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** **Brittany DeHaven NP**

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 ______Lab results and radiology studies
______Progress Notes ______Operative Reports/Procedure Notes
______Pathology Reports ______Consultations
______Other__________________

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

______Mental Health Information ______HIV testing and/or treatment
______Substance Abuse 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______/_____/_______