Quality Medical Care Comes to You

949 Piney Forest Road
Danville VA 24540
434-835-4876
434-333-7018 Fax

Patient Information

Name:_____ Date: _____

Sex: M/F DOB: _____ Social Security # _____

Address: _____

City: _____ State:_____ Zip Code_____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Place of Employment: _____ Phone Number: _____

How did you hear about our office: Piedmont Shopper Online Newspaper Friend
Other _____

Emergency Contact Person

Name: _____

Relationship to the Patient: _____

Address: _____

City: _____ State_____ Zip Code_____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Primary Insurance Carrier

Name of Insurance Company: _____

Subscribers Name: _____ DOB: _____ SS# _____

Subscribers ID# _____ Group# _____

Secondary Insurance Carrier

Name of Insurance Company: _____

Subscribes Name: _____ DOB: _____

Subscribers ID# _____ Group# _____

Laboratory Services

GoDocs uses Labcorp for our lab draws. If you are not in network with Labcorp, please advise the provider prior to having any labs drawn to avoid any out of network lab charges to you. Your provider will write you an order for you to go to your in network laboratory. Please initial _____.

Preferred Pharmacy _____ **Phone Number:** _____

IF YOU ARE 65 OR OLDER, HAVE YOU HAD YOUR FREE MEDICARE WELLNESS EXAM AND WOULD YOU LIKE TO SCHEDULE THAT TODAY?

YES **NO**

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Permission to Disclose Information

Due to HIPPA Compliance (the privacy act), we are asking our patients to provide for us the people they would want to have access to their healthcare information. You must complete the following form if you wish us to disclose any of your information, including billing, appointment times, and financial information. I have been offered a copy of the Notice of Privacy Practices.

Name/ Relationship	Check Information They May Receive	
_____/_____	_____ Medical	_____Billing
_____/_____	_____ Medical	_____Billing
_____/_____	_____ Medical	_____Billing
_____/_____	_____ Medical	_____Billing

By signing below, I authorize the above named listed access to my healthcare information. I am also authorizing the providers of GoDocs to examine and medically treat me. I authorize GoDocs to contact me by all phone numbers I have listed.

_____ _____

Patient's Name Date

Quality Medical Care Comes to You

650 Spring Street
Danville VA 24541
434-835-4876
434-333-7018 Fax

Financial Policy

Our office will file your health insurance for your visit as a courtesy to you. All deductibles, co-pays and co-insurance are due at the time of your visit. We cannot file your insurance claims unless you provide us with your current insurance card and accurate information. Please bring your insurance card at the time of your visit if there is any change in coverage.

Please make sure that we have your correct address and phone number so that we may contact you regarding any unpaid claims, balances and upcoming appointments etc.

I understand that insurance is not a guarantee of payment. I understand if my claim remains unpaid over 60 days or my coverage has been suspended or terminated I am financially responsible for any balance with GoDocs. I understand that any unpaid balances may result in further collection fees, attorney fees and court cost and will be due by me.

_____ _____ _____
Patient's Signature Parent/Guardian Signature Date

Assignment of Benefits and Release of Information

I authorize GoDocs to file my insurance claim for services I have received. By signing below I am authorizing the assignment of benefits to GoDocs. By signing below I give my consent to treatment by GoDocs.

_____ _____
Patient's Signature Date

_____ _____
Date

I am the legal guardian of _____ and give my permission for him/her to be treated by GoDocs Healthcare Center.

Parent/Guardian: _____ Date: _____

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get 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 some of our responsibilities to help you.

- **Get an electronic or paper copy of your medical record:** You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 14 business days of your request. We do charge a reasonable, cost-based fee for this service so please check with the medical records department to get an estimated cost.
- **Ask us to correct your medical record:** You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We do have the right to say "no" to your request but we have to tell you why in writing within 60 days of your request.
- **Request confidential communications:** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. Also, please be aware that we make courtesy calls to remind patients of their upcoming appointments. If you require special circumstances, such as, you work third shift and do not want us to call during the day, let us know how you would like to receive your reminder calls and we will be happy to accommodate your request.
- **Ask us to limit what we use or share:** You can ask us NOT to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket 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 say "yes" unless a law requires us to share that information.
- **Get a list of those with whom we've shared information:** You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. This accounting only applies to certain items.
- **Get a copy of this privacy notice:** You can 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. You can also access and print it on our website at www.godocsmed.com.
- **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 are violated:** You can complain if you feel we have violated your rights without fear of retaliation by contacting us by mail, email, or by phone. Ask for our Privacy Officer, Gail Megginson. You can also 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.

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, talk to us. Tell us what you want us to do, and we will follow your instructions.

- **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; Please be aware we do not need your consent if you are involved in an emergency situation, for example if you are unconscious, or unable to communicate. We have the right to disclose your information if we believe it is in your best interest or when needed to lessen a serious and imminent threat to your health or safety.
- **In these cases we NEVER share your information unless you give us written permission:** Marketing purposes; Sale of your information; Sharing of psychotherapy notes, alcohol, or drug abuse notes.

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:

- **Treat you:** We can use your health information and share it with other professionals who are treating you without your consent.
- **Run our organization:** We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- **Bill for your services:** We can use and share your health information to bill and get payment from health plans or other entities.

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 by law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- **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.
- **Comply with the law:** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- **With a medical examiner or funeral director:** We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- **Address workers' compensation, law enforcement, and other government requests:** We can use or share information about you for workers' comp claims; law enforcement purposes or with a law enforcement official; with health oversight agencies for activities authorized by law; for special government functions such as military and national security.
- **Respond to lawsuits and legal actions:** We can share health information 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 PHI; let you know if a breach occurs; follow the duties and privacy practices described in this notice; offer you a copy of it. We can change the terms of this notice. You can stay up to date by requesting a copy or visiting our website.

_____ _____ ____ Pt received copy of signed notice

Patient Signature Date

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Ph: 434-835-4876
Fax: 434-835-4875

MEDICAL RECORD REQUEST

(Please Print)

Patient Name:_____ **DOB:**_____ **Last Four of Social:**_____

_____ I authorize *GoDocs to release* information contained in my medical record to the following facility:

Facility Name: _____

Address: _____

City, State Zip _____, _____ _____

Phone Number: _____-_____-_____ Fax: _____-_____-_____

_____ I authorize the *Facility listed above to release* protected health information contained in my medical record to GoDocs.

Reason for Disclosure: (Check)		**Information to be released:** (Check) Write in dates	
	Continuation of Care:		Progress Notes for Dates:
	Medical Consultation:		History & Physical:
	Attorney		Operative Report:
	Workers' Comp:		X-Ray Report:
	Employer Request:		Lab Report:
	Other:		Entire Record:
	Notes:		Other:
			Check or Circle one if you want this information released:
			Alcohol / Drug Abuse
			Mental Health
			HIV/AIDS

This authorization to disclose information may be revoked by the patient at any time. A written revocation can be sent to GoDocs, Attn: Medical Records at the address listed at the top of this page. This authorization expires one year from the date of signature.

Signature of Patient:_____ Date:_____

Signature of Witness:_____ Date:_____

Provider Requesting Records:	Date Records Received:	Scanned for Review: