Family Physicians of Marion

Royal Oak Medical Associates, P.C.

1020 Terrace Drive, Suite 200

Marion, VA 24354

(P) 276-783-7167 (F) 276-783-6432

Patient Name:_____ Date of Birth:_____

Social Security #:_____

Address:_____

_____

Home Phone:_____ Cell Phone:_____

Primary Insurance:_____

Secondary Insurance:_____

Patient Employer:_____ Work Phone:_____

Address of Employer:_____

_____

Marital Status: (Circle One) Single Married Widowed Divorced

Spouse Name:_____ Social Security #:_____

Spouse Employer:_____ Work Phone:_____

Emergency Contact:

Name:_____ Phone #:_____

Name:_____ Phone #:_____

Name:_____ Phone #:_____

DEEMED CONSENT FORM

I understand that the laws of Virginia provide if my physician, or any person employed by or under the direction and control of my physician(s), is directly exposed by my body fluids in any manner which may, according to the then current guidelines for the Center of Disease Control (CDC), transmit the human immunodeficiency virus (HIV) or Hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or Hepatitis B or C viruses. I further understand that, by law, I will have deemed to consent to the release of these test results to the person who is exposed to my body fluids.

Patient Signature:_____ Date:_____

Witness:_____ Authorized Person:_____

MEDICARE PATIENTS ONLY

Lifetime authorization to permit payment of Medicare benefits to provider/physician and patient

I certify that the information given me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical of medical or other information about me to release to the Health Care Financing Administration or its intermediaries of carriers any information needed for this or a related Medicare claim. I request that payment of authorization benefits be made on my behalf. I assign the benefits payable for covered Medicare services to the physicians.

Patient Signatures:_____ Date:_____

Authorized Person:_____

PERMISSION TO DISCUSS PATIENT INFORMATION

Patient Name:_____ Date:_____

I hereby give my permission to the person(s) listed below to receive information about the care of the above named patient:

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Signature of Patient, Parent or Guardian Date

In order to obtain information by telephone, the party calling the practice must share the patient identifier with the staff.

Patient Identifier:_____

This notice describes how information about you may be used and disclosed and how you can gain access to this information.Please review carefully.

NOTICE OF INFORMATION PRACTICES

1. Family Physicians of Marion may use and disclose protected health information for treatment, payment and healthcare operations. Example of these include, but are not limited to, requested preschool, or sports physicals, referral to nursing homes, foster care homes, home health agencies and/or referral in other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers and collection agencies. Healthcare operations include, but are not limited to, internal quality control and assurance including auditing of records.

2. Family Physicians of Marion is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. Two examples of such are for public health requirements or court orders.

3. Family Physicians of Marion will not make any other use or disclosure of a patient's protected health information without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.

4. Family Physicians of Marion will abide by the term of this notice currently in effect at the time of the disclosure.

5. Family Physicians of Marion reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains. Family Physicians of Marion will provide each patient with a copy of any revisions of its Notice of Information Practices at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our office.

6. Any patient, guardian or personal representative has the right to object to the use of their health information for directory purposes.

7. Any patient, guardian or personal representative has the right to request, inspect and obtain copies of their medical records for a fee.

8. Any patient, guardian or personal representative has the right to request amendments to be made to their medical records.

9. Any patient, guardian or personal representative has the right to request a six-year accounting of certain disclosures of their medical record. The history will be provided within 60 days of the request and a reasonable charge may be assessed for any copies after the first requested in a 12-month period.

10. Any patient, guardian or personal representative has the right to request restrictions as to how their health information may be used or disclosed to carry out treatment, payment or healthcare operations. Family Physicians of Marion is not required to agree to the restrictions requested, but if the Practice does agree, the Practice must abide by those restrictions.

11. Any person/patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, please contact the Privacy Officer at the following address and/or phone number: Family Physicians of Marion, 1020 Terrace Drive, Suite 200, Marion, VA 24354; Phone: 276-783-7167; Fax: 276-783-6432. All complaints will be addressed and the results will be reported to the Privacy Officer.

12. It is the policy of Family Physicians of Marion that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

Name of Patient:_____ Effective Date:_____

Signature of Patient/Legal Guardian:_____ Date:_____

For Use and Disclosure of Protected Health Information for Treatment, Payment or Healthcare Operations

I understand that as part of my healthcare, Family Physicians of Marion originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I also understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can certify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand the Practice reserves the right to change their notice and practices, and prior to implementation, will mail a copy of any revised notice to the address that I have provided if there is a need to use or disclose any protected health information. I also understand that I have the right to restrict how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

With this consent, Family Physicians of Marion may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

With this consent, Family Physicians of Marion may mail to my home or other designated location, any items that assist the practice in carrying out TPO, such as appointment reminders and other correspondence as long as they are marked Personal and Confidential.

With this consent, Family Physicians of Marion may e-mail to me appointment reminders and patient statements. I have the right to request that Family Physicians of Marion restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Family Physicians of Marion to use and disclose my PHI to carry out my TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Family Physicians of Marion may decline to provide treatment to me.

Printed Name:_____

Signature of Patient/Legal Guardian:_____

Date:_____