STEPHENS CITY
FAMILY MEDICINE, LLC

Dr. Jennifer Carter
Dr. Chris Craig
Dr. Joel Grant
Dr. Crista Warniment
Ekaterina Wood, FNP-C
160 Warrior Drive • Stephens City, VA 22655
office: 540-868-4100 • fax: 540-868-0888

www.scfammed.com

Dear Patient,

Thank you for contacting Stephens City Family Medicine and requesting a welcome packet. We are located in the Sherando Towne Centre near Miller's Hardware, Walgreens, First Bank and Children of America. Our office strives to provide quality care for the whole family. We also offer a wide range of pediatric care for children of all ages enabling you to go to one place for care for the entire family. If you would like to establish your family with our practice, please take time to complete this packet for each family member and return it to our office. To meet the needs of your family we have five providers in our office, Drs. Craig, Grant, Hawkins and Warniment along with Kacey Sebert who is a Physician Assistant. They work hard to ensure you receive proper medical care when needed.

We are providers with the following insurance companies: Anthem, Aetna, Medicaid, Va Premier (HMO Medicaid), Medicare, Optima Health, Mamsi, Optimum Choice, One Net, Virginia Health Network, United Healthcare, Tricare, Health Smart and Cigna. Under the Healthcare Insurance Marketplace the only plan accepted is the Optima Health Vantage plans. **It is your responsibility to make sure we are a provider with your plan. We may be a provider with your insurance but please verify we are a provider with your specific plan type. Please call the member service number located on the back of your insurance card and verify directly with your insurance.**

If you are currently on pain medications we do not take new pain management cases. We require all patients on chronic pain medications to be followed by a pain management specialist to help manage pain and medications.

Please take the time to read and complete the entire welcome packet. **All** forms must be completed (both sides) and signed in order for our office to schedule you an appointment. *Welcome packets must be filled out for each patient.*

Once you have completed the package, please return it to our office either by dropping it off at our office, by fax or by mail. Once the packet has been reviewed by a provider our office will call to schedule your initial visit appointment. It is not unusual for the initial visit to be scheduled out as far as a month. Please be patient with us. *Initial visits are required for all patients prior to being seen for an acute (sick) visit.* Once you are established we can normally see you for acute visits on the same or next day. Due to the amount of time allotted for initial visits, please give at least a 24 hour notice if you need to reschedule. However, after the third rescheduling our office **will not** reschedule your initial visit, which means you will not become our patient. If you fail to show for your initial visit without rescheduling, our office **will not** reschedule your appointment, which means you will not become our patient. If you have any questions about these forms, please feel free to contact our office.

Sincerely,
Monica Hott
Office Manager

Hours:
By Appointments Only
Monday- Friday: 7:00am – 5:00pm
Closed for lunch 12:00pm – 1:30pm

Web View Information

Web View is a patient portal which allows us to share sections of your medical records safely and conveniently with you online.

If you would like to register please complete the following questions:

Patient's Name: _____

Username (First Name, Last Name: EX JohnSmith): _____

Temporary Password: _Welcome#1_____

Security Question: _____

Answer to Security Question: _____

Within four business days of your initial appointment, we will provide you access based off the username and password you've provided.
Please visit our website at www.scfammed.com in order to login to Web View.
On our home page is an icon "Click Here for WebView Login."
Please contact our office at *contactus@scfammed.com* if you have any problems with Web View.

Acknowledgement of Receipt of Notice of Privacy Practices (Required)

Notice to Patient:
We are required to advise you of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. A copy of the Notice of Privacy Practices will be provide upon request.

I acknowledge that I have been made aware of this office's Notice of Privacy Practices. I may refuse to sign this acknowledgement if I wish.

_____ _____
Patient's Name **Patient's Date of Birth**

_____ _____
Please print your name here *(if different from above)* **Relationship to Patient**

_____ _____
Signature **Today's Date**

For Office Use Only

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

- ☐ **The parent/patient refused to sign.**
- ☐ **Due to an emergency situation it was not possible to obtain an acknowledgement.**
- ☐ **We weren't able to communicate with the parent/patient.**
- ☐ **Other: (Please Specify)** _____

_____
Employee Signature

_____
Date

STEPHENS CITY
FAMILY MEDICINE, LLC

SCFMFORM: 001

Notice of Privacy Practices for Protected Health Information

STEPHENS CITY
FAMILY MEDICINE, LLC

Your Information. Your Rights. Our Responsibilities.

This notice, available on paper and on our website, describes how medical information about you may be used and disclosed and how you can obtain access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and our responsibilities.

View your medical record and/or get an electronic or paper copy of your medical record	• You may request to inspect and obtain a copy of your health record and billing record. You may request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office. • We will provide a copy or a summary of your health information, usually within 15 business days of your request. We will charge a reasonable, cost-based fee, in accordance with state guidelines.
Ask us to correct your medical record	• Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office. We may deny your request if you ask us to amend information that: • Was not created by us, unless the person or entity that created the information is no longer available to make the amendment • Is not part of the health information kept by or for the office. Is not part of the information that you would be permitted to inspect and copy; or • Is accurate and complete. • If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records.
Request confidential communications	• You can ask us, in writing, to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will abide by all reasonable requests.
Ask us to limit what we use or share	• You may request a restriction on certain uses and disclosures your health information by delivering the request to our office – the request will be reviewed, but we are not required to grant it. • You may request a restriction on disclosures of medical information to a health plan for purposes of carrying out payment. • If you pay for a service or health care item out-of-pocket and in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will abide by this request, unless we become legally required to share that information.
Get a list of those with whom we've shared information	• You can obtain a list (accounting) of disclosures of your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost based fee if you ask for another one within 12 months.

Get a copy of this privacy notice	• You may ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney, or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights have been violated	• You may file a complaint if you feel we have violated your rights by contacting our Compliance Officer. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. • If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact our Compliance Officer at 540-868-4100. • Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to our Compliance Officer at 160 Warrior Drive, Stephens City, VA 22655. You may also file a complaint by mailing it to the Secretary of Health and Human Services, whose street address is: U.S. Department of Health & Human Services, 200 Independence Avenue SW, Washington, D.C. 20201. • We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office. • We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services. • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, let us know.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious,we may go ahead and share your information, if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information, unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes

In the case of fundraising:	• We may contact you for fundraising efforts, but you may ask us not to contact you again.	

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

To treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
To run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary. • We will share information about you with insurers or other business associates, as necessary, to obtain quality assessment and improvement, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance.	***Example:*** *We use health information about you to manage your treatment and services.*
To bill for your services	• We can use and share your health information to obtain payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan to charge for our services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues	• We can share health information about you for certain situations such as: – Preventing disease – Helping with product recalls – Reporting adverse reactions to medications – Reporting suspected abuse, neglect, or domestic violence – Preventing or reducing a serious threat to anyone's health or safety
Do research	• We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
Comply with the law	• We may disclose your protected health information for law enforcement purposes as required by law. • We may disclose your protected health information for specialized government functions as authorized by law, such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We may release health information to a coroner, medical examiner, or funeral director. This may be necessary to identify a decease individual or to determine the cause of death.
Address workers' compensation, law enforcement, and other government requests	• We may release health information about you at the request of your employer, if services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury.
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and practices described in this paper/web notice and provide a copy when requested.
- We will not use or share your information other than as described here, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of This Notice

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact our Compliance Officer at 540-868-4100.

For more information:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

RELEASE OF MEDICAL HISTORY AND ASSIGNMENT OF BENEFITS

I hereby authorize and give permission to Stephens City Family Medicine to release billing and medical information, to include the transcript of my medical records to my insurance carrier(s) upon their request, for the purpose of determining benefits payable under the contract. I hereby assign to Stephens City Family Medicine any and all benefits incurred for the services provided by them. I understand that I am financially responsible for charges not covered by my insurance. This includes payment of any deductible amount and/or any unpaid balance after payment by my insurance carrier(s). I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made in my behalf.

_____ _____

Signature of Patient or Responsible Party Date

FINANCIAL RESPONSIBILITY

I hereby accept responsibility for payment in full for services provided by Stephens City Family Medicine within thirty (30) days of receiving services. In the event that I do not meet any financial responsibility with Stephens City Family Medicine, I agree to pay cost for collection, including the collection agency and/or attorney's fee. I agree to be responsible for payment of all services rendered on my behalf or my dependent including any insurance benefits which are disputed, denied, or unpaid by my insurance company in 90 days from the date of service. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account.

_____ _____

Signature of Patient or Responsible Party Date

STEPHENS CITY
FAMILY MEDICINE, LLC

Authorization for Disclosure of Protected Health Information

I Authorize The Use / Disclosure Of Health Information About Me As Described Below

Patient Name:_____ Date of Birth:_____
(Please Print)

A. Person(s) or Organization(s) authorized to receive the information: (example; grandparents, neighbor, nanny, etc.)

B. Specific description of the information that may be used or disclosed (only immunizations, full records, etc.)

C. Specific description of how the information will be used:

1) I understand that this authorization will expire one (1) year from today's date.
2) I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Stephens City Family Medicine, LLC in writing.
3) I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4) I may inspect or copy any information used or disclosed under this agreement.
5) I understand that, if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations.

_____ _____
Patient's Signature or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

NOTE: You have the right to know specifically what information you are authorizing for release (e.g., "results of a lab test performed on 1/4/03" or, if your entire medical record is included, "all health information.").

Revised 11/2013

Notice Of Deemed Consent To HIV Blood Testing

I have been informed by this notice that a law was enacted in Virginia in 1989 and 1993 which authorizes the hospital to test me for Human Immunodeficiency Virus (HIV) and Hepatitis B or C antibodies when any health care provider is exposed to my body fluids in a manner which may transmit HIV and Hepatitis B or C. Pursuant to this law, in the event of such an exposure, I am deemed to have consented to such testing, and to have consented to the release of the test results to the health care provider who may have been exposed.

_____
Patient's Signature

_____
Signature of Witness

IF PATIENT IS UNABLE TO SIGN OR IS A MINOR, COMPLETE THE FOLLOWING:

_____
Signature of closest relative or guardian

_____
Signature of Witness

_____
Relationship to Patient

STEPHENS CITY
FAMILY MEDICINE, LLC

CONFIDENTIAL PATIENT INFORMATION

Stephens City Family Medicine
160 Warrior Drive, Stephens City, VA 22655 Today's Date:
____/____/____
540-868-4100 New Patient___ Established Patient___

PLEASE PRINT CLEARLY

PATIENT INFORMATION:

Name:_____ Birth Date: ___/___/_____ Social Security #:_____

Home Phone:_____ Work Phone:_____ Cell Phone: _____

E-mail:_____

Male____ Female____ Marital Status: Single_____ Married_____ Divorced_____ Widowed _____

Mailing Address:_____
Street City State Zip Code

Race: American Indian___ Asian___ African American ___ Native Hawaiian or Pacific Islander ___ White___ Declined___

Ethnicity: Hispanic or Latino ___ Not Hispanic or Latino ___ Declined ___

Preferred Language: _____ Preference for reminders: Phone _____ Printed _____ Web View _____

Place of Employment: _____ Address:_____ How Long:_____
(Patient) Company Name Company Address

Nearest Relative not living with you: Name:_____ Phone:_____

Spouse Name: _____ Birth Date: ___/___/_____ Social Security#: _____

Place of Employment: _____ Address:_____ How Long:_____
(Spouse) Company Name Company Address

RESPONSIBLE PERSON'S INFORMATION (This section only needs to be filled out if patient is a minor, under age 18):

Name:_____ Birth Date: ___/___/_____ Social Security #:_____

Mailing Address:_____
Street City State Zip Code

Home Phone:_____ Work Phone:_____ Cell Phone: _____

Place of Employment: _____ Address:_____ How Long:_____
Company Name Company Address

Place of Employment: _____ Address:_____ How Long:_____
(Other Parent) Company Name Company Address

INSURANCE INFORMATION:

Insurance Company:_____ Policy Name Under:_____ Birth Date: ___/___/_____

Policy #:_____ Group Name or #:_____

Secondary Insurance Company:_____ Policy Name Under:_____

Policy #:_____ Group Name or #:_____

PATIENT AND RESPONSIBLE PARTY AUTHORIZATION

I authorize Stephens City Family Medicine for _____ (patient) to apply for benefits on my behalf for the covered services rendered and request that payments from the above named insurance company(ies) be made directly to Stephens City Family Medicine for the treated person named. I certify that the information reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim to the above named agent. I permit a copy of this authorization to be used in place of the original. IN ALL CASES, PROFESSIONAL FEES ARE THE PATIENT, SPOUSE, GUARDIAN AND/OR PARENTS' RESPONSIBILITY. Finance Charge (no charges if paid in 30 days of billing date) may be computed by a "Periodic Rate" of 1 1/2% per month, which is an ANNUAL PERCENTAGE RATE of 18% applied to the previous balance without deducting current payments and/or credits appearing on any given bill. Patient or responsible party(ies) further agree to pay any and all collection fees incurred and legal expenses, including but not limited to Collection Agency and attorney fees, all court related costs, service and filing fees, interrogatory and garnishment fees as well as any interest that may be adjudicated for the collection of past due debts.

Print Name:_____ Signature:_____ Date:____/____/_____

Signature from Stephens City Family Medicine:_____ Date: ____/____/_____

STEPHENS CITY
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All sections of this form must be completed. If a section is not applicable please list "N/A".

Name _____ Date ___/___/___ D.O.B. ___/___/___

Why are you coming in to be seen? _____

_____

Preferred Pharmacy: _____

Who do you see for your medical problems now? _____

If changing doctors, why are you changing? _____

Current Medications	
Medication	Dose
Attach list if needed	

Current Medical Problems: (Diagnoses)	
Reason for taking each medication:	When diagnosed:

Past Surgeries	
Date	Procedure

Drug Allergies	
Drug	Reaction

Family History		
	Known Health Problems	Date of Birth
Mother		
Father		
Siblings		
Extended Family		

Social History	
How much do you smoke or chew?	
How much alcohol do you drink?	
Any "recreational" drug use now or in the past?	
What type of work do you do?	
Marital Status?	

When Was Your Last...	
Physical	
Labs	
Tetanus Shot	
Colonoscopy	
For Females: Pap Smear	
Mammogram	

I, as the patient, state the information is correct and accurate to the best of my knowledge.

Patient Signature _____ Date ___/___/___

If you are under the age of 30 we want a copy of your immunization record. Please complete so we can request your immunizations only.

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www.scfammed.com

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO STEPHENS CITY FAMILY MEDICINE.

Directions: Type or Print all requested information with exception of signatures on page 2.

Individual's Name: _____ Individual's ID Number: _____

Street Address: _____ Individual's Date of Birth: _____

City:_____ State: _____ Zip:_____ Phone: _____

I authorize the name or person/organization listed below to disclose the above-named individual's health information as described below to:

Stephens City Family Medicine, LLC, 160 Warrior Drive, Stephen's City, VA 22655

_____

Name of Person/Organization authorized to release the protected health information.

_____

Street Address

_____

City, State, ZIP

Phone Number: _____ Fax Number: _____

❑ Immunization Record Only

❑ Other: _____

_____

I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV Infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex) and any other communicable disease. It may also include information about behavioral or mental health services, and referral and/or treatment for alcohol and drug abuse.

This disclosure and use is for the following purpose(s):*

_____

_____

(*Note: The statement "at the request of the individual" is sufficient when the individual initiates an Authorization and does not, or chooses not to, state the purpose.) I understand that if I give permission, I have the right to change my mind and revoke it. This must be in writing to Stephen's City Family Medicine, LLC that maintains the individual's records that I authorized on Page 1 of this form. I also understand that any uses or disclosures already made with my permission cannot be taken back. If this authorization is needed as a condition to obtain health care coverage and I revoke it, then I understand that the above person/organization who would have received the information may have the right to contest health care coverage claims. Unless otherwise revoked, this authorization will expire on the following date, event or condition. (If I fail to specify an expiration date, event or condition, this authorization will expire one year from the signature date.)

Date, Event or Condition _____

I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or eligibility for benefits unless the information is necessary to demonstrate that I meet eligibility or enrollment criteria. By signing this Authorization, 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 privacy rules. I further understand I may request a copy of this signed Authorization. I may inspect or copy any information used or disclosed under this agreement. I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be disclosed and would no longer be protected by these regulations.

_____

Patient's Signature or Patient's Representative **Date**

_____

Printed Name of Patient's Representative **Relationship to Patient**

Our Privacy Officer can be contacted as follows:

Monica Hott
Stephens City Family Medicine
160 Warrior Drive
Stephens City, VA 22655
540-868-4100 • 540-868-0888 fax

Stephens City Family Medicine Use Only

This authorization was revoked:

_____

Signature **Date**

STEPHENS CITY
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Cancellation Policy and No-Show Policy

Effective June 2, 2017

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed medical care. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is <u>not cancelled</u> at least 24 hours in advance you will be charged a twenty-five-dollar ($25) fee; this will not be covered by your insurance.

If you <u>fail to show</u> to an appointment you will be charged a fifty-dollar ($50) fee; this will not be covered by your insurance.

We understand that delays can happen, however we must try to keep the other patients and doctors on time.

If a patient arrives late to an appointment we have the right to reschedule the appointment. If a patient continues to arrive late to appointments then a fifty-dollar ($50) fee will be charged; this will not be covered by your insurance.

By signing this cancellation policy and no-show policy, you are indicating that you understand and agree to the terms of service explained above. You are also indicating that you have given your permission to be charged and will be responsible for paying the charge in full within thirty days if any of the above stipulations apply to you.

Name of Patient or Legal Guardian: _____

Signature: _____

Date: _____