VIRGINIA HOSPITAL CENTER
Physician Group

Hernia & Heartburn Institute

PATIENT INFORMATION FORM

(Please make sure to print clearly and sign at the bottom of this page)

Patient's Last Name: First: Middle Initial:			Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced
Birthdate:	Social Security Number:		Sex: ☐ Male ☐ Female
Street Address: Apt#	City:	State: Zip Code:	
Home Phone:	Work Phone:	Cell Phone:	
Email Address:		Preferred Method of Contact: ☐ Email ☐ Phone ☐ Mail	
Race: ☐ Decline ☐ Asian ☐ Black ☐ Hispanic ☐ White ☐ Other: _____		Ethnicity: ☐ Hispanic or ☐ Non-Hispanic Preferred Language: _____	
Referring Dr. **(Full Name)** Phone Number:		Primary Care Dr. **(Full Name)** Phone Number:	
Occupation:		Employer:	
Emergency Contact & Number:		Relationship:	
Preferred Pharmacy Name & Number:		**Consent to retrieve medication history? ☐ Yes ☐ No**	
How did you hear about our practice?: ☐ Internet/Media ☐ Family/Friend ☐ Physician Referral ☐ Other:_____			

INSURANCE INFORMATION

(PLEASE PRESENT ALL INSURANCE CARDS AND A PHOTO ID TO THE RECEPTIONIST)

Primary Insurance:	Member ID#:
	Group ID#
Subscriber's Name:	Relationship:
Subscriber's Social Security #:	DOB:
Secondary Insurance:	Member ID#:
	Group ID#
Subscriber's Name:	Relationship:
Subscriber's Social Security #:	DOB:

Responsible Party(If same as patient- you do not need to fill this portion out)

Name:	Address:	Relationship:
Social Security #:		

By signing here, I attest that the above information is true and accurate to the best of my knowledge.

_____ _____

Patient/Guardian Signature **Date**

VIRGINIA HOSPITAL CENTER

PHYSICIAN GROUP

PATIENT FINANCIAL POLICY

The providers and staff of The Virginia Hospital Center Physician Group are committed to providing you with the best possible care and to help insure that you receive the maximum allowable insurance benefits. While the filing of insurance claims for contracted insurance carriers is our obligation, all fees are ultimately the responsibility of the patient. It is recommended that you be completely familiar with your individual coverage, benefits and limitations. All questions in this regard should be addressed to your insurance carrier directly.

- It is the responsibility of the patient to keep all insurance and demographic information up to date.
- Co-payments are expected at the time of the visit as well as any deductibles, co-insurance payments, or payment for any non-covered services
- If referral is required for your visit, it is the sole responsibility of each patient to arrive with that required referral. If you do not have the required referral at the time of your appointment, payment will be due at the time of service.
- Appointments that are not cancelled or rescheduled will be charged a No Show Fee of $40. **(Proposed fee from P&P)**
- Appointments cancelled or rescheduled with less than 24 hours prior to the scheduled appointment time will be charged a Late Cancellation fee of $25. **(Proposed fee from P&P)**
- Payment for services rendered is expected to be paid at the time of the visit. In most cases, a discount is given for services paid at the time of visit.
- Payment is accepted in the form of cash, money order, check and credit card in most cases. A fee of $30.00 will be assessed for returned checks. **(Proposed fee from P&P)**

I hereby authorize Virginia Hospital Center Physician Group to apply for benefits for services rendered. I certify that the information that I have provided with regard to insurance coverage is correct. I further authorize the release of any necessary information including medical information, for any related claim to my insurance carrier in order to determine benefits payable. I request that payment of authorized benefits be made payable to Virginia Hospital Center Physician Group or any individual provider, on my behalf.

I understand that I am financially responsible for the total charges for services rendered which may include non-covered services. I agree that all amounts are due upon request and are payable to Virginia Hospital Center Physician Group. I further understand should my account become delinquent; I shall pay the reasonable attorney fees or collection expenses of Virginia Hospital Center Physician Group.

I have read the above Patient Financial Policy and have provided true and correct insurance and demographic information. I will promptly notify you of any changes to my health insurance carrier, including new ID #'s with my current carrier.

Patient Signature	**Printed Name**	**Date**
Legal Representative	**Printed Name**	**Date**

Virginia Heartburn & Hernia Institute
Minimally Invasive… Maximum Benefit

Dr. G Kevin Gillian, MD FACS

VIRGINIA HOSPITAL CENTER

INSURANCE VERIFICATION POLICY

Due to the number of health plans and varying benefits, our office cannot predetermine whether a patient/parent's visit will be covered by insurance. Even if the doctor participates with the insurance company, the doctor may not be within a specific "preferred network" so it is the responsibility of the patient/parent to verify all coverage to understand what out-of-pocket cost may apply. Our office does not prescreen eligibility or benefits.

It is the patient/parent's responsibility to know whether their insurance requires a referral for the visit.
Check with the front desk, each visit, to see, if a valid referral is on file.

SPECIAL NOTE: Kaiser Permanente & Tricare Prime will ALWAYS require a referral on each visit. Generally, HMO, EPO, QPOS, POS, MDPIA, and Optimum Choice plans require a referral (this is not the complete list). If there is a question, please call your member services or ask us for help determining whether your plan requires a referral.

_____ _____

Patient's Name Date

_____

Patient's Signature

Medical Questionnaire **Patient Name: _____ DOB: _____**

Social History:

Are you a current smoker? ☐ Yes ☐ No Have you ever been a smoker? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No If so, how often to do you drink? _____

Do you currently use any recreational drugs? ☐ Yes ☐ No If yes, for how long have you been using? _____

CURRENT MEDICATIONS: *(please list all medications, including those without a prescription)*

Medication:	***Dosage:***	***Medication:***	***Dosage:***
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

ALLERGIES: (please list)

Drug:	***Reaction/Symptoms:***	***Environmental:***		***Reaction:***
1.		Latex Allergy?	☐ Yes ☐ No	
2.		Iodine Containing Components?	☐ Yes ☐ No	
3.		IV Dye?	☐ Yes ☐ No	
4.		Food?		
5.		Other:		
6.		**Metal Allergy?**	☐ Yes ☐ No	

ADDITIONAL HISTORY:

☐ VRE	☐ Clostridium Difficile	☐ Hepatitis B	☐ Hepatitis C
☐ HIV Infection	☐ MRSA	☐ Tuberculosis	☐ Other? _____

SURGERIES:

1.		Year:
2.		Year:
3.		Year:
4.		Year:
5.		Year:

REVIEW OF SYSTEMS:

General:
- ☐ Feeling fired (fatigue)
- ☐ Fever
- ☐ Chills
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Other: _____

Head/ Ear/ Nose/ Throat:
- ☐ Recent change in taste
- ☐ Nasal drainage
- ☐ Snoring
- ☐ Vision problems
- ☐ Snoring
- ☐ Postnasal drip
- ☐ Hoarseness
- ☐ Difficulty Swallowing
- ☐ Other: _____

Respiratory:
- ☐ Chronic Cough
- ☐ Wheezing
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chest congestion
- ☐ Chest tightness
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Tuberculosis Exposure
- ☐ Sleep Apnea
- ☐ Other: _____

Gastrointestinal:
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Belching
- ☐ Diarrhea
- ☐ Flatulence
- ☐ Gastroesophageal Reflux

Urologic:
- ☐ Painful urination
- ☐ Flank pain
- ☐ Urinary incontinence
- ☐ Chronic/Acute Renal failure
- ☐ Blood in urine
- ☐ Impotence
- ☐ Frequent urination
- ☐ Other: _____

Cardiovascular:
- ☐ Cardiovascular Disease
- ☐ Congestive Heart Failure
- ☐ Varicose Veins
- ☐ Arrhythmia
- ☐ Coronary Artery Disease
- ☐ Hypertension
- ☐ Myocardial Infraction
- ☐ Peripheral Vascular Disease
- ☐ Other: _____

Musculoskeletal:
- ☐ Muscle Weakness
- ☐ Muscle Pain
- ☐ Muscle Cramps
- ☐ Osteoporosis
- ☐ Other: _____

Psychiatric:
- ☐ Addiction
- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations
- ☐ Mania
- ☐ Other: _____

Endocrine:
- ☐ Adrenal Disorders
- ☐ Diabetes Inspipidus
- ☐ Diabetes Mellitus Type 1
- ☐ Diabetes Mellitus Type 2
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Goiter
- ☐ Other: _____

- ☐ Heartburn
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Vomiting
- ☐ Hiccups
- ☐ Other: _____

Dermatologic:
- ☐ Cellulitis
- ☐ Skin Growths
- ☐ Herpes Simplex
- ☐ Lesions
- ☐ Skin Cancer
- ☐ Recurring Infections
- ☐ Other: _____

Hematologic:
- ☐ Anemia
- ☐ Clotting Disorders
- ☐ Prolonged Bleeding Time
- ☐ Slow Wound Healing
- ☐ Venous Thrombosis
- ☐ Arterial Thrombosis
- ☐ Other: _____

Neurologic:
- ☐ Seizures
- ☐ Alteration of Consciousness
- ☐ Sudden loss of Consciousness
- ☐ Chronic Pain
- ☐ Headaches/ Migraines
- ☐ Confusion
- ☐ Dizziness
- ☐ Tremors
- ☐ Memory Loss
- ☐ Mental Status Change
- ☐ Numbness
- ☐ Muscle Weakness
- ☐ Tingling Sensations
- ☐ Other: _____

FAMILY HISTORY: Please ☒ the box if there is a history in your family history.

Member	Father	Mother	Paternal Side	Maternal Side	Children	Siblings
Status *(alive, deceased, unknown)*						
Y.O.B.						
Age						
Stroke	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hypertension	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Obesity	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Please answer in the space provided:

Siblings:	Brothers		Sisters		Healthy? ☐ Yes ☐ No
Children:	Sons		Daughters		Healthy? ☐ Yes ☐ No

Notes:

_____ _____

Printed Patient Name **Date**

VIRGINIA HOSPITAL CENTER

Physicians Group

MRN: _____

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form you acknowledge receipt of the Notice of Privacy for Virginia Hospital Center Arlington Health System and its affiliated medical groups. Our Notice of Privacy Practices provides information about how we amy use and disclose your protected information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change.

_____ _____

Signature of Patient/ Patient Representative Date

_____ _____

Name of Patient/Patient Representative (please print) Relationship to Patient

OFFICE USE ONLY:

We attempted to obtain written acknowledgement of patients' receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained from the patient for the following reason:

☐ Patient Refused to Sign

☐ Patient Representative Refused to Sign

☐ Patient/ Patient Representative Refused Copy of Notice of Privacy Practices

☐ Emergency Situation Prevented Signature

☐ Other (please specify) _____

_____ _____

Provider Representative Signature Date

VIRGINIA HOSPITAL CENTER
Physician Group

Patient Communication Preference

Please indicate below the person(s) you give permission to access your medical records or test results for future reference. This form should be returned to our office accompanied by a copy of your photo ID as verification that you have authorized the release of information.

This release will remain active in your electronic health record, and will not be cancelled unless there is written authorization from the patient to do so on file.

Please call our office if there are any questions.

I, _____, give *Virginia Hernia & Heartburn Institute*, permission to release any/all of my PHI (personal health information) to the following person(s):

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

In the event we do contact you, is it suitable to leave a message(s) in the following manner (Check all that apply)
___ on answering machine ___ with an ADULT household member ___ exclusively with patient
___ on cell phone voicemail other _____

Who is authorized to receive patient and billing information? (Check all that apply)
___ Patient ONLY
___Spouse
___Family Member (Include name and Relationship) _____
___Other (Please Specify) _____

_____ _____
Patient Signature **Date**

VIRGINIA HOSPITAL CENTER

Physician Group

Surgery Cancellation Policy

Scheduling of your operation requires a coordinated effort of multiple departments; beginning with your doctor and including the Hospital. Evaluation at the hospital by administrative, nursing, and anesthesia staff is also a time consuming and expensive period. Also authorization by your insurance carrier must be obtained for your operation.

Cancellation of surgery is sometimes unavoidable due to medical problems or significant conflicts which cannot be avoided. These cancellations, however, can result in unused operative time. Other patients who could have benefited from that operation time cannot do so unless the operative time is available soon enough.

Therefore, **a minimum of 72 hours (3 business days)** notification is requires for surgery cancellation. This allows the physician and his staff to make arrangement to the schedule. If you must cancel your surgery, please call the office at 703-372-2280.

Failure to notify us of the cancellation in the required time will result in a charge of **$500.00**. This charge will be posted to your account.

** Exceptions to this policy will be made only for emergencies and conflicts beyond your control.*

I _____have read this policy and understand that cancellation of my surgery may results in a fee of **$500.00.**

_____

Patient's Name

_____ _____

Guarantor's Signature Date

VIRGINIA HOSPITAL CENTER
PHYSICIAN GROUP

CONSENT FOR TREATMENT

1. **General Consent for treatment.** I hereby authorize employees and agents of Virginia Hospital Center Physician Group, including physicians, physician assistants, nurse practitioners, nursing and other staff members to render medical evaluations and care to the patient indicated below.
   I acknowledge that according to Virginia state law, I shall be deemed to have consented to the testing for infection with Human Immunodeficiency virus (HIV), Hepatitis B, Hepatitis C viruses should any healthcare provider, or any person employed by or under the direction and control of a healthcare provider, by directly exposed to my body fluids in connection with rendering care to the patient, in a manner which may, according to the current guidelines of the Center for Disease Control, transmit HIV, Hepatitis B, or Hepatitis C viruses. Test results may be released to the person exposed.
2. **E- Prescribing Consent.** The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:
   - **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.
   - **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

   By signing this consent form you are agreeing that this office can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.
3. **Other Consents**. Virginia Hospital Center participates in an affiliated teaching program; physicians may be assisted in patient care by residents and/or medical students. I understand I have the right to refuse residents or medical students be involved in my care and will notify my care provider (s) of any such decision.
   I agree to receive a survey from a premier polling company. The surveys are used to assess the quality of care delivered to our patients and ensure that we are providing the best care possible. I have the right to refuse participation by notifying the registration representative
4. **Patient Information**. I authorize the practice to provide _____(Print Person's Name/Relationship) with information (including both medical and billing information) . This release will remain active in your electronic health record, and will not be cancelled unless there is written authorization from the patient to do so on file.
5. **Health Information Exchange**. Virginia Hospital Center participates in HIE which is the transfer of healthcare information electronically across physician offices and affiliates to the Hospital. I understand that: my Hospital providers will access externally available electronic health records including medication history and medication prescribing information; the Hospital will transmit/receive electronic health information between affiliated physicians and organizations who are involved in my care using HIE**. I understand that I may decide to opt out of participation at any time either in writing, or by completing the VHC Health Information opt-out form.**

❖ The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in the case of an emergency.

_____ _____
Patient Name (please print) Date

_____ _____
Signature of Patient, Parent or Legal Guardian Date

Contact information If Minor:

Family Address_____

Telephone: Guardian _____home _____cell _____ work

In the event we do contact you, is it suitable to leave a message(s) in the following manner (Check all that apply)
___ on answering machine ___with an ADULT household member ___ exclusively with patient
Please circle: Cell Home or Other

_____ _____
Provider Representative Signature Date