Internal Medicine Ltd.

1011 East Jefferson Street, Suite 202
Charlottesville, VA 22902
Phone 434-977-7950 FAX 434-977-3157

Steven A. Tatar, MD
Gregory H. Doull, MD
Jeffrey D. Davis, MD
J. Devon Lowdon, MD
Renee L. Fischer, MD
Joshua M. Greenhoe, MD

PATIENT INFORMATION AND MEDICAL SCREENING FORM

PATIENT INFORMATION

Name	Date of Birth	Social Security Number

Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other	Number of Children

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Oth Pacific Islander ☐ White ☐ Other Race	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Home Address *(e.g., P.O. Box or Street, City, State, Zip)*	Mailing Address *(if different)*

Home Phone	Work Phone	Cell Phone

Occupation	If retired, previous occupation:	Email Address

PERMISSION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS/FRIENDS

The following person(s) have permission to access my medical records, to receive information about me and my medical history, and to speak to the physician on my behalf.

Name	Relationship	Phone

FINANCIAL POLICIES

Internal Medicine Ltd. accepts most major insurance plans, and we will file your insurance claims for you. Please bring your insurance card(s) with you to your appointments.

Patients are financially responsible for all charges not paid by insurance. **Your co-pay is expected at the time of service.** We accept cash, checks, and VISA, MasterCard, and Discover. If you believe that you will have difficulty paying your bill on time, please contact our Billing Office before or during your visit.

There will be a fee of $50.00 charged by this office for each check returned to us by your bank.

In fairness to others, we require advance notice to cancel or change an appointment. You may be charged a fee for each appointment or test missed or not cancelled with appropriate advance notice. Missing more than two appointments without providing advance notice is grounds for discharge from the practice.

In the event that your account is forwarded to a collection agency, you agree to pay an additional fee equal to 33% of the balance forwarded to the collection agency and any additional attorney fees or court costs.

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Name of Patient:	

NOTICE OF PRIVACY PRACTICES

I understand that I have certain rights to privacy regarding my protected health information. I further understand that this information can and may be used for any of the following:

1. To conduct, plan and direct my care and follow-up with the multiple healthcare providers who may be directly or indirectly involved in the treatment(s).
2. To obtain payment from third party payers (insurance, etc.)
3. To conduct normal and required healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received or been offered a copy of Internal Medicine Ltd. Notice of Privacy Practices (available in our office or on our website).

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Internal Medicine Ltd. for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations.

SIGNATURE

I have read and agree to the above policies.

Patient Name:	Signature Of Patient Or Legal Representative	Date

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other