patient)

First Name _____ Middle _____ Last Name _____ Relationship _____

Home Address _____ City _____ State _____ Zip _____

Phone _____ Secondary Phone _____ E-mail _____

Date of Birth _____ Sex _____ Social Security # _____

Employer _____

Address _____ City _____ State _____ Zip _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the surgical and/or Medical Benefits, if any. Otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

Signature (Patient or Parent of Minor) _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.

Signature (Patient or Parent of Minor) _____ Date _____

Patient SSN # _____ Patient DOB _____

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Office Policies

Appointments

It is the patient's responsibility to come to the appointment with/without a courtesy reminder phone call from the staff. For same day cancellations, there will be a charge of $25.00. There will be a $75.00 charge for House Call appointments cancelled the same day. There will be a $75.00 charge for no shows.

It is necessary to set up an appointment to review lab work or any diagnostic testing. Results will not be given over the phone.

Financial Policy

Insurance plans vary in terms of coverage. It is the patient's responsibility to understand his/her medical benefits. Patients are responsible for copays, deductibles and uncovered billable services.

Insurance copays are due at the time of service before seeing the doctor. There will be a $10.00 fee assessed for unpaid copays.

We accept credit cards and cash. Balances are due within 30 days of when a bill is issued. If a bill is not paid within 90 days, it will be forwarded to our collection agency. Payments can be made through the mail, by phone or at our office.

Referrals and Prescription Refills

Referrals and prescriptions will be given without an office visit only if the patient has seen the doctor within three months. Once it has been more than three months since the last visit, referrals and medications will be denied. It is the patient's responsibility to set up a new appointment.

Medical Records, Forms and Patient Requested Letters

For copies of medical records, there is a fee of $22.88 + .76 per page + postage

For forms and letters, the fee will vary according to the length and complexity as

determined by the physician. These services are not covered by insurance.

Thank you,
The Staff at Accessible Physician Home Care.

Patient/Responsible Party Date

Patient SSN # Patient DOB _____

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MEDICAL QUESTIONNAIRE

PATIENT NAME _____ **DOB** _____

DATE _____ _____

MEDICAL PROBLEMS BEING TREATED/ OR EVER TREATED BY A DOCTOR

Date/Duration	**Problem**	**Treatment**

SURGERIES (INCLUDING EYE SURGERY AND DERMATOLOGIC PROCEDURES)

Date	**Surgery/Treatment**

HOSPITALIZATIONS (DATES/ REASON FOR ADMISSION)

Date	**Reason for Admission**

MEDICATIONS (INCLUDING NONPRESCRIPTION MEDS) WITH PRESCRIPTION STRENGTH AND DOSE

Medication	**Strength**	**Dose**

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ALLERGIES/ SENSITIVITIES

SOCIAL HISTORY
- SMOKE CIGARRETTES
- ALCOHOL USE
- PARTNER/ SIGNIFICANT OTHER
- CAREER/JOB

FAMILY HISTORY (DISEASES IN FIRST OR SECOND DEGREE RELATIVES)
- MOTHER
- FATHER
- SIBLINGS
- CHILDREN
- OTHER DISEASES IN FAMILY MEMBERS

PREVENTATIVE
- EXERCISE (times /week)/ strenuous vs. non-strenuous
- DIET –typical

(date of last test)

- MAMMOGRAM-
- COLONOSCOPY-
- STOOL SCREENING-
- PAP (date/ result)-

- Cholesterol (date/ cholesterol)- / BP
- (date- BP)- -
- Bone Density (date/ T-score (hip/ spine)) / (/)

IMMUNIZATIONS/ VACCINATIONS (date received)

- TETANUS
- HEP B INFLUENZA
- PNEUMOVAX MEASLES
- MUMPS RUBELLA
- Tb/ PPD/ BCG

Signature of Person Completing Form/ Relationship: _____Date:_____

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Guarantee of Payment and Assignment of Insurance Benefits

Consent to receive medical care, assignment of Benefits Authorization, Responsibility for Payment and Acknowledgement of Receipt of Notice of Privacy Practices

I give my consent to receive medical care by professionals associated with Accessible Physician Home Care, LLC and I understand that I am financially responsible for the services provided to me by Accessible Physician Home Care, LLC regardless of insurance coverage. I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Accessible Physician Home Care, LLC for any services provided to me Accessible Physician Home Care, LLC. I authorize and direct any holder of medical information or documentation about me to release to the centers for Medicare and Medicaid Services and its carriers and agents, as well as to Accessible Physician Home Care, LLC and its billing agents and any other payers or insurer any information or documentation needed to determine these benefits or benefits payable for any services provided to me by Accessible Physician Home Care, LLC, now or in the future. I agree to immediately remit to Accessible Physician Home Care, LLC any payments that I receive from any source for the services provided to me and I assign all rights to such payment to Accessible Physician Home Care, LLC. The undersigned hereby guarantees payment to Accessible Physician Home Care, LLC of all charges incurred, and if account is turned over for collection, he/she agrees to pay all cost of collection including collection fee equal to 33.3% of all sum due and payable. The undersigned here agrees to pay interest at a rate of 18% per annum (annual percentage rate) on all outstanding balances.

I also acknowledge that Accessible Physician Home Care, LLC Inc manages the physicians' house call services and charges $95 (management fee) per visit. I understand that this fee is not covered by your medical insurance carriers and is an out of pocket expense.

I, _____, also acknowledge Accessible Physician Home Care, LLC has given me a copy of the Notice of Privacy Practices. For additional information and/or questions, I am aware that I may contact the privacy officer of Accessible Physician Home Care, LLC.

Patient Signature _____ Date _____

_____ _____

Patient Representative's Signature Relationship to Patient

Patient SSN # Patient DOB _____

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSEDAND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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 your physician, 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 pay your health care bills, to support the operation of the physician's practice, 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. For example, we would disclose our protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be 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 your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training 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 practice.
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. These situations include: 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: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security Worker's Compensation: Inmates: Required Use 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 the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Patient SSN # Patient DOB _____