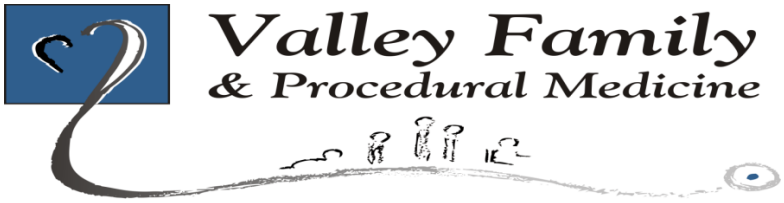

Patient Information Form

DATE: _____

NAME: _____

BIRTH DATE:_____ MALE _____ FEMALE _____

ADDRESS: _____

_____

EMAIL: _____

HOME PHONE: (_____)-_____-_____ WORK PHONE: (_____)-_____-_____

CELL PHONE: (_____)-_____-_____

CHECK ALL THAT APPLY: Single_____ Married_____ Widow(er)_____ Student_____

SOCIAL SECURITY # _____

EMPLOYER:_____ ADDRESS: _____
(Parent's if patient is a minor)

PARENT/GAURDIAN NAME & S.S# _____

EMERGENCY CONTACT: _____ PHONE: _____

CHECK ALL THAT APPLY: Single_____ Married_____ Widow(er)_____ Student_____

Spouse: NAME_____ EMPLOYER _____ WORK #_____

PREFERRED PHARMACY:_____

INSURANCE INFORMATION: PLEASE ALLOW US TO PHOTOCOPY YOUR INSURANCE CARD(S)

Patients Relationship to Insured: SELF_____ SPOUSE_____ CHILD_____ OTHER_____

PRIMARY INSURANCE:_____ SECONDARY:_____

Insured's Name If Other Than Self:_____ Insured's S.S #_____

Insured's Address If Different Than Above:_____

Insured's Birth Date: _____ Insured's Sex MALE_____ FEMALE_____

Allure
MEDICAL

MODEL/PHOTOGRAPHY RELEASE

I hereby grant the following rights and permissions to Allure Medical Company and its legal representatives, and those acting with their authority and permission:

They have the irrevocable, perpetual and unrestricted right and permission to take, use, re-use, publish, and republish photographic portraits or pictures or videos of me or in which I may be included, in whole or in part, or composite or distorted in character form, without restriction as to changes or alterations, in conjunction with my own or a fictitious name, or reproductions thereof in color or otherwise, made through any medium at his/her studios, or elsewhere, an in any and all media now or hereafter known, specifically including but not limited to print media and distribution over the internet for illustration, promotion, art, editorial, advertising, trade, or any other purpose whatsoever.

I specifically consent to the digital compositing or distortion of the portraits or pictures, including without restriction any changes or alterations as to color, size, shape, perspective, context, foreground or background. I also consent to the use of any published matter in conjunction with such photographs.

I hereby waive any right that I may have to inspect or approve the finished product or products and the advertising copy or other matter that may be used in connection with them or the use to which they may be applied. I also waive right to compensation for use of any images.

I hereby warrant that I am of full age and have the right to contract in my own name. I have read the above authorization, release, and agreement, prior to its execution, and I am fully familiar with the contents of this document. This document shall be binding upon me and my heirs, legal representatives, and assigns.

DATE: _____

SIGNATURE: _____

NAME: _____

Financial Policy Statement

Thank you for choosing our physicians for your health care needs. We are committed to provide the very best medical care and treatment. The following is a statement of our Financial Policy, which you must read, agree to and sign, prior to treatment. Our financial Policy applies to all service rendered by our physicians and staff whether inpatient or outpatient.

Practice Payment Policy Guidelines:

- **Patients (guardians) are financially responsible for all charges, regardless to third-party involvement.**
- **Full payment is due at time of services, unless prior insurance billing arrangements have been made.**
- **Patients with insurance will be required to pay all "out-of-pocket" financial obligations at time of service.**
- **We accept: Cash, and the following credit cards: Visa/MasterCard/Discover.**

Patient Responsibilities and Financial Policies:

Provide accurate information: You have a responsibility to provide accurate complete information about your health history, mailing address, health insurance, and other billing information. If any information changes-name, address, phone insurance coverage, etc. –You must inform this practice immediately. Insurance denials or billing errors due to patient supplied information will result in the transfer of the account balance to the patient's immediate financial responsibility.

Know Your Insurance Coverage, Benefits, and Referral Requirements: Your health insurance is a contract between you and your health insurance plan(s). Patients are responsible for understanding their health insurance coverage(s), benefits and referral requirements to receive diagnostic and therapeutic services from our physicians. Patients are for securing the necessary written referrals, pre-authorizations or pre-certifications from your primary care physicians or health plan prior-to services rendered. If we have not received the necessary authorizations prior-to your appointment, the appointment will be rescheduled. Please present your Insurance ID card to our staff upon registration for each office visit.

Self-Pay Patients: Patients without insurance coverage are expected to for services received in full at time of service, unless a satisfactory payment agreement has been arranged with our billing manager prior-to services being rendered.

Patients with Private Insurance/Medicare/Medical Coverage: Our Physicians participate with the Medicare and Medicaid Programs, and with most major insurance companies. We will file claim(s) to your insurance provided you authorize the "assignment of benefits" below for payment directly to our practice. For participating insurance plans, the practice will accept payment based on contractual agreements. For plans that we do not participate (i.e., there is no contractual agreement), the practice will expect full payment from the patient at time of service. Any coverage or payment dispute is a matter between the insurance policyholder and the insurance company.

Patient Payment Agreement:

I understand that I am fully responsible for all charges regardless of third-party involvement. I agree to pay any deductable, coinsurance, co-payment, or services deemed as "non-covered" by my insurance carrier at the time of service. If my insurance has not paid on my account in 60 days, the outstanding services will become my responsibility for immediate payment (unless Medicare and Medicaid). Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, non-payment at time of service and/or any other reason; I agree to pay all charges within 30 days of notice. I understand that if I fail to pay outstanding balances or make payment arrangements within 75 days, the amount will be considered delinquent and subject to legal action. I further understand that delinquent accounts will be assessed a 1.5% interest charge per month (18% APR), and the possible dismissal of the patient from our care. If my account is forced to "collections", I agree to pay all collection costs, including, but limited to, court costs attorneys fees equal to 33.33% of the amount owed, and accrued interest charges to date. I agree to pay a $50.00 fee for each missed appointment not cancelled at least 24 hours in advance. Copies of my medical records can be obtained with advanced notice in accordance with §8.01-413 of the Code of Virginia, with charges not to exceed $0.50 per page and for the first 50 pages and $0.25 per page thereafter, in addition to a $10.00 handling fee plus postage expense. The completion of special forms or reports has a charge of $50.00.

Authorization & Assessment of Insurance Benefits:

I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of specific medical or other protected health information, whether manual, electronic or telephonic. I authorize the Practice to apply benefits for services rendered to myself or minor child under any health insurance policies providing benefits and do hereby also assign and authorize payment of benefits from my insurance company to the Practice (including benefits payable under Title XVIII of the Social Security Act and/or any other governmental agency.) I irrevocably authorize all such payments to the Practice. I authorize the Practice to contact the employer or insurance company regarding insurance information, existence of insurance and coverage of my benefits.

Medication Agreement:

As a patient of Valley Family and Procedural Medicine/Allure Medical, I give authorization to view previous medications electronically and I agree to have all my medications electronically submitted for pick up at my pharmacy.

In consideration for medical services rendered, I acknowledge receiving notice of the financial policy and agree to pay for said medical services according to the above terms. My signature below indicates that I have read and agreed to the above policy.

_____ _____

(Patient/Responsible Party/Guardian Signature) **(Date)**

Valley Family
& Procedural Medicine

Consent for Release and Use of Confidential Information
and Acknowledgement of Notice of Privacy Practices

I, _____hereby give my consent to Valley Family and
(Name of Patient or Authorized Agent)

Procedural Medicine to use or disclose, for the purposes of carrying out treatment, payment, or health care operations, all information contained in my private health record.

I acknowledge the review and/or receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information. I understand that the physician has reserved a right to change his or her privacy practices that are described in this Notice. I understand that I can request a copy of The Notice of Privacy Practice at any time. I also understand that a copy of any revised Notice will be available to me upon a written request to the Privacy Officer.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this Notice at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office

I understand that I have the right to request that the practice restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment, or health operations. I understand that the practice does not have to agree to such restrictions, but that once such restrictions are agreed to, the practice and their agents must adhere to such restrictions.

Due to the HIPPA Privacy Act, we are not permitted to release information regarding your care. If you wish to grant your permission, please list below the person(s) that we may speak with on your behalf. Please be aware those listed below will be given full access to your Private Health Information.

(1)_____ _____
Name Relationship to Patient

(2)_____ _____
Name Relationship to Patient

Signed:_____ Date:_____

If not the Patient, please specify your relationship to the patient:_____

Valley Family & Procedural Medicine

Patient's Name: _____ Today's Date: _____

Social Security Number: _____ Date of Birth: _____

Past Medical History

Previous Physician's Name_____ Date of Last Exam: _____

Have you ever been hospitalized? ☐Yes ☐ No If Yes, what for? _____

Which of the following conditions are you currently being treated or have been treated for in the past (please check)

☐Heart disease / Murmur / Angina	☐Shortness of breath	☐Eye disorder / Glaucoma	☐Diabetes
☐High cholesterol	☐Asthma	☐Seizures	☐Kidney/Bladder problems
☐High blood pressure	☐Lung problems/cough	☐Stroke	☐Liver Problems/Hepatitis
☐Low blood pressure	☐Sinus problems	☐Headaches/Migraines	☐Arthritis
☐Heartburn (reflux)	☐Seasonal allergies	☐Neurological problems	☐Cancer
☐Anemia or blood problems	☐Tonsillitis	☐Depression/Anxiety	☐Ulcers/colitis
☐Swollen ankles	☐Ear Problems	☐Psychiatric care	☐Thyroid problems

Have you had a sexually transmitted disease? ☐Yes ☐ No Diagnosis:_____

Please describe any current or past medical treatment not listed above:

_____

_____

Please list your past surgeries:

_____

_____

Allergies:

Are you allergic to penicillin or any other drugs? ☐Yes ☐ No

Please list: _____

Medications:

Please list: _____

_____

Social and Preventative History

Do you currently smoke or chew tobacco? ☐Yes ☐ No If no, have you in the past? ☐Yes ☐ No

How many packs per day? _____

Do you drink alcohol, beer or wine? ☐Yes ☐ No If no, have you in the past? ☐Yes ☐ No

How many drinks per week? _____

Do you currently drink coffee and/or tea? ☐Yes ☐ No If yes, how many cups per day? _____

Do you exercise daily/weekly? ☐Yes ☐ No If yes, how often? _____

What is your occupation? _____ What is your marital status? _____

Do you have children? _____ How many? _____

Do you have a history of substance abuse? ☐Yes ☐ No If yes, what? _____

Do you have a history of mental illness? ☐Yes ☐ No If yes, what illness(s)? _____

Family History

	Living		Age (or at death)	List serious illnesses
Mother	☐Yes	☐ No		
Father	☐Yes	☐ No		
Sisters	☐Yes	☐ No		
	☐Yes	☐ No		
	☐Yes	☐ No		
	☐Yes	☐ No		
Brothers	☐Yes	☐ No		
	☐Yes	☐ No		
	☐Yes	☐ No		

Has any member of your family (including children and parents) had any of the following illnesses:

Illness	Which family member?
Anemia or blood disease	
Cancer	
Diabetes	
Glaucoma	
Heart disease	
High Blood Pressure	
HIV disease/AIDS	
Mental Illness/Depression	
Stroke	
Other serious illness	

Females: Gynecological History

How many times have you been pregnant? _____ Date of last Pap Smear: _____

Have you had an abnormal Pap Smear? ☐Yes ☐ No Diagnosis: _____ Follow up: _____

Date of last mammogram: _____ Mammogram results: _____

Have you ever had a breast biopsy? ☐Yes ☐ No Biopsy results: _____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature _____ **Date** _____