Valley Family Practice & Internal Medicine
812 Amherst Street, Suite 101
Winchester, Virginia 22601
Phone: 540-722-0220
Fax: 540-722-0191

Robert Duck M.D. Meenu Gopal M.D. Brittany DeHaven FNP
Fern Kumar FNP Tyler Stephenson FNP

Thank you for choosing Valley Family Practice for your medical care. We realize you have high expectations from your providers, and our first and foremost goal is to exceed those expectations. We look forward to providing you with personalized, comprehensive health care focusing on wellness and prevention. As continuity and coordination of patient care is essential in meeting your healthcare needs, our physicians, nurse practitioner, physician assistant, nursing and front staff work closely in a "team approach" to support your patient care.

Please carefully and completely fill out the "New Patient Packet." While we have you sign a medical record release to get your previous primary care and specialist medical records, we also ask that you contact your providers and ask that a copy of your records be sent to us. (Fax: 540-722-0191) Please let us know if you are seeing pain management and/or psychiatry for prescribed medication. Our providers do not take on the writing of current narcotic prescriptions or some psychiatric medications you may currently be prescribed. You will need to continue to receive the respective medication(s) from your specialist. Your provider will need to review your new patient packet along with your previous records prior to us scheduling your new patient appointment. We attempt to make your appointment as expeditiously as possible so having your previous records in hand would help to speed up the making of your new patient appointment.

Our practice makes every effort to see all patients that request us as their primary care provider, however, sometimes it may be necessary to decline your acceptance to our practice as your needs may be better met by another provider in the community. Our providers do not admit or consult patients that are admitted to the hospital. We do work collaboratively with the hospitalist and specialist and have access to your medical records while you are hospitalized. A hospital follow-up appointment is normally scheduled within 7-10 days post your discharge from the hospital.

Please remember to bring your insurance card(s), photo ID, a complete medication list that includes the dosage, directions, and prescriber. All medication bottles should be brought with you to your first appointment. Please arrive 20 minutes early to check in with the receptionist. You will have additional consents to sign, your insurance card and photo ID will be scanned to your chart and your copayment will be collected at check-in. Failure to arrive 20 minutes early for an appointment may result in having to reschedule your new patient appointment.

We respectfully request a minimum of 24-hour advance notice if you need to cancel or reschedule to avoid a "NO Show" fee of $50.00. We understand you may have changes to your own schedule; however, our goal is to maximize appointment availability to ensure all patients can avail themselves of unexpected appointment openings.

Again, thank you for choosing Valley Family Practice. If you have any questions prior to your visit, please feel free to contact us at 540-722-0220 and we will be happy to assist you.

Sincerely,
The Providers and staff at Valley Family Practice

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Insurance: As a patient, you are responsible for knowing what is covered or required by your insurance company. If you have any questions, contact your insurance company or employer. We do not verify benefit coverage. As a service to our patients, we obtain pre-authorization for medications, tests, procedures, or physical therapy when required.

It is very important that you notify our office of any change in your insurance, and that you present our office with your insurance card so that we can make a copy to put in your file. If you do not inform our office of a change in your insurance coverage, whether it be a new insurance or a number change and the bill is denied payment by your insurance, you, the patient, will be personally responsible for payment of the bill. You will be responsible for contacting your insurance company with all the needed information so that the insurance company can reimburse you for the payment.

Payment: We take cash, check, Visa, and MasterCard. If a check is returned for non-payment there is a $50.00 charge. All co-payments, co-insurances, deductibles, and balances are due at the time of service.

If payment is not made on an account and the account is referred to collections, no requested appointments or services will be provided by this office until the debt is paid in full. Patient is responsible for any and all fees associated with an account being turned over to collections.

By signing below, you acknowledge that you have read and understand the above.

Patient Signature: _____ Date: _____

Patient printed name: _____ DOB: _____

Physician Signature_____

Date: _____

New Patient Information

Name: _____

Address:_____

_____

DOB: _____/_____/_____

Social Security #: _____/_____/_____

Phone #: _____/_____/_____

Alt. Phone: _____/_____/_____

Insurance: _____ID#_____Group#_____

Referred By: _____ Previous Primary Physician_____

Requested Physician (circle):

Robert W. Duck M.D. **Meenu Gopal M.D.** **Brittany DeHaven FNP** **Fern Kumar FNP**

Tyler Stephenson FNP

Do you have medications that are prescribed by a Pain management specialist or psychiatrist?
Yes_____No_____ If yes what medications_____

_____

Current Prescription Medications: **Vitamins or OTC Medications:**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please be advised that the physicians of this practice will NOT take on the writing of any narcotic medications that you are currently taking. Your signature signifies that you understand the above statement.

Patient Signature: _____ Date: _____/_____/_____

Personnel Signature: _____Date_____/_____/_____

VALLEY FAMILY PRACTICE & INTERNAL MEDICINE
812 Amherst St. Suite 101
Winchester, VA 22601

Robert W. Duck M.D **Meenu Gopal M.D.** **Brittany DeHaven FNP** **Fern Kumar FNP**
Tyler Stephenson FNP

Date: _____

PATIENT INFORMATION

Patient Name (last/first): _____ Home Ph#: (___)_____-_____

Address: _____ Work Ph#: (___)_____-_____

City: _____ State: _____ Zip: _____ Date of Birth: ___/___/_____

Sex (M/F): _____ Employed (Y/N): ___ Student (FT/PT):_____ SSN: _____-_____-_____

Email address: _____

Employer/School Name: _____ Marital Status: _____

Responsible Party: _____

Billing Address: _____

Referred by: _____ Family MD: _____

Emergency Contact: _____

Relationship to Patient: _____ Emergency Contact Phone#: (___) _____-_____

Is it okay to leave a detailed message on your answering machine? (Y/N) _____

Allergies: _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____ Phone: (___) _____-_____

Address: _____ Group#/Name: _____

City: _____State: _____ Zip:_____ ID#: _____

Name of Policy Holder: _____Sex (M/F)____ Date of Birth: ___/___/_____

Policy Holder Address: _____

Policy Holder Employer/School Name: _____

Policy Holder SSN: _____/_____/_____Policy Holder Phone: (_____) _____-_____

Employer Insurance Plan (Y/N): _____ Relationship of Patient to Policy Holder: _____

Secondary Insurance Carrier: _____ Phone: (_____) _____-_____

Address: _____ Group#/Name: _____

City: _____State: _____ Zip:_____ ID#: _____

Name of Policy Holder: _____Sex (M/F)____ Date of Birth: ___/___/_____

Policy Holder Address: _____

Policy Holder Employer/School Name: _____

Policy Holder SSN: _____/_____/_____Policy Holder Phone: (_____) _____-_____

Employer Insurance Plan (Y/N): _____ Relationship of Patient to Policy Holder: _____

PATIENT AND RESPONSIBLE PARTY AUTHORIZATION

I authorize the physician(s) at Valley Family Practice or Privia Medical Group for _____ (patient) to apply for benefits on my behalf for the covered services rendered and request that payments from my insurance company be made directly to Valley Family Practice or Privia Medical Group. 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(s). I permit a copy of this authorization in place of the original. In all cases, professional fees are the patient, spouse, guardian and/or parents' responsibility. Finance Charge may be computed by a "periodic rate" of 1 ½ % 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 the past due debts.

_____ _____ _____

Print Name Signature Date

ELECTRONIC MEDICAL RECORDS (EMR)

As of April 2006, Valley Family Practice implemented a community based electronic medical record system. This system will replace the existing paper based methodology of medical record keeping. The records will be in a centralized data base, accessible by all offices that are members of the Shenandoah Independent Practice Association (SIPA) and or Privia Medical Group However, only practices that are treating you are permitted to access your medical record. SIPA's and Privia Medical Group centralized database employees the latest security and data protection technology required by state and federal law to ensure that there is no unauthorized access to your records.

HIPAA STATEMENT

I have read Valley Family Practice's "Notice of Privacy Practices", and I hereby authorize Valley Family Practice to furnish to my insurance company or authorized agent information regarding my protected health information for the purposes of treatment, payment, or health care operations. I further authorize the physicians of Valley Family Practice to consult as needed at their sole discretion with other medical providers regarding my medical care. I wish to place the following restrictions concerning the disclosure of my protected health information. Valley Family Practice can discuss my medical condition/information with the following:

**** If you check "yes" in any of these boxes, please provide us with a name. ****

Spouse: Yes ☐ No☐ Name: _____ Child: Yes ☐ No☐ Name: _____

Parents: Yes ☐ No☐ Name: _____ Friends: Yes ☐ No ☐ Name: _____

_____ _____ _____

Patient Signature Signature Authorized Person Date

VALLEY FAMILY PRACTICE
New Patient Questionnaire

Name: _____ Age: _____ Sex: _____

Occupation: _____ Marital Status: __single __married __divorced __widowed

Indicate whether you or your family members (parents, grandparents, siblings) have had the following:

	You	Your Family	
Heart Disease	Y N	Y N	
Stroke	Y N	Y N	
Cancer	Y N	Y N	What type? _____
High Cholesterol	Y N	Y N	Last time it was checked: _____
High Blood Pressure	Y N	Y N	
Ulcers or Reflux	Y N	Y N	
Diabetes	Y N	Y N	

List any other conditions you have:

_____ _____ _____

_____ _____ _____

List any surgeries you have had (what type and when):

_____ _____

_____ _____

_____ _____

List the medications you take (both over the counter and prescribed)

Drug Name	Dosage (mg)	How often/when	When started

List other doctors/providers including Pain Management and or Psychiatry (name and specialty)

_____ _____

_____ _____

Are you allergic to any medication? Y N

Drug Name	What happens/type of reaction

NAME: _____ DATE: _____

Please circle Yes or No:

1. Do you have trouble with your vision? Yes No
2. Do you have trouble with hearing? Yes No
3. Do you have any trouble swallowing? Yes No
4. Do you ever have difficulty breathing? Yes No
5. Do you frequently have a cough? Yes No
6. Do you ever have chest pain or tightness? Yes No
7. Do you ever have palpitations or feel your heart racing? Yes No
8. Do you have trouble with indigestion? Yes No
9. Do you ever have abdominal pain? Yes No
10. Do you have trouble with diarrhea? Yes No
11. Have you ever had blood in your stool? Yes No
12. Have you had unexplained weight loss? Yes No
13. Do you have trouble with heartburn? Yes No
14. Do you ever have blood in your urine? Yes No
15. Do you ever have pain with urination? Yes No

Female Only:

16. How old were you when you had your first period? _____
17. Are your periods regular? Yes No
18. How many days do you bleed? _____
19. How many pads or tampons do you use on your heaviest day? _____
20. Do you ever miss school or work because of your period? Yes No
21. Are you sexually active? Yes No
22. If yes, do you or your partner use anything to prevent pregnancy? Yes No
23. If yes, what do you use? _____
24. Is your sexual activity satisfactory? Yes No
25. Do you leak urine with coughing or laughing? Yes No
26. Do you have trouble making it to the bathroom on time? Yes No
27. When was your last pap smear? _____
28. When was your last mammogram? _____

Males Only:

29. Are you sexually active? Yes No
30. Is your sexual function satisfactory? Yes No
31. Do you have trouble starting your urine flow? Yes No
32. Do you dribble urine or have poor flow? Yes No
33. Do you get up more than once a night to urinate? Yes No

Do you smoke? Yes No
Have you ever smoked? Yes No
If no to both above, skip to the next section.
How much do you smoke? _____
For how long? _____
Do you have any interest in quitting? Yes No
Have you ever quite before? Yes No

Do you drink alcohol? Yes No
If no, please skip to the next section.
How often? _____
How many drinks? _____
Has your drinking ever caused a problem at work? Yes No
Do you ever feel guilty about your drinking? Yes No
Do you ever drink in the morning? Yes No
Have you ever been annoyed by people commenting on your drinking? Yes No
Have you ever thought you should cut back? Yes No

Do you ever feel sad, blue or down? Yes No
Do you have trouble sleeping? Yes No
Do you have trouble with your appetite? Yes No
Do you cry for no apparent reason? Yes No
Do you have trouble concentrating? Yes No
Do you feel guilty a lot of the time? Yes No
Have you withdrawn from activities you used to enjoy? Yes No
Have you had a decrease in your sex drive? Yes No
Have you ever thought of hurting yourself? Yes No
Are you being physically or emotionally abused by anyone in your household? Yes No

Office Use Only:

Reviewed _____

Date _____

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PRIVIA HEALTH

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):
   _____
2. Be sent to the following person / entity at the address listed below:
   Valley Family Practice & Internal Medicine
   Name
   812 Amherst Street Suite 101 (540) 722-0220
   Address Telephone
   Winchester VA 22601 (540) 722-0191
   City State Zip Code Fax or Email Address for Delivery
3. I hereby authorize disclosure of the following information: ☐ My entire medical record ☐ Immunization Records Only ☐ Service Dates Only:
   _____ to _____ ☐ Specific Information Only:
   _____

NOTES

1. INFORMATION ABOUT ALCOHOL/SUBSTANCE USE, 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 TO YOUR PROVIDER. **WE WILL NOT SEND INCOMPLETE RECORDS DIRECTLY TO A TREATING PROVIDER.☐ PLEASE *EXCLUDE* THE FOLLOWING INFORMATION:**
   _____ **Signature:** _____
3. 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 producible 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; **or** ☐ other (please specify) We cannot accept CD's _____.
4. If I have requested records be sent **un**encrypted, I understand and acknowledge the risk of sending my PHI in an unsecured manner.
5. If I requested records be mailed to me, I understand 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 that device.
6. I understand that the information used or 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.
7. 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 reversed, and my revocation will not affect those actions.
8. 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.
9. My purpose/use of the information is for ☐ personal use; or ☐ other (please specify) _____.
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 describe/specify event). If no expiration date is provided, this authorization will expire on one year from the date signed.
    _____.

NOTE: FEES FOR COPIES: When a patient requests a copy of his/her PHI for personal use, federal law permits a reasonable, cost-based fee that includes only labor for copying the PHI, costs for supplies, labor for creating a summary/explanation of the PHI if a summary or explanation was requested, and postage. If these charges are expected to exceed $25, we will attempt to inform you prior to your request being filled.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING; INCOMPLETE FORMS WILL NOT BE PROCESSED.

Signature of Patient	Date of Patient's Signature	Patient's Date of Birth
If Patient unable to sign, signature of Patient's Legal Guardian or Personal Representative of Patient's Estate	**Date of Legal Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**