Culpeper Medical Clinic
Walk-in & Primary Care

451 James Madison HWY, #104
Culpeper, VA 22701
P – 540.727.8880 F – 540.727.8882

Patient Name: _____ **Date of Birth:** _____

Reason for Visit: _____

Allergies: (Please list type of reaction)

Food Allergy?	**Yes / No**	
Medication Allergy?	**Yes / No**	

Current Medications: Include prescription and non-prescription medicine

Medication	Dose	Frequency	Medication	Dose	Frequency

Past Medical History: Please Check any that apply to you

	Anemia		Cancer		High Blood Pressure		Thyroid Problems
	Anxiety		Diabetes		Hearing Problems		Alcohol Use
	Arthritis		Dyslipidemia		Heart Attack		Tobacco Use
	Asthma		GERD		Stroke		Substance Abuse
	Heart Disease		Gout		Depression		Nerve Pain
	COPD		Headaches		Vision Problem		Memory Problems

Other Medical History: _____

Routine Screenings: Please list the Month and Year of your…

Last Annual Physical		**Currently Pregnant?**	
Last Colonoscopy		**If Yes, How Far?**	
Last Prostate Check		**Last PAP Smear**	
Last Menstrual Cycle		**Last Mammogram**	

Past Surgical History:

Surgery		**When**		**Where**	
Surgery		**When**		**Where**	
Surgery		**When**		**Where**	
Surgery		**When**		**Where**	

Family Medical History: Please Check all that apply and List the Relation of person with condition

	Heart Disease			Thyroid Disease	
	Hypertension			Cancer	
	Asthma			Kidney Disease	
	Diabetes			Stroke	
	Cystic Fibrosis			Migraines	
	High Cholesterol			Osteoporosis	

Substance Use: Please answer honestly, All responses are strictly confidential

Do You Use?	Y/N	Type	How Much?	How Long?	When Quit?
Tobacco					
Alcohol					
Drugs					
Caffeine					

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Patient Information:

Patient Name: _____ **Date of Birth:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Marital Status: _____ **Ethnicity:** _____ **Gender:** _____

Primary Care Provider: _____

Health Insurance Information:

Insurance: _____ **ID #:** _____

Subscriber Name: _____ **Subscriber DOB:** _____

HIPAA NOTICE:

Culpeper Medical Clinic Notice of Privacy Practices is available to you in its entirety in hard copy. I acknowledge that I have been offered this clinic's notice of Privacy Practices. Culpeper Medical Clinic's Notice of Privacy practices describes how medical information about you may be used and disclosed. It also explains how you can get access to this information, as well ad who to contact if you feel that your privacy rights have been violated.

Patient Signature: _____ **Date:** _____

Preferred Methods of Communication:

To reach you more effectively to confirm appointments, leave messages regarding your healthcare, and to discuss insurance billing issues, we are asking you to complete the following telephone contact information. While we prefer to NOT leave messages, we would like to ensure your medical information is properly protected as required by HIPAA guidelines. By providing the following information, you are authorizing the representatives of this clinic to leave messages with those individuals listed at the phone numbers you list below.

Please list the names of individuals with whom you authorize us to discuss your medical care:

1) _____ **Relation:** _____ **Phone:** _____

2) _____ **Relation:** _____ **Phone:** _____

Please list your personal contact information below:

Home Phone: _____ **May We Leave a Message? Yes No**

Work Phone: _____ **May We Leave a Message? Yes No**

Cell Phone: _____ **May We Leave a Message? Yes No**

Email Address: _____

Please List any Emergency Contacts:

Name: _____ **Relation:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone #1: _____ **Phone #2:** _____

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Contract for Services and Assignment of Benefits

In consideration of Culpeper Medical Walk-In Clinic providing the patient named below with medical services, we the undersigned patient, sureties, and co-signers for the patient agree as follows:

A.) In connection with third-party (insurance carriers, etc.) payment:

1. **To authorize the practice to release information acquired in the course of examination and treatment for the purposes of insurance, Medicare and/or other insurance benefit payments.**
2. **To further authorize payment directly to the practice of physician(s)/authorized medical provider(s) accepting assignments for all medical benefits applicable and otherwise payable to the patient, but not to exceed the reasonable and customary charge for these services rendered by physician(s)/authorized medical provider(s).**
3. **That we hereby certify that this information given by us in applying for insurance payment is correct, and request that said payment of authorized benefits is made on the patient's behalf.**
4. **To authorize Culpeper Medical Walk-In Clinic to act on the patient's behalf as attorney in fact in (1) the collection of benefits from any reasonable third party through whatever means may be deemed necessary; and (2) in the endorsement of benefit checks made payable to me and/or the physician(s)/authorized medical provider(s) or practice.**

B.) To guarantee payment of all charges to the patient, regardless of granting extension of time for the payment of these charges or the practice acceptance of a note for the payment of these charges from either the patient or any third person or party.

C.) That the payment for these services is due at the time of service.

D.) A charge of $35.00 will be added to your account for non-sufficient funds each time your financial institution processes your transaction for payment.

E.) Please allow 24-48 hours for any prescription refill request to be processed. Request authorizations and referrals a minimum of 48-hours in advance of your scheduled appointment or earlier for those insurance companies that require a longer timeframe.

F.) If this account should go into default you understand that you may be held liable for all reasonable collection fees and/or attorney fees incurred to collect this debt which may be up to 35% of the account balance.

G.) To pay all expenses incurred in collecting the account including reasonable attorney's fees and collection fees if this account is turned over to an attorney or collection agency for collection.

H.) I understand that if, during the course of care, a health care provider is directly exposed to my blood or body fluids in a manner which may transmit blood-bourne pathogens (including HIV, Hepatitis, etc.), for the protection and well-being of the healthcare provider it is necessary that testing be done to my blood without charge to determine whether I am carrying these pathogens and under Virginia law, (Section 32.1-45.1 et.seq) I am deemed to have consented to said test(s) and to the release of the test results to the exposed health care provider. I also understand that health care providers are deemed to consent to the same test(s) and the release of the results to me should I be similarly exposed.

In addition, there will be a $50.00 fee applied to the patient's account for failing to show up for a scheduled appointment without notifying the staff beforehand of a cancellation. This fee will not be covered by your insurance.

Patient Name: _____ **DOB:** _____

Patient/Responsible Party Signature: _____ **Date:** _____