Patient Registration Form (eCW)

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) _____ (First) _____ (MI) ____ Previous Name _____

Address Line 1 _____

City, State _____ ZIP _____

Home Phone _____ Cell No. _____ Work Phone _____ Ext. _____

Primary Care Provider (PCP) _____ Referring Provider _____

Rendering Provider Name (this practice) _____ E-Mail Address: _____

Date of Birth MM _____/DD _____/YYYY _____ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Hispanic ☐ Other ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other ☐ _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number ____-____-____ Employer Name _____

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name _____ First Name _____

Phone Number _____ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient _____ ☐ Guardian

Address Line 1 _____

City, State _____ ZIP _____

Home Phone _____ Work Phone _____ Ext. _____

Referring Provider Name _____

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Guarantor Account Number _____ Date of Birth MM _____/DD _____/YYYY _____

Social Security Number _____-____-_____ Telephone _____

E -Mail Address _____ Sex ☐ F – Female ☐ M - Male

Address Line 1 _____

City, State _____ ZIP _____

Employer _____ Employer Phone Number _____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (____) _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM _____/DD _____/YYYY _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (____) _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM _____/DD _____/YYYY _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ ***Date*** _____

LewisGale Physicians
HCA Virginia Health System
An HCA affiliate

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Patient Name (Printed): _____ Date of Birth: _____

Notice of Privacy Practice/clinics.

_____ (Patient/Representative initials) I acknowledge that I have received the practice/clinic's Notice of Privacy Practice/clinics, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice/clinic's Notice of Privacy Practice/clinics.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?"

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent ____ (Patient/Representative Initials) to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

-OR-

I do not consent ____ (Patient/Representative Initials) to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice/clinic's health care operations purposes (e.g., quality improvement activities).

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications:

We want to stay connected with our patients. Patients in our practice/clinic may be contacted via email, calls to your cellular telephone (including prerecorded/artificial voice messages and/or calls from an automatic dialing device), and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If at any time, you provide an email, cellular telephone number, address or text number below, you understand that you may get these communications from the Practice/clinic. You may opt out of these communications at any time (see next page).The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

I authorize to receive text messages and/or cellular telephone calls for appointment reminders, feedback, and general health reminders/information and **the cell phone number is** _____.

I authorize to receive email messages for appointment reminders and general health reminders/feedback/information and **the email that is**_____.

-OR-

I **decline** _____ (Patient/ Representative Initials) to receive communication via text.

I **decline** _____ (Patient/ Representative Initials) to receive communication via cellular telephone call.

I **decline** _____ (Patient/ Representative Initials) to receive communication via email.

Note: *This clinic uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.*

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

[Practice:OPTIONAL ON FORM- REMOVE THIS Prescription Order Pick up Section **ONLY** if NA to your practice/clinic]
Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ***I do want*** ____ (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:
  - Name: _____ Date: _____
  - Name: _____ Date: _____
- ***I do not want*** ____ (Patient/ Representative Initials) to designate anyone to pick-up my prescription order.

Patient/Parent/Guardian/Patient Representative Signature _____ Date: _____

Patient/Parent/Guardian/Patient Representative Name (Printed) _____

Patient Name (Printed): _____ Date of Birth: _____

Only If you have previously consented to receive communication via text/cellular telephone call/email and wish to remove the consent/Opt Out/Revocation of communications via email and/or text or cellular telephone call. In other words, I do not want my email address or cell number to be used any longer for the above mentioned communications.

*__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **text**.*
*__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **cellular telephone call**.*
*__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **email**.*

Patient Name: _____

Patient/Patient Representative Signature: _____
Date: _____ Time: _____

Patient Name:_____Date of Birth_____

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent form(s) prior to the test(s) or procedure(s).

If there is an exposure, and the patient's test is positive, the attending physician will notify the patient, any person exposed, and the Public Health Department and appropriate counseling will be offered.

PATIENT FINANCIAL AGREEMENT

1. _____(Patient or Guardian Initials)
Financial Agreement.

- I acknowledge, that as a courtesy, **LewisGale Physicians** may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. _____(Patient or Guardian Initials)
Third Party Collection. I acknowledge that **LewisGale Physicians** may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. _____(Patient or Guardian Initials)
Assignment of Benefits. I hereby assign to **LewisGale Physicians** any insurance or other third-party benefits available for health care services provided to me. I understand **LewisGale Physicians** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **LewisGale Physicians,** I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Patient Name:_____Date of Birth_____

4. _____(Patient or Guardian Initials)

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **LewisGale Physicians** by the Medicare or Medicaid program.

5. _____(Patient or Guardian Initials)

Consent to Telephone Calls for Financial Communications. I agree that, in order for **LewisGale Physicians**, or EBO Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **LewisGale Physicians** or Extended Business Office (EBO) Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **LewisGale Physicians** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. _____(Patient or Guardian Initials)

I understand that **LewisGale Physicians** includes consent at satellite offices under common ownership. A photocopy of this consent shall be considered as valid as the original.

7. _____(Patient or Guardian Initials)

This entire consent will remain in full force until revoked in writing.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature of Patient or Personal Representative **Date**

_____

Printed Name of Patient or Personal Representative

If you are not the patient, please identify your relationship to the patient. (Circle or mark relationship(s) to patient from list below):

Spouse
Parent
Legal Guardian
Guarantor
Healthcare Power of Attorney
Other (please specify)_____

_____ _____

Printed Name of Witness (Employee) Employee Job Title

_____ _____

Signature of Witness Date

First Point of Contact Screening

Patient Name_____ **Date**_____
Please print full legal name

We are committed to providing the safest environment for our patients and together we can prevent the spread of germs.

Please complete the questionnaire below. If you answer yes to any of the questions, please be considerate of others and act appropriately such as covering your cough, washing your hands, and covering any open wounds.

For the protection of our patients, we gladly supply and encourage the use of tissue, masks, hand sanitizer, and Band-Aids.

1. Do you have any of the following symptoms? YES NO

   If yes, please circle the symptoms you have now, or have had, over the past seven days?
   - **Fever**
   - **Night sweats**
   - **Sneezing or runny nose**
   - **Cough**
   - severe headache
   - stiff neck
   - muscle or joint pain (circle one or both)
   - new rashes or open sores on your skin or in your mouth
   - redness, swelling, or discharge of your eyes (pink eye)
   - unexplained bleeding
   - vomiting or diarrhea

2. In the past three weeks, have you traveled outside the U.S.? YES NO

   If yes, please list where: _____

3. In the past three weeks have you had close contact with someone who has traveled outside the U.S.? YES NO

   If yes, please list where: _____

Thank you for your help and support in caring for our patients and community.

TO BE FILLED OUT BY OFFICE STAFF

Reviewed by: _____

Action taken:
- ☐ No action taken
- ☐ Isolate
- ☐ Cough/ hand washing etiquette provided
- ☐ Mask provided
- ☐ PM/ Lead clinical provided

Thank you for trusting us with your healthcare!

LGP The Spine Center **James M Leipzig, MD**

Patient Name: _____ Gender: ☐Male ☐Female Date: _____

Date of Birth (MM/DD/YYYY):_____ Current Age: _____ Height:_____Weight:_____

Primary Care Physician: _____Referring Physician:_____

What are you being seen for today?

_____

How and when did your problem begin? (Please mark each answer that applies to your current pain)

☐ I don't know how it began ☐ It comes and goes ☐ I've had it a long time (_____years)

☐ Injury (Date of Injury_____)
On the job? ☐Yes ☐No
Have you been laid off work? ☐Yes ☐No

Are you in current litigation with regards to current pain? ☐Yes ☐No

What makes your pain better?

_____
_____

What makes your pain worse?

_____
_____

How would you rank your pain?

1 2 3 4 5 6 7 8 9 10
No pain Worst Possible

Previous Treatment and Diagnostic Testing:

Have you had any of the following for your current problem? If Yes, did it make your condition better or worse?			Have you had any of the following in regards to your current pain? If Yes, when and where did you have them performed?
NSAID Therapy	☐Better	☐Worse	Plain X-rays Date:_____ Where:_____
Physical Therapy	☐Better	☐Worse	MRI Scan Date:_____ Where:_____
Chiropractic Care	☐Better	☐Worse	CT Scan Date:_____ Where:_____
Corticosteroid injection	☐Better	☐Worse	EMG/NCV(nerve test) Date:_____ Where:_____
Other _____	☐Better	☐Worse	Other _____ Date:_____Where:_____
Have you had previous surgery for your current pain or problem? Yes No Type of Surgery _____Date:_____Surgeon_____ Did it make your pain: ☐Better ☐Worse			
Have you had any other alternative forms of medical treatment that we should know of? _____			

Patient Initials Date

LGP The Spine Center **James M Leipzig, MD**

Medical History:

☐Heart Attack	☐Colon Problems	☐Gout	☐Enlarged Prostate
☐Heart Murmur	☐Diabetes	☐Anxiety	☐Menstrual Problems
☐Angina	☐Hepatitis A, B, C	☐Depression	☐Cancer-Type_____
☐High Blood Pressure	☐Cirrhosis	☐Emphysema	☐Osteoporosis
☐Stroke	☐Kidney Stones	☐Tuberculosis	☐Multiple Sclerosis
☐Varicose Veins	☐Kidney Infection	☐Chronic Bronchitis	☐Visual Changes
☐Stomach Ulcer	☐Degenerative arthritis	☐Frequent Pneumonia	☐Blood Clots
☐Duodenal problems	☐Rheumatoid arthritis	☐Asthma	☐Dizziness
☐Anemia	☐Bleeding Tendency	☐Seizure Disorder	☐Other_____
☐ALS	☐HIV	☐Tremor	

Current Medications:

Medication	Reason Taken	Dose	Frequency	Prescribing Physician

Allergies:

Medication/Allergen	Reaction

Gyn History:

Ob History:

Surgical History:

Surgery	Date

Hospitalizations:

Reason	Date

Patient Initials Date

LGP The Spine Center **James M Leipzig, MD**

Family History:

	Alive/Deceased	Diabetes	High Blood Pressure	Asthma	Cancer (type)	Heart Attack	CAD	High Cholesterol	Other
Mother									
Father									
Sister									
Brother									
Son									
Daughter									

Social History:

Alcohol	☐None ☐ Occasional _ drinks per ☐ day ☐week ☐month
Tobacco Use	☐Never ☐Current daily ☐Current some ☐ Smokeless former ☐Smokeless current
Caffeine	☐Yes ☐No If yes, frequency ____cups a day
Illicit Drug Use	☐Yes ☐No
Exercise	☐Yes ☐No If yes, how many days per week? _____
Marital Status	☐Married ☐Separated ☐Divorced ☐Single ☐Widow/Widower
Work Status	☐Full time ☐Part time ☐Disabled ☐Retired
Education	☐Grammar School ☐High School ☐College

Review of Systems:

General

Recent weight loss of more than 10 lbs	☐Yes ☐No
Recent weight gain of more than 10 lbs	☐Yes ☐No
Fever	☐Yes ☐No
Chills	☐Yes ☐No
Night Sweats	☐Yes ☐No
Have you seen your primary care physician in the past year?	☐Yes ☐No

Cardiac

Chest Pain	☐ Yes ☐ No
Shortness of Breath	☐ Yes ☐ No

Pulmonary

Wheezing	☐ Yes ☐No
Pneumonia	☐ Yes ☐No
Chronic cough	☐ Yes ☐No

Gastrointestinal

Abdominal Pain	☐ Yes ☐No
Nausea	☐ Yes ☐No
Vomiting	☐Yes ☐No
Diarrhea	☐Yes ☐No
Liver Problems	☐Yes ☐No

Dermatological

Open sores	☐Yes ☐No
New Moles	☐Yes ☐No
Poor Healing	☐Yes ☐No
Skin Infection	☐Yes ☐No
Easy Bruising	☐Yes ☐No

Endocrine

Diabetes	☐Yes ☐ No

Dental

Significant problems	☐Yes ☐No

Musculoskeletal

Shoulder pain	☐Yes ☐No
Wrist/Hand pain	☐Yes ☐No
Hip Pain	☐Yes ☐No
Knee Pain	☐Yes ☐No
Low Back Pain	☐Yes ☐No
Lupus	☐Yes ☐No
Muscle weakness	☐ Yes ☐No
Fibromyalgia	☐Yes ☐No

Neurological

Headaches	☐Yes ☐No
Tremors	☐Yes ☐No
Seizures	☐Yes ☐No
Changes in Vision	☐Yes ☐No

Psychological

Sleep trouble	☐Yes ☐No
Feeling of hopelessness	☐Yes ☐No

Genitourinary

Poor Kidney Function	☐Yes ☐No
Pain with urination	☐Yes ☐No
Frequent UTI	☐Yes ☐No

Hematological

Transfusion	☐ Yes ☐No
Transplant	☐ Yes ☐No
Blood Thinner	☐ Yes ☐No

Patient Initials Date

PAIN DRAWING

PATIENT: _____ AGE: _____ DATE: _____

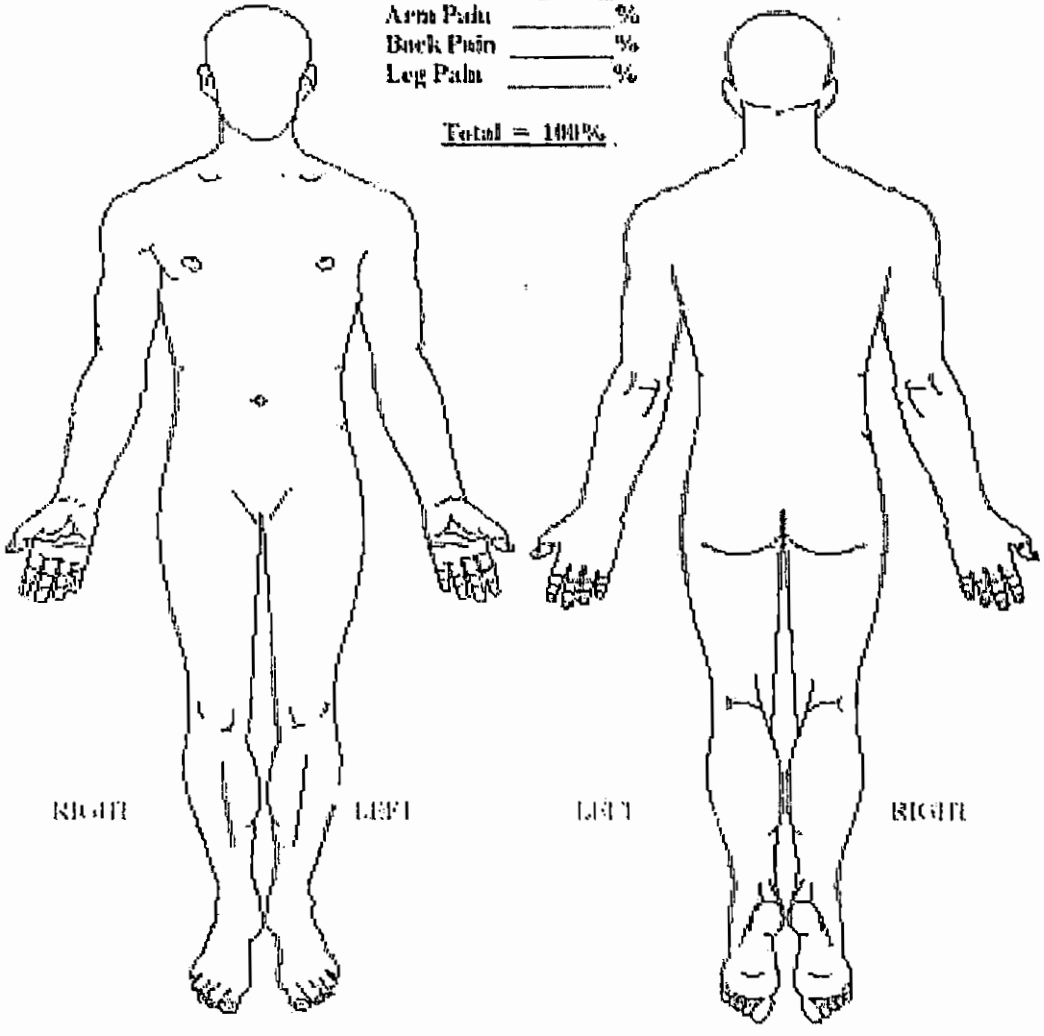
WHERE IS YOUR PAIN NOW?

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas. Just to complete the picture, please draw in your face.

ACHE ^ ^ ^	NUMBNESS O O O	PINS & NEEDLES	BURNING X X X	RADIATING PAIN ///
^ ^ ^	O O O		X X X	///
^ ^ ^	O O O		X X X	///

Neck Pain _____%
Arm Pain _____%
Back Pain _____%
Leg Pain _____%

Total = 100%



PLEASE MARK ON THE LINE:

How bad is your pain now?

① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

NO PAIN — INTERMEDIATE PAIN — WORST PAIN