Downtown Family Health Care | PRIVIA MEDICAL GROUP

A-MedRecReq

HIPAA AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient's Full Name _____ **Patient's Date of Birth** _____

Address _____ **Patient's Telephone Number** _____

City, State Zip Code _____ **Any Other Names Used** _____

I request that my provider share my protected health information (PHI) as directed below. Specifically, I request that my PHI:

1. From the following Care Center locations and/or providers (list all locations):
   _____
2. Be sent to the following person / entity at the address listed below:
   Name _____
   Address _____ Telephone _____
   City _____ State _____ Zip Code _____ Fax or Email Address for Delivery _____
3. I hereby authorize disclosure of the following information: ☐ My entire medical record ☐ Immunization Records Only ☐ Service Dates Only:
   _____ to _____ ☐ Specific Information Only:
   _____

NOTES

1. INFORMATION ABOUT ALCOHOL/SUBSTANCE USE, HIV/AIDS AND MENTAL HEALTH ISSUES IS INCLUDED UNLESS YOU SPECIFICALLY REQUEST THAT IT BE EXCLUDED IN THE SPACE BELOW. PSYCHOTHERAPY NOTES, HOWEVER, ARE NEVER INCLUDED.
2. IF YOU REQUEST WE SEND ONLY A PORTION OF YOUR RECORDS TO A TREATING PROVIDER, WE WILL SEND YOUR RECORDS TO YOU TO GIVE TO YOUR PROVIDER; **WE WILL NOT SEND INCOMPLETE RECORDS DIRECTLY TO A TREATING PROVIDER.☐ PLEASE *EXCLUDE* THE FOLLOWING INFORMATION:**

_____ **Signature:** _____

3. I understand that I have the right to receive a copy of my PHI in the form and format and manner I request, if readily producible in that way, or as I may otherwise agree. **If I do not specify a format below, I understand that my PHI will be mailed to at the address listed above in hard copy/paper format. I hereby request that my PHI be provided in the following format:** ☐ via secure electronic delivery; **or** ☐ other (please specify)_____.
4. If I have requested records be sent **un**encrypted, I understand and acknowledge the risk of sending my PHI in an unsecured manner.
5. If I requested records be mailed to me, I understand I will be charged for the cost of paper and postage; if I request my records on a USB drive or similar, I will be charged the cost of that device.
6. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or entity receiving it and will then no longer be protected by federal privacy regulations.
7. I understand I may revoke this authorization by notifying my provider OR privacy@priviahealth.com in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
8. I understand that my care and treatment may not be conditioned on providing this authorization, if such conditioning is prohibited by the HIPAA Privacy Rule.
9. My purpose/use of the information is for ☐ personal use; or ☐ other (please specify)_____.
10. This authorization expires on _____ ____, 20___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: (please describe/specify event). If no expiration date is provided, this authorization will expire on one year from the date signed.
    _____.

NOTE: FEES FOR COPIES: When a patient requests a copy of his/her PHI for personal use, federal law permits a reasonable, cost-based fee that includes only labor for copying the PHI, costs for supplies, labor for creating a summary/explanation of the PHI if a summary or explanation was requested, and postage. If these charges are expected to exceed $25, we will attempt to inform you prior to your request being filled.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING; INCOMPLETE FORMS WILL NOT BE PROCESSED.

_____ **Signature of Patient**	_____ **Date of Patient's Signature**	_____ **Patient's Date of Birth**
_____ **If Patient unable to sign, signature of Patient's Legal Guardian or Personal Representative of Patient's Estate**	_____ **Date of Legal Guardian's/Personal Representative's Signature**	_____ **Description of Authority to Act for the Individual**

E-HealthHx

REVIEW OF SYSTEMS

Please check all that apply:

Allergic/Immunologic
- ☐ Frequent Sneezing
- ☐ Hives
- ☐ Itching
- ☐ Runny Nose
- ☐ Sinus Pressure

Cardiovascular
- ☐ Arm Pain on Exertion
- ☐ Chest Pain on Exertion
- ☐ Chest Heaviness/Pressure on Exertion
- ☐ Irregular Heart Beats (Palpitations)
- ☐ Known Heart Murmur
- ☐ Light-headed on Standing
- ☐ Shortness of Breath When Lying Down
- ☐ Shortness of Breath When Walking
- ☐ Swelling (edema)

Constitutional
- ☐ Exercise Intolerance
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain (____lbs)
- ☐ Weight Loss (____lbs)

Eyes
- ☐ Dry Eyes
- ☐ Irritation
- ☐ Vision Change

Date of Last Exam:_____

Ears/Nose/Mouth/Throat
- ☐ Bleeding Gums
- ☐ Difficulty Hearing
- ☐ Dizziness
- ☐ Dry Mouth
- ☐ Ear Pain
- ☐ Frequent Infections
- ☐ Frequent Nosebleeds
- ☐ Hoarseness
- ☐ Mouth Breathing
- ☐ Mouth Ulcers
- ☐ Nose/Sinus Problems
- ☐ Ringing in Ears

Endocrine
- ☐ Fatigue
- ☐ Increased Thirst/Hunger/Urination

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Black or Tarry Stool
- ☐ Blood in Stool
- ☐ Change in Appetite
- ☐ Frequent Indigestion
- ☐ Hemorrhoids
- ☐ Trouble Swallowing
- ☐ Vomiting
- ☐ Vomiting Blood

Genitourinary
- ☐ Blood in Urine
- ☐ Difficulty Urinating
- ☐ Incomplete Emptying
- ☐ Increased Urinary Frequency
- ☐ Urinary Loss of Control

Hematologic/Lymphatic
- ☐ Easy Bruising/Bleeding
- ☐ Swollen Glandsv

Integumentary (Skin)
- ☐ Changes in Moles
- ☐ Dry Skin
- ☐ Eczema
- ☐ Growth/Lesions
- ☐ Itching
- ☐ Jaundice (Yellow Skin/Eyes)
- ☐ Rash

Musculoskeletal
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Aches
- ☐ Muscle Weakness

Neurological
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Memory Loss
- ☐ Migraines
- ☐ Numbness
- ☐ Restless Legs
- ☐ Seizures
- ☐ Weakness

Psychiatric
- ☐ Alcohol Overuse
- ☐ Anxiety/Stress
- ☐ Depression
- ☐ Do Not Feel Safe in Relationship
- ☐ Mania
- ☐ Sleep Problems

Respiratory
- ☐ Cough
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Wheezing

Please add any other information about your health that you would like your provider to know here:

Patient,Parent, Guardian, or Caregiver Signature

Date

Downtown Family Health Care | PRIVIA MEDICAL GROUP

Preferred Communication:
The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them. This could, for example, include sending correspondence to your office instead of your home. Please tell us your preferred place and manner of communication. **You may update or change this information at any time; please do so in writing.**

Patient Name: **Date of Birth:**

I prefer to be contacted in the following manner (check all that apply):

☐ **Send all communication through my Patient Portal.**

☐ **Home Telephone:**_____ ☐ **Cell Phone:**_____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **Work Telephone:**_____ ☐ **Written Communication:**_____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Please send all of my mail to my home address on file
- ☐ Please send all mail to THIS address:

_____
_____

☐ **Other:**_____

My Preferred Contacts:

We respect your right to tell us who you want involved in your treatment or to help you with payment issues. Our secure patient portal is our primary means of patient communication, such as to share your test results. **You** have the ability to control access to your patient portal.

Please indicate the person(s) with whom you prefer we share your information below.**Please update this information in writing promptly if your preferences change.**

Please note that in some situations, it may be necessary and appropriate for us to share your information with other individuals. This may include information about your general medical condition and diagnosis (including information about your care and treatment), billing and payment information, prescription information and scheduling appointments.

Note that we generally do not share your information via email; if you wish, you can give another individual access to your secure patient portal. You can set this up yourself through the portal or contact our Patient Experience team at 1-888-774-8428 - Monday – Friday 8 am – 6 pm ET.

•**Name:**_____**Telephone:**_____**Relationship:**_____
Email::_____

•**Name:**_____**Telephone:**_____**Relationship:**_____
Email::_____

•**Name:**_____**Telephone:**_____**Relationship:**_____
Email::_____

ACKNOWLEDGMENT: I understand that HIPAA may permit my provider to share my information with other persons **not** named on this form as needed for my care or treatment or to obtain payment for services provided.

Patient Signature: _____ **Date:** _____
(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)

Downtown Family Health Care | PRIVIA MEDICAL GROUP

Authorization and Consent to Treatment

Assignment of Benefits and Authorization to Release Medical Information. I hereby certify that the insurance information I have provided is accurate, complete and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize my provider to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay my provider directly, I agree to forward to my provider all health insurance payments which I receive for the services rendered by my provider and its health care providers. I authorize my provider or any holder of medical information about me or the patient named below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I understand that if my provider does not participate in my insurance plan's network, or if I am a self-pay patient, this assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification. In consideration of the services provided by my provider, I agree that I am responsible for all charges for services I receive that are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by law, I will reimburse my provider for all costs, expenses and attorney's fees incurred by my provider to collect those charges.

If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payments and that I will be responsible for all balances due.

Consent to Treatment. I voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary for my health and well-being; however I may refuse any particular treatment or procedure.

If I request or initiate a telehealth visit (a "virtual visit'), I hereby consent to participate in such telehealth visit and its recording and I understand I may terminate such visit at any time.

My consent shall cover medical examinations and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing), cast application/removals and vaccine administration. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my provider nor any of his or her staff have made any guarantee or promise as to the results that I will obtain.

Consent to Call, Email & Text. I understand and agree that my provider may contact me using automated calls, emails and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand that I may opt-out of receiving all such communications from my provider by notifying my provider's staff, by visiting "My Profile" on my myPrivia Patient Portal, or by emailing the Privacy Officer at privacy@priviahealth.com.

HIPAA. I understand that my provider's Privacy Notice is available on my provider's website and at priviahealth.com/hipaa-privacy-notice/ and that I may request a paper copy at my provider's reception desk.

I hereby acknowledge that I have received my provider's Financial Policy as well as my provider's Notice of Privacy Practices. I agree to the terms of my provider's Financial Policy, the sharing of my information via HIE,* and consent to my treatment by my provider. This form and my assignment of benefits applies and extends to subsequent visits and appointments with all Privia Health affiliated providers.

Printed Name of Patient: MEGAN WILLIAMS **Email:** _____

Signature: _____ **Date:** _____

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent.

Name and Relationship of Person Signing, if not Patient: _____

***Note: If you do not want to participate in Health Information Exchange (HIE), it is<u>your</u> responsibility to follow the instructions outlined on the my provider HIE Opt-Out Request Form and/or contact the HIE directly.**

Patient Name_____ DoB_____

Downtown Family Health Care Housekeeping Policies

Welcome to Downtown Family Health Care and thank you for choosing us for your healthcare needs. We strive to provide the best possible service to our patients. In order to make your visit as pleasant as possible and prevent any misunderstandings, please review the following policies:

- **Office Hours:**
  - Monday-Friday, 8:00 am-5 pm, closed for lunch from 12:00-1:00.
  - Our on-call services are available for urgent issues after hours.
  - For after-hours emergencies please go to your nearest urgent care provider or emergency room.
- **Appointments**:
  - We do not accept walk-in appointments.
  - A minimum of 24 hours' notice if you need to cancel an appointment; less than 24 hours' notice is considered a "Late Cancellation" and will generate a late fee. Failure to provide notification will be considered a "No Show." Two "no shows" will result in dismissal from the practice.
  - If you are more than 15 minutes late for your appointment you will be asked to reschedule.
  - Please be considerate if the office is running behind: emergencies occur and each patient will be treated with the time and care it takes to address their problem, including you. If you are under a specific time constraint, please speak with our staff to discuss rescheduling your appointment.
  - Children under the age of 18 require a parent or guardian present for treatment.
- **Paperwork:**
  - Plan to arrive 15 minutes early to complete and/or update needed forms.
  - Please bring all medical records from previous providers.
  - Please bring a complete list of all medications, supplements, and vitamins that you are currently taking including the dose and frequency or bring the actual medications.
  - Please bring your most current insurance card and photo ID to every visit. Patient demographics are updated each visit. It is your responsibility to ensure we have the most up-to-date information.
  - Special forms/letters will be completed by the provider within 72 hours at a charge of $25. You will be notified if a delay in completion occurs.
- **Prescriptions:**
  - Prescription refills will be provided at scheduled appointments in quantities sufficient to last until your next scheduled appointment. It is your responsibility to let us know before you need refills. Turnaround time for refill requests is 48 hours.
  - Controlled substance prescriptions require a scheduled appointment for refills. No exceptions.
  - Prior authorizations for medications will be submitted within 48 hours of receipt of the request. Insurance companies vary on processing time. It is your responsibility to be sure we have an updated copy of your pharmacy benefits.
- **Miscellaneous:**
  - Only trained service animals will be permitted in the office.
  - Termination of the physician-patient relationship can occur due to noncompliance with treatment; failure to keep appointments; threatening, demanding, deceptive or abusive behavior directed toward our staff; medication abuse; or failure to pay consistent with the financial policy. Only emergency care only will be provided for 30 days to allow appropriate time to find another provider.

I have read and understand the above and agree to abide by this policy in exchange for quality medical care.

Patient's Name/Legal Guardian's Name _____ Signature of Patient or Legal Guardian _____ Date

Financial Policy

Downtown Family Health Care is committed to providing you with the best possible medical care. The following information is provided to avoid any misunderstanding or disagreement concerning the professional services rendered by Downtown Family Health Care.

Downtown Family Health Care's contractual agreement is with you, our patient, not with your insurance company. You are responsible for all services provided to you and/ or your family by Downtown Family Health Care.

INSURANCE PARTICIPATION: Our office participates with many insurance plans, and we will file insurance claims daily on behalf of our patients. It is **Your** responsibility to:

* Know if we participate and/ or are in network with your insurance plan.

*Become familiar with all the terms of your insurance plan. If you have any questions about your insurance, you should direct them to your plan's Member Services Department. **(The telephone number is usually on your insurance card.)**

*Bring your insurance card to every visit.

*Be prepared to pay your co-pay at each visit and any outstanding balance. We accept cash, check, debit/credit card (except American Express). A $35 fee will be charged if your co-pay is not paid at the time of visit.

*Make payment in full at time of the visit for all medical care not covered under your insurance plan. If you have a balance due, it MUST be paid before check-in, or you will not be seen.

*Self-pay patient must pay the $240 deposit at the time of check-in, or you will not be seen.

MEDICAL BENEFITS – LIFETIME SIGNATURE ON FILE: I request that payment of authorized Medical Benefits be made on my behalf to Downtown Family Health Care for any services furnished to me by the provider. I authorize any holder of medical information about me to release Health Care Financing Administration and its agents any information to determine these benefits payable to related services.

DELINQUENT ACCOUNTS: I hereby authorize insurance benefits to be paid to Downtown Family Health Care realizing I am responsible to pay non-covered services, and I hereby authorize release of pertinent medical information to insurance carriers. In the event of that a check is returned for insufficient funds, a return check fee will be added. A letter will be sent to you and payment is expected in 10 days. If my account becomes assigned to a collection agency, I agree to pay all cost of collection, including 25% of the balance for agency fees, court costs, and interest and attorney's fees.

2 No-Show appointments will result in dismissal from the practice.

If you are sent to collections more than once it will result in dismissal from the practice.

Your balance must be paid in full before you can be seen by a provider.

I have read, understand, and agree to all terms specified in the financial policy.

_____ _____

Signature of Patient/Responsible Party Date