Dominion Family Healthcare

PATIENT INFORMATION (Who is being seen today?)

Social Security #:	**Employer:**
Name:	**E-Mail:**
Address:	**Married:** Married Single Divorced Widowed
City, Zip:	**Employed:** Full time Part time Retired
Primary Phone#:	**Student:** Full time Part time
Work Phone#:	**Emergency Contact:**
Alt Phone#:	**Emergency Phone#:**
Sex: Birth Date:	**Emergency Relationship:**
Race: Ethnicity: Preferred Language:	
Can we leave message? Yes No **with spouse?** Yes No **with children?** Yes No **with parents?** Yes No	
Can we use email to communicate? Yes No **Can we call you at work?** Yes No	
Have you gone by another name? (Maiden, etc.)	
How did you hear about us?	

GUARANTOR INFORMATION (Whose insurance is it?)

Name:	**Sex**
Address:	**Birth Date:**
City, Zip:	**Social Security#:**
Home Phone#:	**Employer:**
Work Phone#:	**Relationship to Guarantor:**
Cell Phone#:	

INSURANCE INFORMATION (If copy of current card/s is provided, please disregard this section)

Primary Insurance:	**Secondary Insurance:**
Subscriber Name:	**Subscriber Name:**
Patient's Relationship:	**Patient's Relationship:**
Certificate#:	**Certificate#:**
Group Name:	**Group Name:**
Group#:	**Group#:**
Payor#:	**Payor#:**
Claims Telephone#:	**Claims Telephone#:**
Accept Assignment?	**Accept Assignment?**
Claims Address:	**Carrier Address:**
City: State: Zip:	**City: State: Zip:**

- **Log in after 3 days to see test results at dominionmd.com**
  Need a password? Ask us today!
- **We do not see work related injuries or motor vehicle injuries.**
- **As a service to you, our office can file insurance.**
- **I authorize the release of any medical information necessary to process my claim and I authorize payment of benefits directly to Dominion Family Healthcare and Kimberly L. Warfield, MD.**

Patient (or Responsible party): _____Date: _____

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PATIENT HISTORY

Name: _____ Age: _____ Date: _____

Reason for Visit: _____

List all other chronic medical problems:

1) _____
2) _____
3) _____
4) _____
5) _____

List all medication dose and frequency:

1) _____
2) _____
3) _____
4) _____
5) _____

List all prior surgeries (include date):

1) _____
2) _____
3) _____

Allergies and drug sensitivities:

1) _____
2) _____
3) _____

FAMILY HISTORY

Has a blood relative had any of the following: (Circle answer & indicate relative, i.e. Mother, Sister, Maternal Aunt, Father, Paternal Grandfather etc. If uncertain, leave blank)

		Relationship			Relationship
Cancer (type)	no yes	_____	Asthma	no yes	_____
Tuberculosis	no yes	_____	Emphysema/COPD	no yes	_____
Diabetes	no yes	_____	Allergies	no yes	_____
Heart disease	no yes	_____	Drug/Alcohol Prob	no yes	_____
High Cholesterol	no yes	_____	Depression	no yes	_____
High blood Pressure	no yes	_____	Mental Illness	no yes	_____
Obesity	no yes	_____	Gout	no yes	_____
Migraine Headaches	no yes	_____	Thyroid Disease	no yes	_____
Stroke	no yes	_____	Ulcer	no yes	_____
Epilepsy/Seizure	no yes	_____	Kidney Disease	no yes	_____
Anemia	no yes	_____	Glaucoma	no yes	_____
Bleeding Tendency	no yes	_____	Other (specify)	no yes	_____
Blood Clots	no yes	_____	Other (specify)	no yes	_____

SOCIAL HISTORY

Do You Smoke? no yes Number of years _____ How much? _____ Are you interested in quitting? no yes

Do you drink alcohol? no yes How many drinks per day? _____

Do you regularly drink caffeinated beverages, i.e. cola, coffee, tea? no yes How much per day? _____

Do you use any illicit drugs? no yes What kind? _____

Are you sexually active? no yes Marital Status M D S W Sexual preference? Hetero / Homo / Bi

Current Occupation _____ Prior Occupations _____

Females: Pregnancy History: Number of pregnancies _____ Number of deliveries____ Ages of children _____

Any complications with pregnancy or delivery? _____ Number of miscarriages: _____abortions: _____

Immunizations: Last Tetanus _____ Flu _____ Pneumonia _____

Rate your overall wellness/wellbeing: 1 2 3 4 5 6 7 8 9 10 What would increase this number by one or two?_____

_____

Patient Signature: _____

Dominion Family Healthcare

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

We promise we will not share your private health information without your permission AND you give us permission to file your insurance for you.

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that 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 verify 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 a *Notice of Privacy Practices* has been posted that provides a more complete description of information uses and disclosures. I understand that I have the right to request my own copy and I have the right to review the notice before signing this consent. I understand that I have the right to object to the use of my health information. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization 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 organization has already taken action in reliance thereon.

Authorization for Release of Medical Information

I, _____authorize ***Dominion Family Healthcare*** to discuss with or release my medical information with the following:

Spouse: _____

Parents: _____

Children: _____

Other: _____

- **As a courtesy to you, our office can file insurance to primary and secondary insurance.**
- **I authorize the release of any medical information necessary to process my claim and I authorize payment of benefits directly to Dominion Family Healthcare and Dr. Warfield**
- **Log in after 3 days to see test results at dominionmd.com - Need a password? Ask us today!**

I understand that I may revoke this consent, in writing, at any time by submitting written notification to Dominion Family Healthcare, attention Medical Release Correspondent, at the above address.
I hereby authorize Dominion Family Healthcare to disclose my medical information as requested. Information used or disclosed by this authorization may be subject to subsequent disclosure by the recipient and no longer protected by this rule.

_____ _____
(Signature of Patient) (Date)

_____ _____
(Signature of Parent/ Executor/Legal Representative) (Date)

Dominion Family Healthcare

KIMBERLY WARFIELD, M.D. is board certified by: **American Board of Internal Medicine** and **American Board of Family Practice**

Dominion Family Healthcare is committed to providing comprehensive, high quality medical care and to work with you, the patient, to achieve the highest level of personal health possible.

THANK YOU for giving us the opportunity to serve you & your family in your healthcare needs.

INSURANCE FILING is done on your behalf as a service to you and requires the presentation of your current insurance card & drivers' license at each visit. It is vital that you notify us **ASAP** of any changes (Insurance, job, address, phone, etc) or you may be required to pay in full and file your insurance yourself. Remember that it is your responsibility to provide us with your correct insurance information, correct address and correct phone contact information before your visit. If your account is turned over to collections, you will incur an additional $25 fee. We utilize Merchants & Professional Credit Bureau for collections.

AFTER HOURS: "On Call" For Urgent medical problems - Call our main line (512) 834-9999 and choose option 1. Please have your pharmacy number & your current medications & doses on hand. When you call after hours, we will respond promptly. If you do not receive a response within 15 minutes, please call back and verify your phone number. Make sure your phone line does not block caller ID restricted lines. The doctor will not be able to return your call. Please note you may be assessed a $25 fee for a non-urgent after hours call. Routine refills are not considered urgent.

REFILLS of regular medicines take 24-72 hours to process. Do not wait until your prescription runs out because you may be charged $25 rush fee. Contact your pharmacy to begin the refill process at least 2-3 days before running out of medication. Even if your prescription says 0 refills, the pharmacy will submit a refill request to *Dominion.* Please note that you must keep follow up appointments or your meds will not be refilled.

REFERRALS are a labor-intensive process. Your cooperation is appreciated. •You need to be seen by a ***Dominion*** physician to obtain a referral. •Contact your insurance to find out who accepts your insurance and please notify us if you have a specific specialist you prefer. •Once the physician orders the referral, our referral coordinator will contact your insurance carrier to obtain authorization. Response times from insurance plans varies and can be anywhere from 1-7 business days. Once we receive approval, the information will be entered into your chart, faxed to the specified specialist and we will contact you. •Once we receive your referral, you may then call and make an appointment with the approved specialist. Do NOT go without an approval. You may be turned away or billed personally for services. **HELPFUL HINTS for referrals:** Not all insurance plans require a referral. Contact your insurance if you are unsure. Physical therapy and mammograms do not usually require a referral. Referrals are not always necessary for OB/GYN visits. Please call the office at least one week in advance for referral changes or extension requests.

PREVENTIVE CARE and IMMUNIZATIONS are vital to both young & old. Please provide us with a shot record and schedule appropriate exams. Preventative care is important - for men, women and children.

LABWORK AND RESULTS: When a physician orders lab work for you, if you come in and have it drawn within one week you will **NOT** be charged an additional co-pay. Once the blood is drawn, the specimen will be sent to a lab to be tested. Most results will be received back in our office within 3-7 days, depending on the type of test. Once received, a physician will review the results. If the results are out of the normal range or a meds change is needed, we will contact you. If they are normal, you can view the results on the secure website. Please note that HIV and STD results must be picked up in our office and can not be given out over the phone.

BILLS FROM LABS: You should call the lab to make sure they have your correct insurance information and to find out why they are billing you. It may be that you are responsible for a deductible. Occasionally, a test may not be covered by your insurance and the lab will bill you.

WE SCHEDULE APPOINTMENTS: based on type and number of problems in an attempt to keep our schedule on time. When scheduling, we ask you to list ALL the problems that you would like to have the doctor address. You are asked to call us back should anything else come up so that we can adjust the appointment or reschedule if necessary. Please feel secure in providing the reason for your visit with our receptionists. They have been trained in HIPAA practices and will keep your information confidential.

WORK-INS: We discourage walk-in appointments, please call ahead. We allow space for "work-in" slots throughout the day to address one acute / urgent care issue. As a work-in, you will be worked into the first available space on the schedule; therefore, your visit may be associated with a wait. Due to schedule constraints, we cannot guarantee which provider you will see. As a work-in, the provider will address one acute issue. Issues such as routine care, refills or follow-ups will **not** be addressed on a work-in basis. You will be asked to schedule a full appointment for these visits.

PLEASE CANCEL: If a situation arises where you cannot make your appointment, please notify our office 24 hours before your appointment or you may be charged a "no show" fee. If you arrive late to your appointment, please note that you may be asked to reschedule and you may be assessed a "no show" fee of $25. Please note that these fees are not covered by insurance and will be the patient's responsibility.

WORKER'S COMP: We will not be able to see you for Worker's Comp Injuries. Please contact your employer for further instructions.

PRE-OPERATIVE EXAMS: Please bring your surgeon's information, any records pertaining to the surgery and the surgeon's orders with you.

TB TESTS: Once you receive a TB test, you will need to return to have the test read within 48-72 hours. TB Tests are not given on Thursdays.