7864 Richmond Tappahannock Hwy
Aylett, VA 23009
www.afwellness.com
☏ **Phone: 804-796-2015**
Fax: 804-796-2014

Date________________________

Dear____,

You have been scheduled for a New Patient Appointment on________________________________, at _______________am/pm with____.

Please arrive no later than_______________am/pm.

WELCOME

Aylett Family Wellness is committed to partnering with you to make a difference.

Clinic Hours:

Monday - Friday: 8:30 AM – 4:30 PM

Please fill out the packet completely and make sure to bring with you: the packet, photo ID, your insurance card(s) and your copay (if applicable). **PLEASE BE ADVISED, IF YOUR NEW PATIENT PACKET IS NOT FULLY COMPLETED BY YOUR APPOINTMENT THEN YOU WILL BE RESCHEDULED**.

If you need to change your appointment or cancel for any reason, please make sure to give a 24 hour notice (if possible) or you may be charged. ***If you miss 2 appointments without calling or cancelling then you may no longer be allowed to make appointments or be a patient with Aylett Family Wellness***

If you have any questions, please feel free to call.

Thank You,

New Patient Coordinator

Personal Information

Patient Last Name ____________________ Today's Date ____________________

Patient First Name ____________________ MI ______ Date of Birth ____________________

Sex Assigned at Birth: ☐ Female ☐ Male ☐ Other ☐ Decline

Patient Preferred Name ____________________

Address Line 1 ____________________ SSN# ____________________

Address Line 2 ____________________ Responsible Party ____________________

City ____________ State ______ Zip Code ________ Responsible Party Relationship ____________________

Home Phone ____________ Cell Phone ____________ Emergency Contact - Name ____________________

Work Phone ____________ Work Phone Ext ____________ Emergency Contact – Phone # ____________________

Email ____________________ Emergency Contact Relationship ____________________

Ethnicity: ☐ Upper Mattaponi Tribal Member ☐ American Indian/Alaskan Native ☐ African American ☐ Asian ☐ Caucasian ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ N/A

Employment Status: ☐ Employed ☐ Retired ☐ Student ☐ Other

Language Preference ____________________

Preferred Hospital ____________________ Hospital Phone# ____________________

Insurance Information

Insurance: ☐ Medicaid ☐ Medicare ☐ Other ☐ Self Pay

Insurance Plan ____________________

Policy ID # ____________ Insurance PH # ____________ Group # (if applicable) ____________

Policyholder name (if not self) ____________________ Insured Signature ____________________

Purpose of Today's Visit ____________________

How did you hear about us? ____________________

Physician/Pharmacy Information

Are you now under the care of a physician or have a pharmacy? If yes, please complete the information below

Physician Name

Physician Phone #

Current Pharmacy Name

Pharmacy Phone #

Current Pharmacy Address

Pharmacy Zip Code

Pregnancy *(Women Only)*

	Yes	No	DK
Are you pregnant?......................	☐	☐	☐
If yes, how many weeks?.......	______		
Are you taking birth control?.......	☐	☐	☐

Known Allergies

Allergy	Reaction

Procedural History

Surgery	**Year**

Medications & Supplements

Medication	**Dose**	**Frequency**

Medical History

Please mark your response to indicate if you have or have not had the following?

	Yes	No		Yes	No
Artificial Heart Valve....................	☐	☐	Cancer/Chemo/Radiation............	☐	☐
Previous Infective Endocarditis..	☐	☐	*If yes, specify cancer................*	______	
Atrial Fibrillation...........................	☐	☐	Chest Pain	☐	☐
Cardiovascular Disease................	☐	☐	Chronic Pain......................................	☐	☐
Angina..	☐	☐	Type 1 Diabetes.................................	☐	☐
High Cholesterol...........................	☐	☐	Type 2 Diabetes..............................	☐	☐
Congestive Heart Failure.............	☐	☐	Eating Disorder..............................	☐	☐
C.O.P.D..	☐	☐	Malnutrition......................................	☐	☐
Heart Attack...................................	☐	☐	G.I. Disorder	☐	☐
Heart Murmur..............................	☐	☐	G.E.R.D./Heartburn	☐	☐
Low Blood Pressure.....................	☐	☐	Ulcers...	☐	☐
High Blood Pressure....................	☐	☐	Thyroid Problems..............................	☐	☐
Other Congenital Heart Defects.	☐	☐	Stroke..	☐	☐
Mitral Valve Prolapse..................	☐	☐	Glaucoma......................................	☐	☐
Pacemaker.....................................	☐	☐	Chronic Colitis..................................	☐	☐
Rheumatic Fever..........................	☐	☐	Hepatitis / Liver Disease...............	☐	☐
Blood Clots....................................	☐	☐	Epilepsy..	☐	☐
Abnormal Bleeding......................	☐	☐	Neurological Disorders.................	☐	☐
Anemia...	☐	☐	*If yes, specify...........................*	______	
Hemophilia.....................................	☐	☐	Sleep Disorder...............................	☐	☐
AIDS or HIV Infection...................	☐	☐	Mental Health Disorders............	☐	☐
Arthritis..	☐	☐	Anxiety...	☐	☐
Autoimmune Disease.................	☐	☐	Depression......................................	☐	☐
Rheumatoid Arthritis..................	☐	☐	Kidney Problems............................	☐	☐
Psoriatic Arthritis........................	☐	☐	Rapid Weight Loss..........................	☐	☐
Chron's Disease.............................	☐	☐	Gall Bladder Disease......................	☐	☐
Asthma...	☐	☐	Excessive Urination.......................	☐	☐
Bronchitis.......................................	☐	☐	STD..	☐	☐
Emphysema...................................	☐	☐	*If yes, specify............................*	______	
Osteoporosis.................................	☐	☐			

	Yes	No
Joint Replacement: Have you had an orthopedic total joint replacement?............................	☐	☐
If yes, specify: ______________________________		
Do you have any condition or problem not listed above that we should know about?...........	☐	☐
Have you seen any change in your general health during the last year?.........................	☐	☐
If yes, what was the illness or problem? ______________________		

Family History

Has your mother or father ever had any of the following?

Mother:

- ☐ Cancer
- ☐ Diabetes Type 2
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol

Father:

- ☐ Cancer
- ☐ Diabetes Type 2
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Other: ____________________
- ☐ Other: ____________________

Social History

Tobacco Use:

Have you ever smoked or vaped? ☐ Yes ☐ No

If yes:

☐ Current – Daily Smoker ☐ Former Smoker # of packs/day: ____________________

☐ Current – Some Days # of years: ____________________

Alcohol:

Do you drink alcohol? ☐ Yes ☐ No

If yes:

☐ Daily ☐ Infrequently # of drinks/week: ____________________

☐ Socially

Exercise:

Do you exercise? ☐ Yes ☐ No

If yes:

☐ Daily ☐ 2-3 times / week Type of exercise: ____________________

☐ 3-4 times / week ☐ Occasionally

NOTE: Both doctor and patient are encouraged to discuss any and all relevant health issues prior to treatment.

I hereby certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my physician and staff will rely on this information. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my physician or any other member of staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature ____________________ Date ____________________

FAQ'S

Welcome Valued Patients to Aylett Family Wellness! The following are our current patient guidelines for existing patients as well as new patients:

MISSED APPOINTMENTS:

If you are unable to make your appointment, please can and either cancel or reschedule otherwise you may be charged for the visit. ***If you miss 2 appointments without calling or cancelling, then you may no longer be allowed to make appointments.***

TELEPHONE CALLS:

The physicians and clinical staff at Aylett Family Wellness attempt to be thorough and complete during your visit, which includes answering all your questions. You might notice that the provider you see is rarely interrupted by a telephone call during your visit. This is because we ask our patients to respect one another's time by saving questions for their appointment. We encourage patients to write down all questions and have them ready for their appointed provider.

In other words, Aylett Family Wellness physicians and nurses do not accept phone calls unless there are unusual circumstances. If you have a clinical question that you feel cannot wait until your next regularly scheduled visit, you may call Aylett Family Wellness**.** Your question will be assessed and triaged according to the clinical significance and responded to accordingly.

INSURANCE:

As a courtesy, Aylett Family Wellness will file all claims to your insurance carriers for services provided. In order to extend this courtesy, we will need a picture ID and copy of insurance cards. Services that are performed by Aylett Family Wellness may require preauthorization from your insurance carrier. Insurance coverage varies widely; we strongly recommend that you become familiar with your policy and the benefits or restrictions that are specific to your plan. **If any changes in your insurance coverage or benefits occur while being treated at Aylett Family Wellness you are responsible to notify us immediately.**

FINANCIAL POLICY:

I understand that if I am not **eligible** under the terms of my medical and hospital subscriber health insurance agreement, I am **liable for all charges for services rendered**. I understand that I am responsible for any and all charges should any legal representative, court cost, and collection charges as a result of any collection activity. I further understand that lack of financial responsibility on my part may result in dismissal from the clinic.

CO-PAYS/ DEDUCTIBLES

If your insurance coverage requires co-pay, it will be collected when you check in or billed, before you see your provider. Deductibles are determined by your insurance company, and Aylett Family Wellness will notify you of your responsibilities after explanation of benefits are received.

MEDICAL RECORDS

If you request medical records from Aylett Family Wellness, there is no charge.

______________________________________ ____________

Patient/Responsible Party Signature Date

PATIENT ACCOUNT TERMS & WAIVER OF LIABILITY

Billing:

Upon admission to Aylett Family Wellness, you have contractually agreed to pay for services rendered to you. If you have health insurance coverage, Aylett Family Wellness will agree to file your initial claim(s), provided we have complete insurance information and your Insurance forms at the time of admission (if forms are required). However, your health insurance contract(s) are between you and the insurance carrier. Because of this relationship, it is your primary responsibility to pay for services and provide follow-up communication with your health insurance carrier(s), if necessary. Regarding your insurance, they could deny payments for Office Visits & Clinical Procedures for one of the following reasons:

1. **Not a covered benefit**
2. **Not medically necessary**

Should your health insurance reject our claim for any reason, you are financially responsible. If your health insurance coverage requires the insured to pay a deductible and percentage or a copay, these amounts will be due the day of service. We will try to give you an estimate of the amount you may owe before your visit. Payment can be made by cash, Visa, MasterCard, Discover Card, or American Express. We do not accept checks.

If you do not have health insurance you will be required to pay for all services at the time they are received. Liens will **NOT** be accepted under any circumstances.

Missed Appointments:

Any appointment not cancelled with a 24 hour notice may be assessed a fee, as follows:

- Follow Up Evaluation $50.00
- Scheduled Procedure $100.00

These fees will need to be paid before another appointment can be scheduled.

Medicare:

Aylett Family Wellness participates with Medicare and will accept what Medicare allows. Aylett Family Wellness will bill Medicare for you. However, Medicare is a co-pay carrier, which means they will pay 80% of the allowed charges. You will be responsible for 20% of the allowed charges plus any deductible. These amounts will be due the day of service unless you have a supplementary insurance.

Agreement:

I have acknowledged that I understand and have received a copy of this notice. I agree to make payment for services rendered by Aylett Family Wellness according to the above terms. I authorize my Insurance to send payment directly to Aylett Family Wellness. I agree to pay a finance charge of one and half percent (1 ½ %) per month on all amounts due to and owing to Aylett Family Wellness.

____ __________________

Patient Name (*printed*) Date

____ __________________

Patient Signature Date

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PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

NOTICE OF PRIVACY PRACTICES

_______**(Patient Initials)** I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

RELEASE OF INFORMATION

_______**(Patient Initials)** I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other Aylett Family Wellness affiliated facilities may be made available to subsequent Aylett Family Wellness affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other healthcare industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

CONTINUED ON NEXT PAGE

DISCLOSURES TO FRIENDS AND/OR FAMILY MEMBERS

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

I give permission for my protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

AUTHORIZATION TO RELEASE INFORMATION TO:

Name(s)	**Relationship:**	**Contact Number:**
Name(s)	**Relationship:**	**Contact Number:**

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Note: This clinic uses an Electronic Health Record that will update all your demographics to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.

PRESCRIPTION ORDER PICK-UP

There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. For us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

I wish to designate individual(s) to pick up a prescription order on my behalf: ✈Yes ✈No

Name(s)	Name(s)

PATIENT FINANCIAL POLICY

_______(Patient/Guardian Initials) I acknowledge that I have received, reviewed, understand, and will comply with the policies explained in the Aylett Family Wellness Patient Account Terms Form.

CONTINUED ON NEXT PAGE

CONSENT FOR PHOTOGRAPHING OR OTHER RECORDING FOR SECURITY AND/OR HEALTH CARE OPERATIONS

_______(Patient/Guardian Initials) I consent to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recording will be securely stored and protected. Images and/or recordings in which I am identified will not be released and or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted by law.

CONSENT TO EMAIL OR TEXT MESSAGE USAGE FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS:

We want to stay connected with our patients.

Patients in our practice may be contacted vial email and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If at any time, you provide an email address or text number below, you understand that you may get these communications from the practice. You may opt out of these communications at any time. The practice does not charge for this service, but standard messaging rates may apply as provided in your wireless plan (contact your wireless carrier for pricing plans and details).

CELL PHONE AUTHORIZED:	**EMAIL AUTHORIZED:**
Opt Out of text and email alerts ✈**Yes** ✈**No**	

PATIENT ATTESTATION:

I attest that all of the information providers is correct and true to the best of my knowledge.

Patient/Guardian Signature:	**Date:**
Patient/Guardian Name (Printed):	**Date:**