STAR FAMILY MEDICINE
MEDICAL HISTORY

NAME	DOB	INFORMANT NAME:

DRUG ALLERGIES: ❑Yes ❑No	**Reaction** ("e.g.": hives, rush, fever…….)	**Severity** ("e.g." mild, moderate, sever, fatal)
1.		
2.		
3.		

CURRENT MEDICATIONS: *Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:*

Name	Dose, strength, pills/ day	For how long?	Name	Dose, strength, pills/ day	For how long?
1.			4.		
2.			5.		
3.			6.		

Most recent vaccines dates: Td❑/TDaP❑**:_____;** Pneumovax**:_____;** Flu Shot**: _____;**

Date of Last: Pap Smear:_____ ; Mammogram:_____ ; Bone Density Scan_____;

SURGERIES/PROCEDURES	DATE	SURGERIES/PROCEDURES	DATE
1. Colonoscopy: Yes❑ No❑		4.	
2.		5.	
3.		6.	

PAST MEDICAL HISTORY/DIAGNOSIS

❑Acne ❑ADHD ❑Anemia ❑Angina ❑Anxiety ❑Asthma ❑Cancer (type)_____ ❑Cardiovascular Disease ❑Cataracts ❑Crohn's disease ❑GI Disease ❑COPD ❑CVA ❑Depression ❑Diabetes ❑DVT ❑Emphysema ❑Epilepsy ❑Glaucoma ❑Goiter ❑Gout ❑Heart problems_____ ❑Hepatitis _____ ❑HIV/AIDS ❑GERD ❑Hyperthyroidism ❑Hypertension ❑High cholesterol ❑Hypothyroidism ❑Jaundice ❑Kidney disease ❑Leukemia ❑Lung Disease ❑Mental Illness_____ ❑MI ❑Migraines ❑Multiple Sclerosis ❑Osteoporosis ❑Pneumonia ❑Psoriasis ❑Pulmonary embolism ❑Sleep disorder ❑Stomach ulcer ❑Stroke ❑Tuberculosis

Other medical conditions (please list): _____

SOCIAL HISTORY

Exercise: *How many times a week? ___;* **Prescription Medication Abuse:** *❑Yes ❑No*; **E-cigarette use** *❑yes ❑quit ❑never;*
Smoking Status: *❑Never Smoked; Quit _____years ago; Years smoked_____; Passive smoke exposure: ❑yes ❑no;*
Heavy Drinking Consumption*: How many times in the past year have you had more than (**4**-female, **5**-male) drinks at once? _____;*
Alcohol: *How many drinks_____ per: ❑ day; ❑week; ❑ month*; **Diet:** *❑*regular, *❑*vegetarian, *❑*gluten free, *❑*vegan, *❑*diabetic,
Illicit Drugs Use: ❑*Never; Quit _____years ago; Currently use_____; Want to quit? ____;*
Marital Status: *❑Single ❑Married ❑Divorced ❑Widowed ❑Domestic Partner*; **Number of children____;**

FAMILY MEDICAL HISTORY (*list illnesses*)

Mother:	Father:
Siblings: Br.❑Si.❑	Children:
Other:	

Patient / Informant Signature: _____ Date: _____

STAR FAMILY MEDICINE

PRIVIA MEDICAL GROUP

Authorization and Consent to Treatment

Assignment of Benefits and Authorization to Release Medical Information

I understand and agree that payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers will be made to me or on my behalf to the provider or supplier of any services furnished to me by that provider or supplier. I authorize any holder of my medical information to release it to Privia, the Health Care Financing Administration (HCFA), the listed insurer and/or agents of the company and/or the listed responsible person(s), and any information necessary to determine my benefits or the benefit for the related services. If my insurance plan does not participate in the Privia network, or if I am a self-pay patient, assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification

In consideration of services provided to me by Privia and its care centers, I agree to be financially responsible and to pay charges for all services ordered by my provider(s). I understand that any balance due as a result of being uninsured or under-insured is payable immediately. I further understand that if I fail to maintain consistent payments, my account will be referred to a collection agent and/or attorney and I agree to pay all collection related charges.

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

Consent to Treatment

As a Privia patient, I voluntarily consent to the rendering of such care and treatment as the Privia providers and personnel, in their professional judgment, deem necessary for my health and well-being.

My consent shall include medical examination 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 include the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my Privia provider nor any care center staff has made any guarantee or promise as to the results that may be obtained.

Consent to Call

I understand and agree that Privia may contact me using automated calls, emails, and text messaging sent to my landline and mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from Privia.

I understand that I may voluntarily "opt-in" to receive automated text message communications from Privia and its partners by informing my provider's staff or visiting "My Profile" on my Privia Patient Portal, and agreeing to any additional Terms and Conditions established by my mobile carrier.

I hereby acknowledge that I have received Privia's *Financial Policy* and *Notice of Privacy Practices*. I agree to the terms of Privia's Financial Policy, the sharing of my information via HIE,* and consent to my treatment by Privia providers.

Printed Name of Patient: _____ **Date:** _____

➔ **Signature:** _____

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

Note: If patient declines to participate in HIE, patient must follow the appropriate procedure outlined on the Privia HIE Opt-Out Request Form and/or contact the HIE directly.

myPRIVIA™
YOUR HEALTH YOUR WAY

STAR FAMILY MEDICINE

PATIENT REGISTRATION

First Name: _____ **Middle Initial:** ____ **Last Name:** _____

DOB: ____ /____ /_____

SEX: **FEMALE** O **MALE** O
SHE/HER O **THEY/THEM** O **HE/HIM** O
TRANSGENDER FTM O **TRANSGENDER MTF** O
CHOOSE NOT DISCLOSE O **CHOOSE NOT DISCLOSE** O

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Cellphone #: ( ) _____ - _____ **Home #:** ( ) _____-_____

Email: _____
(Securely receive your test results, communicate with the Dr.Livani & Our Medical Stuff, pay your bills and more...)

Emergency Contact:

Name: _____ **Relation to Patient:** _____

Cellphone #: ( ) _____ - _____ **Home #:** ( ) _____-_____

Signature: _____

Today's Date:_____

STAR FAMILY MEDICINE

Asdollah Livani M.D.ABFM

Cancellation Policy

At Star Family Medicine, we strive to provide excellent medical care to our patients. To ensure that we can accommodate all individuals seeking our services, we kindly request adherence to our cancellation policy.

24-Hour Notice Requirement: We require patients to notify us at least 24 hours in advance if they need to cancel or reschedule their appointment. This allows us the opportunity to allocate the time slot to someone else who may be in need of care.

Cancellation Fee: In cases where a patient fails to provide at least 24 hours' notice for cancellation, or in instances of a **'no call, no show'**, a **cancellation fee of $100** will be applied. This fee is necessary to cover the costs associated with the unused appointment time. The fee will need to be resolved in order to book a new appointment

Same-Day Cancellations: We understand that emergencies happen. However, same-day cancellations, unless due to a genuine emergency, will also incur a cancellation fee.

We appreciate your understanding and cooperation with this policy. It helps us maintain the highest standard of care and service for all our patients.

For any questions or to cancel or reschedule an appointment, please contact a Star Family Medicine staff at **703.385.6070 or STARFAMILYMEDICINE3925@GMAIL.COM**

Thank you for choosing Star Family Medicine for your healthcare needs.

Name: _____

Signature: _____

Date: _____

STAR FAMILY MEDICINE

PRIVIA MEDICAL GROUP

Preferred Contacts

The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them, such as sending correspondence to the individual's office instead of the individual's home.

We invite you to share with 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:** _____
(Print Clearly)

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

- ☐ Home Telephone: _____
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Cell Phone: _____
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Work Telephone: _____
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Written Communication: _____
  - ☐ OK to mail to my home address
  - ☐ OK to mail to my work/office address
- ☐ Other: _____

Preferred Contacts:
We respect your right to indicate who you prefer that we involve in your treatment or payment decisions and/or who we share your information with, including information about your general medical condition and diagnosis (such as treatment and payment options), access to medical records (PHI), prescription pick-up and scheduling appointments. **Please note, however, that we may share your information as set forth in our Notice of Privacy Practices to other persons as needed for your care or treatment or the payment of services we have provided.** Please update this information promptly if your preferences change.

Please indicate the person(s) you prefer we share your information with below:

- **Name:** _____ **Telephone:** _____ **Relationship:** _____
- **Name:** _____ **Telephone:** _____ **Relationship:** _____
- **Name:** _____ **Telephone:** _____ **Relationship:** _____

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

STAR FAMILY MEDICINE

Asdollah Livani M.D.ABFM

AUTHORIZATION TO RELEASE MEDICAL RECORDS

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY Act of 1996 (HIPPA) Privacy Standards.

I, _____ (Patient or Legal Guardian of patient) do hereby request the release of My Medical Records as below:

FROM: (Your old Provider)
NAME: _____
ADDRESS: _____
_____
P: _____
F: _____

TO: Star Family Medicine
Dr. Asdollah Livani
9683 MAIN ST
SUITE A & B
FAIRFAX, VA 22031
P: 703.385.6070
F: 703.385.6073

___ Summary of patient record including Immunization Records
___ All records pertaining to _____
___ ENTIRE PATIENT RECORD

RESTRICTIONS: Items not to be released if any: _____
_____

Reason for release of information:
____ Change of Physician
____ For Insurance Purposes
____ Other: If So Explain Why Below.
_____
_____

I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.
I understand this authorization will expire, without my express revocation, either ONE year from the date of signing, or if I am a Minor, on the date I become an adult according to state law, whichever occurs first. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when law provides my insurer with the right to contest a claim under my policy or the policy itself.
I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. The provider cannot condition treatment, payment, and enrollment in the health plan or eligibility for benefits on the signing of an authorization, except as otherwise permitted by law.
I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Patient Name: _____ **Date of Birth:** _____
Signature: _____ **Today's Date:** _____
Witness: _____ **Today's Date:** _____