2696 GREENSBORO ROAD
MARTINSVILLE, VA 24112
PHONE: 276.638.7205
FAX: 276.638.8038 / 276.638.3389

MARTINSVILLE FAMILY MEDICINE

NEW PATIENT APPLICATION

CURRENT LIST OF PROVIDERS:
(Circle Preference)

J. PATRICK FAVERO, D.O., P.C.

EMILY WARRICK, PA-C ***BROOK NELSON, PA-C***

WILLIAM SHOUGH, PA-C ***COURTNEY EURE-HART, PA-C***

MORGAN HANKINS, PA-C ***GINGER EPLING, NP-C***

M. Kevin David, D.O.

PLEASE COMPLETE THE APPLICATION **ENTIRELY**.
IF A SECTION DOES NOT APPLY, ENTER N/A.
YOUR MEDICATIONS AND LAST PCP **MUST** BE LISTED ON THE FORM.
YOUR APPLICATION WILL BE SUBJECT TO DELAY OR DENIAL
IF WE DO NOT HAVE ALL REQUESTED INFORMATION ENTERED ON THE FORM.
THIS FORM MUST BE RENEWED EVERY THREE YEARS.

To be filled out by the providers only: ☐ Approved ☐ Denied

Provider Signature: _____ Date: _____

Patient Demographics:

Please complete this form using your Legal Name as it appears on your social security card.

Name:	DOB:	
Preferred Name:	Address:	
Mobile Phone:	City:	
Home Phone:	State:	
Social Security Number: _____	Zip Code:	
	Email:	
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Other:_____	Race: ☐ Caucasian ☐ African-American ☐ Asian ☐ Native American ☐ Other: _____	Gender Identity: ☐ Male ☐ Female ☐ FTM ☐ MTF ☐ Other
Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Other:_____	Primary Language: ☐ English ☐ Spanish ☐ Other: _____	Legal Sex: ☐ Male ☐ Female

Employer: _____
Address: _____ **City:** _____ **State:** _____
Zip Code: _____ **Phone:** _____

Primary Insurance Company: _____
Member ID#: _____ **Group #:** _____

I authorize the release of all medical information necessary to process insurance claims and I am aware that the deductible, co-insurance, and any non-covered services are ultimately my responsibility.

Signature: _____

Date: _____

Authorization and Consent to Treat

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 to 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 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 my 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 plans' 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, but not limited to, minor surgical procedures, 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/her staff have made any guarantee or promise as to the results I will obtain.

Consent to Call, Email, & Text: I understand and agree that my provider may contact me using automated calls, emails, and/or texts sent to my landline and/or mobile device. These communications may notify me or 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 communications from my provider by notifying my provider's staff, by visiting "My Profile" on 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. **If information is purposely withheld or falsified, it may result in dismissal from the practice.**

Signature: _____

Date: _____

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

Patient/Family Contact List

Preferred Communication:

The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them. 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.**

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

- ☐ **Send all communication through my Patient Portal**
- ☐ **Home Phone:** _____
- ☐ **Cell Phone:** _____
- ☐ **Work Phone:** _____
- ☐ **Written Communication:**
  - ☐ Please send all my 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 with payment. Our secure portal is our primary way of communication. **You** have the ability to control access to your 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, billing and payment information, prescriptions, and scheduling appointments.

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

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: _____

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):

   Name: _____

2. Be sent to the following person/entity at the address listed below:
   Name: Martinsville Family Medicine
   Address 2696 Greensboro Rd. Martinsville, VA 24112 - Fax: 276.638.3389 / 276.638.8038
3. I hereby authorize disclosure of the following information:

☐ My entire medical record ☐ Immunization Records Only ☐ Service Date

NOTES: 1) INFORMATION ABOUT ALCOHOL/SUBSTANCE US, 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 YOUR PROVIDER; **WE WILL NOT SEND INCOMPLETE RECORDS DIRECTLY TO A TREATING PROVIDER.**

☐ **PLEASE *EXCLUDE* THE FOLLOWING INFORMATION:** _____

4. 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 available 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 ☐ other (please specify)_____

5. If I have requested records be sent **un**encrypted, I understand and acknowledge the risk of sending my PHI in an unsecured manner.
6. If I requested records be mailed to me, I understand that 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 the device.
7. I understand that the information used of 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.
8. 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 reserved, and my revocation will not affect those actions.
9. 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.

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 specify). If no expiration date is provided, this authorization will expire one year from the date signed.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING; INCOMPLETE FORMS WILL NOT BE PROCESSED. (Patient sign below)

Signature: _____ **Date:** _____

Patient History Form

Personal Medical History
(Check conditions you have or have had in the past)

Condition	Current	Past
Anemia		
Anxiety/ Depression		
Arthritis		
Asthma		
Cancer		
Cataracts		
CVA (stroke)		
Coronary Artery Disease		
Chicken Pox /Shingles		
Diabetes		
Diverticulitis		
Emphysema/ COPD		
Fractures		
GERD /Heartburn		
Gynecological Conditions		
Heart Attack (MI)		
High Blood Pressure		
High Cholesterol		
Kidney Problems		
Liver Disease		
Neurologic Condition		
Osteopenia/ Osteoporosis		
Prostate Problems (BPH)		
STD		
Thyroid		

Surgical History
(List any surgeries you've had below)

Any Special Needs for Communication:

# of Pregnancies: _____

# of Live Births: _____

Other: _____

Health Maintenance Screening Test

Test	Date	Result
Colonoscopy		
Cardiac Stress Test		
Eye Exam		
Mammogram		
Pap Smear		
Bone Density Test		
Other		

Family History

(MGM - Maternal Grandmother, MGF -Maternal Grandfather, PGM - Paternal Grandmother, PGF - Paternal Grandfather)

Disease	Mom	Dad	Sibling	MGF	MGM	PGF	PGM	Other
Arthritis								
Asthma								
Anemia								
Anxiety								
Alzheimers								
Cancer (what type)								
CVA (Stroke)								
Cataracts								
Diabetes								
Depression								
Emphysema								
Glaucoma								
High Blood Pressure								
High Cholesterol								
Hepatitis/ Cirrhosis								
Hypothyroid								
Hyperthyroid								
Heart Attack (MI)								
Kidney Failure								
Migraines								
Osteoporosis								
Other:								

Personal Medication Form

(List ALL medications) (If none, write **NONE**)

Name of Medication	**Dose** (units, mg, puffs)	**Purpose** (why do you take it)	**Name of Prescriber**

Allergies:

Are you allergic to medications, iodine, food, tape, or latex? List each substance you are allergic to and the reaction you experience.

Allergy	**Reaction**	**Allergy**	**Reaction**

PCP/Specialist History:

List any current/previous PCP/specialist you have seen. I.E, pain management, neurologist, gynecologist.

Vaccines: Check one box for each vaccine

Tetanus	**Pneumonia**	**Influenza**	**Pediatric**
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Social History: Please answer the following questions:

1. Do you smoke? _____
   If yes, how many/day? _____

2. Do you drink alcohol? _____
   If yes, # of drinks/week? _____

3. Do you exercise? _____
   If yes, how often? _____

4. Do you work? _____
   If yes, current occupation? _____

Controlled Substance Policy

Martinsville Family Medicine will not be able to prescribe any opioids or narcotics. Patients will be referred to a pain management provider for these medications.

Controlled Substances from Other Doctors

If I see another doctor who provides a controlled substance medication, (for example, a dentist, a doctor from the Emergency Room or another hospital, etc.), I must notify my primary care doctor of this medication.

Privacy

While I am taking this medicine, my doctor may need to contact other doctors or family members to get information about my care and/or use of this medicine. I will be asked to sign a release at that time.

Termination of Agreement

If I break any terms of this agreement, or if my doctor decides that this medicine is hurting me more than helping me, this medicine may be stopped by my doctor in a safe way. I have talked about this agreement with my doctor and I understand the above terms.

Provider Responsibilities

As your doctor, I agree to perform regular checks to see how well the medicine is working.

Insurance Card and Photo ID Policy

Martinsville Family Medicine is dedicated to providing you with the best service we possibly can. In order to provide this service, we will require all patients to present proof of ID and insurance at your initial visit.

Once established, you will be required to present proof of insurance at every visit afterwards. If you do not present your proof of insurance at the time of visit, you may be asked to reschedule your appointment to a later date. If you are seen without proof of insurance, you may be liable for any and all charges that may be inquired at your visit.

I agree to allow Martinsville Family Medicine to provide any proof of insurance or identification to all parties that request information within HIPAA's compliance to ensure I receive the best possible care.

Signature:_____

Date:_____

Martinsville Family Medicine

No Show Patient Policy

Please be aware that you must call our office to cancel or reschedule your visit if you can't keep your appointment.
If a new patient doesn't show up for their first visit, we will **NOT** reschedule a new patient visit.

There will be a **$50.00** no show fee for returning patients that do not call the office to cancel or reschedule their appointments **BEFORE** their appointment time.

Signature: _____

Date: _____