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, M.D.
Mark D. Niehaus, M.D.
Kimberly Carter, FNP

Deborah Campbell, M.D.
Jane Shaw, M.D.
Kelly J. Maupin, FNP

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 $75.00 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.

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.

(See reverse for details.)

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.

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.

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_____

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	☐ Results of lab tests/radiology.
Phone # _____	☐ 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**

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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

Eyes

____ Eye pain
____ Blurred vision
____ Eyesight problems
____ Eye discharge

ENT

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

Cardiovascular

____ Chest pain
____ Dizziness
____ Palpitations
____ Fast heart rate
____ Large veins in legs
____ Leg swelling

Respiratory

____ Cough
____ Wheezing
____ Shortness of breath
____ Trouble breathing w/exercise
____ Trouble breathing w/lying flat
____ Snoring

Gastrointestinal

____ Abdominal pain
____ Nausea/Vomiting
____ Constipation
____ Diarrhea
____ Heartburn
____ Blood in stool

Genitourinary

____ Pain w/urination
____ Incontinence
____ Urination at night
____ Blood in urine
____ Frequent urination

Muskuloskeletal

____ Back pain
____ Joint swelling
____ Joint stiffness
____ Joint pain
____ Muscle Aches

Skin

____ Skin lesions
____ Rash
____ Itching
____ Change in a mole

Neurological

____ Dizziness
____ Fainting
____ Headaches
____ Memory Loss
____ Numbness
____ Seizures
____ Tremor
____ Weakness

Endocrine

____ Heat/cold intolerance
____ Hot flashes
____ Increase in thirst

Heme/Lymph

____ Easy bleeding
____ Easy bruising
____ Swollen glands

Psychiatric

____ Anxiety
____ Sleep Problems
____ Depression
____ Change in personality
____ Emotional problems

MEN Only

____ Erection difficulties
____ Lump in testicle
____ Sore on penis
____ Discharge from penis

WOMEN Only

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

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:

Surgeries in the past year:

_____
_____
_____
_____

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: _____
_____

Please take a moment to activate your Albemarle Square Family Healthcare Patient Portal Account if you have not already done so. If you have already registered, no further action is required.

Going forward, using the Portal will allow you to:

- View and keep track of your medical information
- Receive important clinical reminders regarding your health care
- Receive and view lab results
- Request prescription refills from your health care provider
- Send non-urgent messages to our staff
- Request referrals
- Submit billing and insurance questions
- Designate a personal representative whom you wish to have access to your protected health information

Future enhancements may include the ability to:

- Schedule, confirm, or cancel an appointment
- Receive appointment reminder notices
- View statements and make payments
- Parents and legal guardians may be granted proxy access to a Portal account for their minor child

Please log on to our website www.albemarlesquarefamilyhealthcare.com to download your Patient Portal User Agreement. Complete the Agreement and return to us by US mail, dropping it by our office or bringing it with you to your appointment. Within one to two business days of receiving your Portal Agreement, we will send you a link via email to activate your account. This link will expire within three days so be sure to keep an eye open for this message.

Begin taking a more active role in managing your health care by enrolling in your Portal Account today!

Your Health Care Team at ASFHC