Divine Health Care, LLC
2100 Executive Drive Hampton, VA 23666
Office: 757-826-1600 Fax: 757-826-0160

## PATIENT INFORMATION

**SS#**_____-_____-_____

**Last**: _____**First**:_____ **MI**____

**Suffix**: _____

**Address**: _____ **City**:
_____ **State**: _____ Zip: _____

**Home Phone** :(_____) _____-_____ **Mobile** :(_____) _____-_____
**Work** :(_____) _____-_____ **Ext**: _____

**Sex**: ___M ___F **DOB**: _____/_____/_____ **Marital Status**: ____Single ____Married
_____Divorced ____Widowed

**Email Address**: _____

**Emergency Contact**: _____ **Phone#**: _____
**Relationship**: _____

## DEMOGRAPHIC INFORMATION

**Race**:

___American Indian or Alaskan Native ___Black or African American ___Asian
___ Native Hawaiian or Pacific Islander ___ White ___Do not wish to provide

**Ethnicity**:

___Hispanic ___Non-Hispanic __Do not wish to provide

**Preferred Language**:

___English ___Other_____

## INSURANCE INFORMATION

Employment Status: ___Full Time ___Part Time ___Self Employed ___Not Employed
___Retired ___Military ___Disabled

**Primary Insurance**: _____
**Member ID**: _____

**Group#**: _____ **Copay Amount**: $_____._____

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# MEDICAL HISTORY FORM

**Patient Name**_____ **Date of Birth** _____

| | PAST MEDICAL HISTORY (Please check any medical problem(s) that you have in the past or are presently having) | | SURGICAL HISTORY (Please check any surgeries that you have had) |
|---|---|---|---|
| | Anemia | | Knee Replacement |
| | Anxiety | | Hip Replacement |
| | Arthritis | | History Cholecystectomy |
| | Asthma | | Hysterectomy |
| | Bleeding Disorder | | Appendectomy |
| | Cancer | | Thyroidectomy |
| | Cataracts | | Heart Stent |
| | Chronic Lung Disease | | Heart Surgery |
| | Cirrhosis | | Other |
| | Colon Polyps | | |
| | Congestive Heart Failure | | |
| | Coronary Artery Disease | | |
| | Crohns Disease | | **SOCIAL HISTORY AND HABITS** (Please check and give average amount) |
| | COPD | | |
| | Depression | | **SMOKE/CHEW TOBACCO** How many years? ____ How many packs per day?_____ |
| | Diabetes | | |
| | Hypertension | | **DRINK COFFEE** Number of cups/glasses per day? ____ |
| | Heart Attack | | |
| | Hepatitis B | | **DRINK BEER, WINE OR HARD LIQUOR** Number of drinks _____ per ___day _week ___month |
| | Hepatitis C | | |
| | Irritable Bowel Disease | | |
| | Jaundice | | |
| | History of Ulcers | | |
| | Infections | | |
| | Seizures | | |
| | Other | | |

**ALLERGIES:**

**FAMILY MEDICAL HISTORY:**

**MEDICATIONS:** (Please bring **ALL** medications to doctor's visit)

| | | |
|---|---|---|
| 1 | | 7 |
| 2 | | 8 |
| 3 | | 9 |
| 4 | | 10 |
| 5 | | 11 |
| 6 | | 12 |

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## PATIENT RIGHTS AND RESPONSIBILITES

### Patient Rights

As a patient, you have the right to:

1. Considerate, respectful care at all times and under circumstances with recognition of your personal dignity.
2. Personal and informational privacy within the law.
3. Information concerning your diagnosis, treatment, and prognosis, to the degree known; confidentiality of records and disclosures. Except when required by law, you have the right to approve or refuse the release of records.
4. The opportunity to participate in decisions involving your healthcare unless contradicted by concerns for your health.
5. Make decisions about medical care including the right to accept or refuse medical or surgical treatment and the right to initiate advance directives such as living will or durable power of attorney. If you already have a living will or other directive or you wish to initiate one, please speak with the doctor.
6. Information concerning implementation of any advance care directive.
7. Impartial access to treatment regardless of race, color, sex, national origin, religion, handicap or disability. The center adheres to all federal and state rules, regulations and policies to promote a nondiscriminatory environment for all of our patients.
8. Receive an itemized bill for all services.
9. Know the identity and professional status of individuals providing service to you.
10. Report any comment concerning quality of care provided to you during the time spent at the facility and receive fair follow-up on your comments.

### Patient Responsibilities

As a patient, you are responsible for:

1. Providing to the best of you knowledge accurate and complete information about your present health status and past medical history and reporting any unexpected changes to the appropriate physician(s).
2. Following the treatment plan recommended by the primary physician involved in your case.
3. Indicating whether you clearly understand a contemplated course of action and what is expected of you.
4. Your actions if you refuse treatment, leave the facility against the advice of the physician, and/or do not follow the physician's instructions relating to your care.
5. Assuring that the financial obligations of your health care are fulfilled as expediently as possible.
6. Providing information about and/or copies of any living will, power of attorney or other directive that you desire us to know about.

**I have read and understand my rights and responsibilities as a patient of Divine Health Care, LLC.**

_____ _____

Patient Signature Date

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# Advance Directives Policy

**Patient's Rights and Responsibilities:**

I certify that I, a patient/responsible party or legal guardian of _____, have received a copy of the "Patient's Rights and Responsibilities" have read them and understand them completely, in their entirety.
Please circle: Yes No

**Living Wills, Do Not Resuscitate Orders**

I have a Living Will:

Please circle: Yes No

Please Note: Our organization honors living wills. On the basis of conscience, "DO NOT RESUSCITATE" ORDERS ARE NOT HONORED AT THIS FACILITY. If an Emergency occurs and you need acute care, our policy is to transfer you to a facility that can provide such care at that time. Please elect with an X the appropriate response below:

_____ I understand this statement and agree to be transferred to an acute care facility if a life threating event occurs; I agree to have all my medical records and belongings transferred with me.

_____ I understand this statement, yet do not wish to waive my right to execute the do not resuscitate clause of my living will. I understand that this means I cannot have my procedure performed in this facility and will discuss this further with my Physician.

HIPAA (Health Insurance and Portability and Accountability Act) I have read the copy of the HIPAA policy and I agree to the following things. Please circle Yes or No to the following questions:

Ok to call my home: Yes No

Ok to leave a voice message on machine: Yes No

Ok to leave a voice message with Spouse/Significant Other: Yes No

List Alternative Contacts: _____

Ok to discuss information regarding my procedure with (list): _____

We will be sharing Medical Information with the following-any objection should be in writing:

- Surgeon
- Insurance Company
- Anesthesia Providers, Laboratory Services, Radiology Services
- Federal, State and Local regulatory agencies
- Peer review, committees for performance, improvement of _____.

We will make available to you the "Notice of Patient Information Privacy Practices" that provides a more complete description of health information uses and disclosure as required by the HIPAA standard.

You have the following right: The right to read the "Patient Health Information Privacy Practices" prior to signing your consent and the right to request a copy for your own personal use.

I fully understand and agree to this consent and acknowledge the above rights and disclosures.

Signature of Patient/Responsible Party:_____ Date:_____

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## Assignment of Benefits/ Financial Responsibilities/ HIPAA

1. _____I understand that this is my responsibility to provide Divine Health Care LLC with a copy of my current insurance card and to obtain a referral from my primary care physician (if required by my insurance). Divine Health Care LLC is not obligated to see patients without a valid referral. If I do not have insurance, I will be considered a self-pay patient and be financially responsible for the total amount of the services provided. I will notify divine health care immediately upon any change in my insurance.
2. _____I understand that in consideration of the services provided, I am directly and primary responsible to pay the amount of all charges incurred for services and procedures rendered at Divine Health Care LLC which are not covered or reimbursed by my insurance. Furthermore, I am responsible for any applicable deductible, copayments, and or coinsurance prior to the provision of services. Divine Health Care LLC will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment, or procedure, this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. If I have Medicare, I will complete in Advance Beneficiary Notice (ABN) form non-covered services. Should my account be referred to a collection agency or attorney, I agree to pay all costs of collection, including interest in attorney's fees and costs.
3. _____I authorize my insurance carrier to release information regarding my coverage to Divine Health Care LLC. I also authorize agents of any hospital, treatment center or previous position to furnish Divine Health Care LLC copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and or reports related to my treatment to any federal, state, or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within Divine Health Care LLC.
4. _____My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, and supplies in nursing/physician services including major medical benefits are hereby assigned to divine health care LLC. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I egg knowledge this document as a legal binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not except Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Divine Health Care LLC.
5. _____I understand that the required notice time for cancellation an office visit is 24 hours. Should I fail to cancel within the required time frame there will be a fee (not billable to my insurance provider) of $25 for the office visit.

Health Insurance Portability and Accountability Act (HIPAA) Acknowledgement

Divine Health Care LLC is required by law to provide you with a copy of your *Notice of Privacy Practices*, which describes how your healthcare information is used and is disclosed.

To ensure our records are accurate, please complete and sign below and return this form to our receptionist to acknowledge that you have been provided with a copy of our notice. Also, please be advised Divine Health Care LLC may use and disclose de-identified health information for purposes of data collection and statistical analysis. De-identified information is information from which all personal identification has been removed. This means the health information can no longer be identified as yours and is no longer considered protected under HIPAA. I acknowledge the use or disclosure of my protected health information by Divine Health Care LLC for the purpose of treatment payment and healthcare operations.

I have received a copy of the notice of Privacy Practices and understand I have the right to review prior to signing this document.

Authorization for voicemail usage for PHI

_____I authorize Divine Health Care LLC to leave a message on my voicemail or answering machine concerning my Protected Health Information.

_____ I authorize the following people to be involved in my care that may require a disclosure of the Protected Health Information. This consents for disclosure includes both health and financial information as it relates to my care.

Contacts

Name: _____Relationship_____ Phone: _____

Cell: _____

Name: _____Relationship_____ Phone: _____

Cell: _____

Name: _____Relationship_____ Phone: _____

Cell: _____

This Agreement/Consent will remain in effect unless revoked by me in writing.

I have read and accepted the terms and conditions of the assignment of benefits and financial responsibilities agreement, as well as, the Health Insurance Portability and Accountability Act Acknowledgement

Patient/Representative Signature: _____ Date: _____

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## Authorization to Release Medical Information

I, _____Date of Birth_____ Social Security#_____

(Hereby agree and authorize)

_____

Health Care Facility or Physician Office

_____

Address City State Zip Code Phone# Fax#

To disclose protected health information to DIVINE HEALTH CARE, LLC via mail, phone, email or fax. I am requesting the release of this protected health information for the purpose of (please check):

___Continued Care ___Personal ___Attorney/Legal ___Insurance ___Disability
___Other (Be Specific) _____

I agree and authorize the release of the following medical information for the following:

___Operative/Surgical Notes ___Labs ___Immunizations__ Phone Notes
___Physician/Office Notes ___Other
(Be Specific)_____

I Understand that I may revoke this authorization at any time by giving written notice of my revocation to the address listed above. A written revocation wills not affected authorized uses and disclosures made prior to receipt of the written revocation. I understand the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy.

I Understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and/or drug abuse.

_____ _____
Patient Signature Date

_____ _____
Signature of Responsible Party (of patient minor) Witness Signature