Valley Family Practice & Internal Medicine
812 Amherst Street, Suite 101
Winchester, Virginia 22601
Phone: 540-722-0220
Fax: 540-722-0191

Robert W. Duck M.D. **Meenu Gopal M.D.** **Kathryn Durbin PA-C**

Insurance: As a patient, you are responsible for knowing what is covered or required by your insurance company. If you have any questions, contact your insurance company or employer. We do not verify benefit coverage. As a service to our patients, we obtain pre-authorization for medications, tests, procedures, or physical therapy when required.

It is very important that you notify our office of any change in your insurance, and that you present our office with your insurance card so that we can make a copy to put in your file. If you do not inform our office of a change in your insurance coverage, whether it be a new insurance or a number change and the bill is denied payment by your insurance, you the patient, will be personally responsible for payment of the bill. You will be responsible for contacting your insurance company with all the needed information so that the insurance company can reimburse you for the payment.

Payment: We take cash, check, Visa and MasterCard. If a check is returned for non-payment there is a $50.00 charge. All co-payments, co-insurances, deductibles and balances are due at the time of service.

If payment is not made on an account and the account is referred to collections, no requested appointments or services will be provided by this office until the debt is paid in full. Patient is responsible for any and all fees associated with an account being turned over to collections.

By signing below you acknowledge that you have read and understand the above.

Patient Signature: _____ Date: _____

Patient printed name_____DOB:_____

Release of Medical Information
Valley Family Practice & Internal Medicine
812 Amherst Street Suite 101
Winchester, VA 22601
Tel. (540)722-0220
Fax (540)722-0191

Robert W. Duck M.D. Meenu Gopal M.D. Kathryn Durbin PA-C

Date: _____

I, _____, _____ hereby authorize:
Name Date of Birth

_____
Physician and/or Establishment

_____
Address

_____ _____
Telephone Fax

To release all medical information for the period: _____ to _____
Including:

_____History and Physical
_____Progress Notes
_____Pathology Reports
_____Other_____
_____Lab results and radiology studies
_____Operative Reports/Procedure Notes
_____Consultations

Please DO NOT include any of the following (if marked):

_____Mental Health Information
_____Substance Abuse treatment
_____HIV testing and/or treatment
_____Other_____

This information is for the continuation of medical care. This release will expire one year from the date of signature.
This information will be used only as outlined in the Privacy Disclosure and HIPPA Compliance Statement on file at Valley Family Practice.

_____ _____
Signature of Patient, Parent or Guardian Date

_____
Relationship to patient (If signed by parent or guardian)

_____ Witness

New Patient Information

Physician Signature_____

Date: _____

Name: _____

Address:_____

_____

DOB:_____/_____/_____

Social Security #:_____/_____/_____

Phone #:_____/_____/_____

Alt. Phone:_____/_____/_____

Insurance:_____ID#_____Group#_____

Referred By:_____Previous Primary Physician_____

Requested Physician (circle):

Robert W. Duck M.D. Meenu Gopal M.D. Kathryn Durbin PA-C

Current Prescription Medications:

_____

_____

_____

_____

_____

Vitamins or OTC Medications:

_____

_____

_____

_____

_____

Please be advised that the physicians of this practice will NOT take on the writing of any narcotic medications that you are currently taking. Your signature signifies that you understand the above statement.

Patient Signature:_____ Date: _____/_____/_____

Personnel Signature:_____Date_____/_____/_____

VALLEY FAMILY PRACTICE
812 Amherst St. Suite 101
Winchester, VA 22601

Robert W. Duck M.D Meenu Gopal M.D. Kathryn Durbin PA-C

Date: _____

PATIENT INFORMATION

Patient Name (last/first): _____ Home Ph#: (___)_____-_____

Address: _____ Work Ph#: (___)_____-_____

City: _____ State: _____ Zip: _____ Date of Birth: ___/___/_____

Sex (M/F): _____ Employed (Y/N): ___ Student (FT/PT):_____ SSN: _____-_____-_____

Email address: _____

Employer/School Name: _____ Marital Status: _____

Responsible Party: _____

Billing Address: _____

Referred by: _____ Family MD: _____

Emergency Contact: _____

Relationship to Patient: _____ Emergency Contact Phone#: (___) _____-_____

Is it okay to leave a detailed message on your answering machine? (Y/N) _____

Allergies: _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____ Phone: (____) _____-_____

Address: _____ Group#/Name: _____

City: _____ State: _____ Zip:_____ ID#: _____

Name of Policy Holder: _____ Sex (M/F)____ Date of Birth: ___/___/_____

Policy Holder Address: _____

Policy Holder Employer/School Name: _____

Policy Holder SSN: _____/_____/_____ Policy Holder Phone: (_____) _____-_____

Employer Insurance Plan (Y/N): _____ Relationship of Patient to Policy Holder: _____

Secondary Insurance Carrier: _____ Phone: (_____) _____-_____

Address: _____ Group#/Name: _____

City: _____ State: _____ Zip:_____ ID#: _____

Name of Policy Holder: _____ Sex (M/F)____ Date of Birth: ___/___/_____

Policy Holder Address: _____

Policy Holder Employer/School Name: _____

Policy Holder SSN: _____/_____/_____ Policy Holder Phone: (_____) _____-_____

Employer Insurance Plan (Y/N): _____ Relationship of Patient to Policy Holder: _____

PATIENT AND RESPONSIBLE PARTY AUTHORIZATION

I authorize the physician(s) at Valley Family Practice for _____ (patient) to apply for benefits on my behalf for the covered services rendered and request that payments from my insurance company be made directly to Valley Family Practice. I certify that the information reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information, for this or any related claim to the above named agent. I permit a copy of this authorization in place of the original. In all cases, professional fees are the patient, spouse, guardian and/or parents' responsibility. Finance Charge may be computed by a "periodic rate" of 1 ½ % per month, which is an Annual Percentage Rate of 18% applied to the previous balance without deducting current payments and/or credits appearing on any given bill. Patient or responsible party(ies) further agree to pay any and all collection fees incurred and legal expenses, including but not limited to Collection Agency and attorney fees, all court related costs, service and filing fees, interrogatory and garnishment fees, as well as any interest that may be adjudicated for the collection of the past due debts.

Print Name _____ Signature _____ Date _____

ELECTRONIC MEDICAL RECORDS (EMR)

As of April 2006, Valley Family Practice implemented a community based electronic medical record system. This system will replace the existing paper based methodology of medical record keeping. The records will be in a centralized data base, accessible by all offices that are members of the Shenandoah Independent Practice Association (SIPA). However, only practices that are actually treating you are permitted to access your medical record. SIPA's centralized database employees the latest security and data protection technology required by state and federal law to ensure that there is no unauthorized access to your records.

HIPAA STATEMENT

I have read Valley Family Practice's "Notice of Privacy Practices", and I hereby authorize Valley Family Practice to furnish to my insurance company or authorized agent information regarding my protected health information for the purposes of treatment, payment, or health care operations. I further authorize the physicians of Valley Family Practice to consult as needed at their sole discretion with other medical providers regarding my medical care. I wish to place the following restrictions concerning the disclosure of my protected health information. Valley Family Practice can discuss my medical condition/information with the following:

**** If you check "yes" in any of these boxes, please provide us with a name. ****

Spouse: Yes ☐ No☐ Name: _____ Child: Yes ☐ No☐ Name: _____

Parents: Yes ☐ No☐ Name: _____ Friends: Yes☐ No ☐ Name: _____

Patient Signature _____ Signature Authorized Person _____ Date _____

VALLEY FAMILY PRACTICE
New Patient Questionnaire

Name: _____ Age: _____ Sex: _____

Occupation: _____ Marital Status: __single __married __divorced __widowed

Indicate whether you or your family members (parents, grandparents, siblings) have had the following:

	You	Your Family	
Heart Disease	Y N	Y N	
Stroke	Y N	Y N	
Cancer	Y N	Y N	What type? _____
High Cholesterol	Y N	Y N	Last time it was checked: _____
High Blood Pressure	Y N	Y N	
Ulcers or Reflux	Y N	Y N	
Diabetes	Y N	Y N	

List any other conditions you have:

_____ _____ _____

_____ _____ _____

List any surgeries you have had (what type and when):

_____ _____

_____ _____

_____ _____

List the medications you take (both over-the-counter and prescribed)

Drug Name	Dosage (mg)	How often/when	When started

List other doctors/providers (name and specialty)

_____ _____

_____ _____

Are you allergic to any medication? Y N

Drug Name	What happens/type of reaction

VALLEY FAMILY PRACTICE
NEW PATIENT QUESTIONNAIRE

NAME: _____ **DATE:** _____

Please circle Yes or No:

1. Do you have trouble with your vision? Yes No
2. Do you have trouble with hearing? Yes No
3. Do you have any trouble swallowing? Yes No
4. Do you ever have difficulty breathing? Yes No
5. Do you frequently have a cough? Yes No
6. Do you ever have chest pain or tightness? Yes No
7. Do you ever have palpitations or feel your heart racing? Yes No
8. Do you have trouble with indigestion? Yes No
9. Do you ever have abdominal pain? Yes No
10. Do you have trouble with diarrhea? Yes No
11. Have you ever had blood in your stool? Yes No
12. Have you had unexplained weight loss? Yes No
13. Do you have trouble with heartburn? Yes No
14. Do you ever have blood in your urine? Yes No
15. Do you ever have pain with urination? Yes No

Female Only:

16. How old were you when you had your first period? _____
17. Are your periods regular? Yes No
18. How many days do you bleed? _____
19. How many pads or tampons do you use on your heaviest day? _____
20. Do you ever miss school or work because of your period? Yes No
21. Are you sexually active? Yes No
22. If yes, do you or your partner use anything to prevent pregnancy? Yes No
23. If yes, what do you use? _____
24. Is your sexual activity satisfactory? Yes No
25. Do you leak urine with coughing or laughing? Yes No
26. Do you have trouble making it to the bathroom on time? Yes No
27. When was your last pap smear? _____
28. When was your last mammogram? _____

Males Only:

29. Are you sexually active? Yes No
30. Is your sexual function satisfactory? Yes No
31. Do you have trouble starting your urine flow? Yes No
32. Do you dribble urine or have poor flow? Yes No
33. Do you get up more than once a night to urinate? Yes No

Do you smoke? Yes No
Have you ever smoked? Yes No
If no to both above, skip to the next section.
How much do you smoke? _____
For how long? _____
Do you have any interest in quitting? Yes No
Have you ever quite before? Yes No

Do you drink alcohol? Yes No
If no, please skip to the next section.
How often? _____
How many drinks? _____
Has your drinking ever caused a problem at work? Yes No
Do you ever feel guilty about your drinking? Yes No
Do you ever drink in the morning? Yes No
Have you ever been annoyed by people commenting on your drinking? Yes No
Have you ever thought you should cut back? Yes No

Do you ever feel sad, blue or down? Yes No
Do you have trouble sleeping? Yes No
Do you have trouble with your appetite? Yes No
Do you cry for no apparent reason? Yes No
Do you have trouble concentrating? Yes No
Do you feel guilty a lot of the time? Yes No
Have you withdrawn from activities you used to enjoy? Yes No
Have you had a decrease in your sex drive? Yes No
Have you ever thought of hurting yourself? Yes No
Are you being physically or emotionally abused by anyone in your household? Yes No

Office Use Only:

Reviewed _____

Date _____