I. NEW PATIENT REGISTRATION FORM (Please Print)

MEDICS USA

PATIENT INFORMATION

Patient's Last Name _____ First _____ Middle Initial:_____

Social Security # _____ Date of birth _____ Age _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Spouse deceased

E-mail _____

Home phone _____ Cell phone _____

Street address _____ Apartment # _____

City _____ State _____ Zip code _____

Occupation _____

Employer _____ Employer phone _____

Emergency contact name _____ Phone _____ Relationship _____

Optional Info

Race _____ Ethnicity _____ Language _____

My preferred pharmacies:

1. Name _____ Location _____
2. Name _____ Location _____

How did you find Medics USA?

☐ Referred by a hospital or another doctor. What was their name? _____

☐ Recommended by insurance plan ☐ Recommended by family ☐ Recommended by friend ☐ Found you online

☐ Saw a newspaper ad ☐ Other _____

INSURANCE INFORMATION

Is this a work-related injury? ☐ NO ☐ YES If YES, will your employer be responsible for the bill? ☐ YES ☐ NO

If employer will be responsible, please give

Employer name _____ Employer phone _____

Employer contact _____

Will some person besides you be responsible for the bill? ☐ YES ☐ NO

Name _____ Birth date (if known) _____ Phone _____

Address (if different from yours) _____

City _____ State _____ Zip code _____

Go to next page

My primary insurance (look on your insurance card for this information)

Subscriber's name _____ Subscriber's SS #_____ Birth Date _____

Carrier_____ Phone _____

Group # _____ Policy # _____ Co-payment $_____

Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other _____

My secondary insurance (look on your insurance card for this information)

Subscriber's name _____ Subscriber's SS #_____ Birth Date _____

Carrier_____ Phone _____

Group # _____ Policy # _____ Co-payment $_____

Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Medics USA Medical Center or insurance company to release any information required to process my claims. Please note there is a $25 fee for all missed appointments if not cancelled 24 hours in advance. I will make Medics USA aware of any changes to the above information. In addition there is a $1.50 fee per returned statement. To ensure continuity of care and proper utilization of prescription medication, we participate in the Virginia Board of Pharmacy Prescription Monitoring program, and by signing below you give us permission to access your prescription history.

Patient/Guardian signature _____ Date _____

II. New Patient Health History Questionnaire

Name (Last, First, M.I.) _____ ☐ M ☐ F Date of Birth _____

What is the reason for your visit today? _____

Previous or Primary doctor _____ Date of last physical exam _____

Have you ever had anesthesia (Novocain)? ☐ YES ☐ NO Any bad reaction? ☐ YES ☐ NO

PAST MEDICAL HISTORY

PLEASE CHECK (✓) IF YOU HAVE:

___ Vertigo
___ Anxiety
___ Arthritis
___ Depression
___ Anemia
___ Alcohol abuse
___ Neurological disorder
___ High blood pressure
___ Bronchitis
___ Abdominal pain
___ Weight loss or gain
___ Swollen ankles
___ Lightheadedness
___ Hepatitis/Jaundice
___ Heart attack
___ Pneumonia
___ Heart burn
___ Hemorrhoids
___ Lower back pain
___ Skin disease
___ Thyroid disease
___ Heart murmur
___ Persistent cough
___ Nausea
___ Ulcers
___ Blood disorder
___ Kidney disease
___ Headache
___ Chest pain
___ TB
___ Vomiting
___ Blood in stool
___ Gout
___ Kidney stones
___ Rheumatic fever
___ Palpitations
___ Asthma
___ Diarrhea
___ Colitis
___ STD
___ Frequent urination
___ Drug abuse
___ Shortness of breath
___ Mucus
___ Constipation
___ Neck pain
___ Fainting
___ Difficult urination
___ Epilepsy

Go to next page

LIST ANY OTHER MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED

_____

_____

_____

CHILDHOOD ILLNESS: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

IMMUNIZATIONS (please give date)

☐ Tetanus _____ ☐ Pneumonia _____ ☐ Hepatitis _____ ☐ Chickenpox/ Varicella _____

☐ Influenza _____ ☐ MMR (Measles, Mumps, Rubella) _____

SURGERIES

Year_____Reason _____ Hospital _____

Year_____Reason _____ Hospital _____

Year_____Reason _____ Hospital _____

LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS

Name the Drug _____ Dosage _____Frequency Taken _____

Name the Drug _____ Dosage _____Frequency Taken _____

Name the Drug _____ Dosage _____Frequency Taken _____

Name the Drug _____ Dosage _____Frequency Taken _____

Name the Drug _____ Dosage _____Frequency Taken _____

ALLERGIES TO MEDICATIONS

Name the Drug _____ Reaction You Had _____

Name the Drug _____ Reaction You Had _____

Name the Drug _____ Reaction You Had _____

Do you drink alcohol? ☐ YES ☐ NO What and how often? _____

Do you use tobacco? ☐ YES ☐ NO What and how often? _____

Do you currently use recreational or street drugs? ☐ YES ☐ NO

Have you ever given yourself street drugs with a needle? ☐ YES ☐ NO

Have you ever been exposed to HIV (AIDS)? ☐ YES ☐ NO

Go to next page

FAMILY HEALTH HISTORY

Relationship _____Age _____ Significant health problems _____

Relationship _____Age _____ Significant health problems _____

Relationship _____Age _____ Significant health problems _____

Relationship _____Age _____ Significant health problems _____

WOMEN ONLY Date of last menstruation _____ Period every _____ days Date of last PAP _____

Are you pregnant? ☐ YES ☐ NO

Signature _____ Date _____

Patient completed this form? ☐ YES ☐ NO Relationship (if not patient) _____

III. New Patient Portal Authorization

Patient Portal (henceforth referred to as "Portal") offers convenient and secure access to your personal health record. As the patient, you are in control of your Portal record. We will not activate your personal account unless you authorize Medics USA to do so. If you choose to consent, you understand that you are consenting for Medics USA to e-mail you a unique link that you will use to create a password in order to access the Portal.

Consent ? ☐ NO ☐ YES E-mail address _____

IV. New Patient Medical Information Release

Do you wish to authorize anyone to discuss your medical information?

☐ NO ☐ YES Name _____ Phone _____

Permission Valid Until _____ / _____ /20___

Do you authorize Medics USA to leave a confidential voice mail?

☐ NO ☐ YES Phone number _____

V. Payment and Treatment Policies

Thank you for choosing Medics USA for your health care services.

The physician-patient relationship benefits when the patient has a clear understanding of his or her rights and obligations. This form provides an explanation of Medics USA's Treatment and Payment Policies and covers such important topics as:

- Patient's consent to receive medical treatment from Medics USA (and your other rights and responsibilities)
- Patient's agreement to pay in full any charges that are your responsibility.

Please review and sign this notice before receiving treatment. You have the right to receive a printed copy of this notice at your request. If you have any questions about our Treatment or Payment Policies, please do not hesitate to ask.

Go to next page

Treatment Policy
By signing below, you indicate that you are the patient or that you have the legal authority to consent to medical treatment on the patient's behalf. You consent to, understand and agree that:

- You will have the opportunity to discuss the risks and benefits of proposed procedures and therapeutic courses of treatment, together with any available alternatives, with the physician or health professional to your satisfaction.
- You have the right to consent to or refuse any proposed procedure or therapeutic course of treatment at any time.
- You have the right to decline further treatment at any time.
- Medics USA will provide the best care possible consistent with the prevailing standards of medical practice but makes no assurances or guarantees as to the results of treatment.
- Subject to the foregoing, Medics USA health care providers may administer any treatment and perform any procedures deemed advisable in your care and treatment.

Medicare Beneficiaries Receiving Durable Medical Equipment (DME)
Medics USA provides its patients with limited DME (such as slings, braces and crutches). By signing below, you agree that you have been advised that:

- While Medicare allows for the purchase or rental of DME, Medics USA only sells the DME that it provides. You are free to seek rental DME from other community providers.

MedicsUSA First notice of Privacy Practices
We will protect the privacy of your health information and will not use or disclose it except as permitted by state and federal law, as more fully described in the Medics USA Notice of Privacy Practices that has been made available to you.

By signing below, you consent to our use and disclosure of your health information in accordance with the Notice of Privacy Practices and applicable law.

Payment Policy
Medics USA is a private organization which relies solely on income from patients and their insurers. In order to provide the best possible medical care at the lowest possible cost, we need your assistance and agreement to our payment policies. As the patient or the person with legal authority to sign on the patient's behalf, you understand and agree to the following:

- <u>All Patients:</u> You are responsible for, and agree to pay, the cost of any services that your health plan determines are not covered, or services that are covered but applied to a deductible or co-insurance. If you do not know whether services to be provided during your visit are covered by your health plan, please contact the carrier using the number found on your insurance card. **Note that it is your responsibility to determine whether services to be provided by Medics USA are covered by your insurer.**
- In the event that your plan requires approval or referral from your Primary Care Physician or insurer prior to a visit and you did not obtain that approval or referral, you will be responsible for, and agree to pay, any costs of care that your insurer determines are not covered under your insurance policy and for which you may be held liable under applicable law.
- If you have health care benefits, Medics USA will submit a claim to your insurer on your behalf and allow no less than 60 days for the insurer to respond. You agree to pay at time of service any required co-payments, coinsurance and deductibles, as well as charges for services not covered by insurance, outstanding balances and delinquent accounts. For your convenience, we accept cash and credit cards.
- You assign to Medics USA any and all health care benefits to which you are entitled under any policy of insurance (hospitalization, major medical, workers' compensation, or any other insurance or benefit plan) and authorize, to the extent permitted by law, payment of those benefits directly to Medics USA.
- Medics USA allows more than the legal and customary amount of time after filing a claim to be reimbursed by insurers. If Medics USA has not received a response within 60 days of having filed a claim for a visit, we will assume that the visit is not covered and is, therefore, your responsibility. At that time, to the extent permitted by law, we will bill you for the visit charges please direct questions regarding non-payment by your insurer to the insurer, not to Medics USA.
- You will be billed for all unpaid balances deemed by Medics USA or your insurer to be your responsibility. You are responsible for paying the bill in full unless special arrangements are approved by Medics USA in its discretion. You must call the Patient Accounts department, at the number printed on the billing statement, in order to make such arrangements. Late fees of 1.5% per month will be charged on balances that are still unpaid starting 30 days after the first statement. There is a fee of $30 for returned checks. Delinquent accounts may be turned over to a collection agency at which time you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 25% of the debt, and all costs, and expenses, including reasonably attorneys' fees, we incur in such collection efforts.
- **You will be asked to verify your address at every visit; if the address verified by you is not correct and account statements are returned, your account will be charged a processing fee of $1.50 per returned statement.**

Go to next page

Radiology/X-Rays
Medics USA offers radiology services in our facility as a convenience for our patients; these services may not be covered by all insurance plans. If your plan does not cover any radiology services performed at Medics USA, payment will be required at time of service.

MedicsUSA reserves the right to deny non-emergency services, if your account is delinquent.

I have read, understand, and agree to the Treatment and Payment Policies described above and understand that Medics USA may refuse non-emergency treatment if my account or the patient's accounts are delinquent. I agree to keep all contact information up to date and understand if I do not update my information I will be charged a processing fee of $1.50 per returned statement.

Name of patient _____ Signature _____ Date _____

If you are signing on behalf of a minor, incapacitated or otherwise legally dependent patient, please sign as "Guarantor" below and indicate your relationship to the patient.

Name of guarantor _____ Signature _____ Date _____

Guarantor's relationship to Patient _____

WITNESS _____

NOTICE OF PRIVACY

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Introduction
At MEDICS USA, INC, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information
Each time you visit MEDICS USA, INC, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment, and a means of communication with other health care professionals, your Health Insurance Company, legal entities, and public health officials in order to promote your general health and that of the general public.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights
Although your health record is the physical property of Medics USA, Inc., the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of information practices upon request.

- Inspect and copy your health record by written request.
- Request an Amendment to your health record.
- Obtain an accounting of disclosures of your health information.
- Request communications of your health information by alternative means or at alternative locations.
- Request a restriction on certain uses and disclosures of your information.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Medics USA Inc. is required to:

- Maintain the privacy of your health information,
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this Notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative
- means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post, and if you request, mail you a revised notice.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice:

MEDICS USA, INC

16882 Clarkes Gap Road
Paeonian Springs VA 20129
Telephone: (202)483-4400
Fax: (540) 338-1975
www.MedicsUSA.com

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will use your health information for payment.
For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.
For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include certain laboratory tests and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. This includes appointment reminders, and lab or other test results.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers' compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law provides for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

MEDICS USA

CREDIT CARD ON FILE FORM

At Medics USA Medical Center, we require keeping your credit or debit card information on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Without this authorization, a billing service charge of 25 percent of the total bill will be charged for each month that the bill remains unpaid after the first 30 days.

Your credit card information is kept confidential and secure, and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to your account. Maximum wait time is 45 days; if your insurance does not process within 45 days of the date of service, the full remaining amount will be considered due.

☐ I authorize Medics USA Medical Center to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ I authorize Medics USA Medical Center to charge a maximum amount of $200 towards my financial responsibility to the following credit or debit card:

I can be contacted at (___) -_____-_____ or e-mail _____

☐ Amex ☐ Visa ☐ Mastercard

Credit Card Number _____ CVV code _____

Expiration Date _____ / _____ / _____

Cardholder Name _____

Signature _____

Billing Address _____

City _____ State_____ Zip _____

I (we), the undersigned, authorize and request Medics USA Medical Center to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Medics USA Medical Center

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Medics USA Medical Center in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____ Date: _____ / _____ / _____