



Albemarle Square  
Family Healthcare

[www.albemarlesquarefamilyhealthcare.com](http://www.albemarlesquarefamilyhealthcare.com)

Location: Albemarle Square Family Healthcare

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## PLEASE TAKE A MOMENT TO REGISTER FOR YOUR PATIENT PORTAL ACCOUNT.

**Following today's appointment your healthcare provider will communicate with you via your portal account. This will include:**

- Viewing and keeping track of your medical information resulting from your visit
- Receiving important clinical reminders regarding your health care
- Receiving and viewing your lab and other test results

**You will also be able to:**

- Request prescription refills from your health care provider
- Send non-urgent messages to our staff
- Request referrals
- Submit billing and insurance questions
- Schedule your own one problem appointment

**What to do:**

- Best practice: complete the attached user agreement and return to a member of our staff today. We are happy to help you register while you are here today!
- Check the email account for the address you supplied to us within 24 hours for the registration link and instructions
- The registration link will expire within 72 hours so please activate promptly

**Let us know if you need assistance!**

D. Andrew Macfarlan, MD  
Mark D. Niehaus, MD  
Deborah Campbell, MD  
Kelly J. Maupin, FNP



Jane Shaw, MD  
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## COMPLETE HEALTH MAINTENANCE EXAM APPOINTMENT CHECKLIST

**It is very important that you bring these completed forms on the day of your appointment so that these can be reviewed with you. If the forms are not complete prior to your appointment, you will need to do so prior to seeing the doctor which will take away from your actual exam time. We ask that you update these forms on a yearly basis.**

**\* For Morning Appointments:** Nothing to eat or drink after midnight except water, black coffee or tea (no cream or sugar) in order to complete fasting blood work that may be ordered by your doctor. Be sure to take your regular medications with as much water as you need!

**\* For Afternoon Appointments:** We certainly understand if you are unable to fast for an afternoon appointment. We will be happy to schedule you to return for a morning appointment with a nurse should your doctor order fasting blood work during your exam.

**\* Medications:** If you are on medications, please bring them with you for review by your medical team and be sure to let us know of any refills you will require prior to your next visit. It is also important to let your doctor know of any medications prescribed for you by another health care professional.

**\* For Women:** If you are scheduled for a Pap Smear, please check your menstrual cycle on the calendar to ensure it will not interfere with your exam. If it does, please call our office to reschedule your appointment.

**\* Missed Appointments:** Please note: There will be a \$25.00 fee for any appointment you do not keep without at least 24 hours notice of cancellation.

**\* Arriving Late For An Appointment:** We ask that you arrive 15 minutes prior to your appointment time. Should you arrive past your scheduled appointment time you may be asked to reschedule your appointment.

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### **Did you know due to changes in health care coding, when you are seen for your annual health maintenance exam (annual physical), you may still have a charge for this visit?**

**\* Insurance and Billing:** Some insurance companies may refer to your yearly Health Maintenance Exam as a "routine physical, routine care and screening, or preventative health maintenance" and may have special benefit plans related to those type visits. You should familiarize yourself with your insurance company's coverage before your appointment to avoid billing surprises. For instance, should your doctor address chronic pre-existing problems or encounter a previously unaddressed problem while performing your yearly Health Maintenance Exam, your insurance company will be billed for this service rather than your being asked to schedule another appointment to address those issues. For patients with high deductible policies, health savings accounts, or other types of insurance policies, this may increase your out of pocket expense. Again, it is important to understand your coverage as well as what will be discussed with your health care provider. Your insurance company's telephone number is usually printed on the insurance card you carry. Or, if you have questions, please feel free to contact our office.

**Register for your Patient Portal Account.**

**Albemarle Square Family Healthcare**

Andy Macfarlan, M.D. - Mark Niehaus, M.D. - Jane Shaw, M.D. - Debbie Campbell, M.D. - Mary Whittemore, M.D.

Kelly Maupin, F.N.P. - Kimberly Carter, NP-C

416 Albemarle Square Charlottesville, Virginia 22901 434-978-2126

**PATIENT REGISTRATION FORM**

Patient Name: \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex M / F (Circle one) Married/Single/Separated/Divorced/Widowed

Address: \_\_\_\_\_  
(Street) (City/State/Zip)

E-mail: \_\_\_\_\_

**Please list all telephone numbers and indicate which is your preferred contact number:**

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

OK To Leave Voicemail

Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

OK To Leave Voicemail

Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

OK To Leave Voicemail

Is this visit due to a Job  
Related Accident or  
Automobile Accident?  
Yes / No  
If yes, please notify the  
receptionist

My primary care provider is: \_\_\_\_\_

**Person responsible for bill or parent**

Guarantor Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Relationship to Patient: (please check): ( ) self, ( ) spouse, or ( ) parent Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Who to call for an emergency:**

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship \_\_\_\_\_

TO BE COMPLETED BY NEW PATIENTS OR WHEN THERE HAS BEEN AN INSURANCE CHANGE

**FIRST INSURANCE INFORMATION**

Plan Name: \_\_\_\_\_ ID: Number \_\_\_\_\_

Address: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Policy Holder's Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F

**SECOND INSURANCE INFORMATION**

Plan Name: \_\_\_\_\_ ID: Number \_\_\_\_\_

Address: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Policy Holder's Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F

Please see reverse.  
This is a double sided form.

Printed Name: \_\_\_\_\_

**FINANCIAL POLICY:**

As a courtesy to our patients we file most insurance. Please be aware that some or perhaps all of the appropriate fees and services rendered may or may not be covered. If your insurance company denies payment, you will be billed and payment in full is due upon receipt. If my account becomes assigned to a collection agency, I agree to pay all costs of collections, including agency and attorney fees. Co-pays are due in full on date of service. You are responsible for obtaining a referral if required by your insurance company. If referral is not obtained, you can be held responsible for payment in full by the Specialist for date of service.

I understand in order for Albemarle Square Family Healthcare to service my account or to collect any amounts I may owe, Albemarle Square Family Healthcare, it's employees, agents or assignees may contact me by telephone at any telephone number associated with my account including wireless telephone numbers which may result in charges to me. Methods of contact include pre-recorded/artificial voice messages and/or use of an automatic dialing device as applicable.

*Insurance and Billing: Many insurance plans cover a yearly wellness visit at 100% without a co-pay. A wellness visit reviews preventative care and screenings. However, if chronic or new problems are addressed at a wellness visit, I understand that I may receive a bill for these services to avoid scheduling a separate appointment to cover these health care issues. I am aware that this applies to both adult and pediatric wellness visits.*

I have read and understand the Financial Policies of Albemarle Square Family Healthcare. I have completed this form to the best of my ability and will not hold Albemarle Square Family Healthcare responsible for my errors or omissions.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**CO-PAYS**

- I understand my co-pay is expected at time of service. If I am unprepared to pay my co-pay, I understand I will not be seen by my healthcare provider.
- A \$50.00 co-pay will be expected from all patients at time of service with a high deductible service plan.

**Missed Appointment Fees:**

I understand the following fees will apply for any appointment I do not keep without at least a 24 hour notice of cancellation:

- \$75.00 for each adult or pediatric wellness visit.
- \$50.00 for all other adult or pediatric visits.

**After Hours Fee:** An after-hours fee of \$25.00 will apply for all appointments at 5:00 pm or later and on weekends by appointment.

**Returned Checks:** The fee for a returned check is \$25.00.

**DEEMED CONSENT FOR DESIGNATED BLOOD BORNE PATHOGENS  
CONSENT TO MEDICAL CARE, AND RELEASE OF INFORMATION:**

Virginia law requires health care providers to notify you that Hepatitis B and C or HIV (Aids) Virus testing on a sample of your blood may be done if a health care worker is exposed to your blood or body fluids. This following notice is to advise you that this is in effect at this facility:

As health care provider under the Virginia Acts of Assembly Section 32.1-45.1, whenever any health care worker associated with or working for Albemarle Square Family Healthcare is directly exposed to body fluids of a patient in a manner which, according to the guidelines of the Center for Disease Control, may transmit human immunodeficiency virus or Hepatitis B and C, Albemarle Square Family Healthcare will proceed to test the patient through his or her physician and to the health care worker(s) who was/ were exposed.

When a person is tested, we automatically test for Hepatitis B and C for the safety of all concerned. Albemarle Square Family Healthcare's policy protects you as a patient, should you be exposed.

I voluntarily consent to medical care at Albemarle Square Family Healthcare which may include examinations, tests, photographs and treatments by doctors and the staff. No promises have been made to me as to the results of treatment or examinations.

I hereby authorize the release of any medical information required to process my insurance claim. I also authorize my insurance benefits to be paid directly to the physician and understand that I am financially responsible for all services provided.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Please see reverse.  
This is a double sided form.

**ALBEMARLE SQUARE FAMILY HEALTHCARE**

**D. Andrew Macfarlan, M.D. – Mark D. Niehaus, M.D. - Deborah Campbell, M.D. - Jane Shaw, M.D. – Mary Whittemore, M.D.**  
**Kelly Maupin, FNP – Kimberly Carter, NP-C**  
416 Albemarle Square, Charlottesville, VA 22901  
434-978-2126

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Albemarle Square Family Healthcare** is authorized to release protected health information about the above patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

**Entity to receive information.**

Check each person/entity that you approve to receive information.

**Description of information to be released.**

Check each box that can be given to person/entity on the left in the same section.

Voicemail

Phone # \_\_\_\_\_

Results of lab tests/radiology.

Other: \_\_\_\_\_

Spouse (provide name and contact number)

\_\_\_\_\_  
\_\_\_\_\_

Financial

All medical records

Specific records \_\_\_\_\_

Parent (provide name and contact number)

\_\_\_\_\_  
\_\_\_\_\_

Financial

All medical records

Other: \_\_\_\_\_

Other (provide name and contact number)

\_\_\_\_\_  
\_\_\_\_\_

Financial

All medical records

Other: \_\_\_\_\_

**Patient information:** I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient and may be updated each year.

\_\_\_\_\_  
**Signature of Patient or Personal Representative**

\_\_\_\_\_  
**Date**

# Albemarle Square Family Healthcare

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## Adult Review of Systems

Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

### CONCERNS YOU WOULD LIKE TO DISCUSS DURING YOUR VISIT:

**SYMPTOMS:** Check symptoms you currently have or have regularly had in the past year.

*\*Your health care provider will review this form with you\**

#### Constitutional

- \_\_\_ Chills
- \_\_\_ Fever
- \_\_\_ Night sweats
- \_\_\_ Feeling tired
- \_\_\_ Weight gain
- \_\_\_ Weight loss

#### Respiratory

- \_\_\_ Cough
- \_\_\_ Wheezing
- \_\_\_ Shortness of breath
- \_\_\_ Trouble breathing w/exercise
- \_\_\_ Trouble breathing w/lying flat
- \_\_\_ Snoring

#### Skin

- \_\_\_ Skin lesions
- \_\_\_ Rash
- \_\_\_ Itching
- \_\_\_ Change in a mole

#### Psychiatric

- \_\_\_ Anxiety
- \_\_\_ Sleep Problems
- \_\_\_ Depression
- \_\_\_ Change in personality
- \_\_\_ Emotional problems

#### Eyes

- \_\_\_ Eye pain
- \_\_\_ Blurred vision
- \_\_\_ Eyesight problems
- \_\_\_ Eye discharge

#### Gastrointestinal

- \_\_\_ Abdominal pain
- \_\_\_ Nausea/Vomiting
- \_\_\_ Constipation
- \_\_\_ Diarrhea
- \_\_\_ Heartburn
- \_\_\_ Blood in stool

#### Neurological

- \_\_\_ Dizziness
- \_\_\_ Fainting
- \_\_\_ Headaches
- \_\_\_ Memory Loss
- \_\_\_ Numbness
- \_\_\_ Seizures
- \_\_\_ Tremor
- \_\_\_ Weakness

#### MEN Only

- \_\_\_ Erection difficulties
- \_\_\_ Lump in testicle
- \_\_\_ Sore on penis
- \_\_\_ Discharge from penis

#### ENT

- \_\_\_ Ear ache
- \_\_\_ Loss of hearing
- \_\_\_ Ringing in ears
- \_\_\_ Nosebleeds
- \_\_\_ Nasal discharge
- \_\_\_ Mouth sores
- \_\_\_ Sore throat
- \_\_\_ Hoarseness

#### Genitourinary

- \_\_\_ Pain w/urination
- \_\_\_ Incontinence
- \_\_\_ Urination at night
- \_\_\_ Blood in urine
- \_\_\_ Frequent urination

#### Endocrine

- \_\_\_ Heat/cold intolerance
- \_\_\_ Hot flashes
- \_\_\_ Increase in thirst

#### WOMEN Only

- \_\_\_ Breast lump
- \_\_\_ Abnormal pap smear
- \_\_\_ Irregular bleeding
- \_\_\_ Severe cramps
- \_\_\_ Pelvic pain
- \_\_\_ Painful intercourse
- \_\_\_ Absence of orgasm
- \_\_\_ Vaginal discharge
- \_\_\_ Nipple discharge

#### Cardiovascular

- \_\_\_ Chest pain
- \_\_\_ Dizziness
- \_\_\_ Palpitations
- \_\_\_ Fast heart rate
- \_\_\_ Large veins in legs
- \_\_\_ Leg swelling

#### Muskuloskeletal

- \_\_\_ Back pain
- \_\_\_ Joint swelling
- \_\_\_ Joint stiffness
- \_\_\_ Joint pain
- \_\_\_ Muscle Aches

#### Heme/Lymph

- \_\_\_ Easy bleeding
- \_\_\_ Easy bruising
- \_\_\_ Swollen glands

Last period:  
Last pap smear (if done by GYN):  
Last mammogram (if done by GYN):  
Pregnant?  Yes  No  
Age onset menses?  
# of pregnancies:  
# of children:

### Please answer the following questions with a yes or no.

In the past two weeks, have you felt little interest or pleasure in doing things? YES NO

In the past two weeks, have you felt down, depressed, or hopeless? YES NO

Do you feel safe in your current relationships? YES NO

Have you had any threats by others to your health or safety in the last year? YES NO

Have you had any significant life changes over the past year? If so, explain: \_\_\_\_\_

### Surgeries in the past year:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_