STEPHENS CITY
FAMILY MEDICINE, LLC

Dr. Jennifer Carter
Dr. Chris Craig
Dr. Joel Grant
Jordan Pacilla, NP-C
Krista Schofield, PA-C
160 Warrior Drive • Stephens City, VA 22655
office: 540-868-4100 • fax: 540-868-0888

www.scfammed.com

Dear Patient,

Thank you for contacting Stephens City Family Medicine and requesting a welcome packet for **patients under the age of 18 years**. We are located in the Sherando Towne Centre near Miller's Hardware, Walgreens, First Bank and Children of America. Our office strives to provide quality care for the whole family. We also offer a wide range of pediatric care for children of all ages enabling you to go to one place for care for the entire family. ***Please note, we are not accepting new pediatric patients who will not receive routine vaccinations as recommended by the CDC, or who plans to not continue to receive recommended child and adolescent vaccinations.*** If you would like to establish your family with our practice, please take time to complete the appropriate age packet for each family member and return it to our office. To meet the needs of your family we have five providers in our office, Drs. Carter, Craig and Grant along with Jordan Pacilla who is a Nurse Practitioner and Krista Schofield who is a Physician Assistant. They work hard to ensure you receive proper medical care when needed.

We are providers with the following insurance companies: Anthem, Aetna, Medicaid, Sentara (HMO Medicaid), Medicare, Sentara Health Plans, Mamsi, Optimum Choice, One Net, Virginia Health Network, United Healthcare, Humana Military (Tricare) and Cigna. We are not in-network with Anthem Healthkeepers. **It is your responsibility to make sure we are a provider with your plan. We may be a provider with your insurance but please verify we are a provider with your specific plan type. Please call the member service number located on the back of your insurance card and verify directly with your insurance.**

If you are currently on pain medications, we do not take new pain management cases. We require all patients on chronic pain medications to be followed by a pain management specialist to help manage pain and medications.

Please take the time to read and complete the entire welcome packet. **All** forms must be completed (both sides) and signed in order for our office to schedule you an appointment. *Welcome packets must be filled out for each patient.*

Once you have completed the packet, please return it to our office either by dropping it off at our office, by fax or by mail. Once the packet has been reviewed by a provider our office will call to schedule your initial visit appointment. It is not unusual for the initial visit to be scheduled out as far as a month. *Initial visits are required for all patients prior to being seen for an acute (sick) visit.* Once you are established, we can normally see you for acute visits on the same or next day. Due to the amount of time allotted for initial visits, please give at least a 24-hour notice if you need to reschedule. However, after the third rescheduling our office **will not** reschedule your initial visit, which means you will not become our patient. If you fail to show for your initial visit without rescheduling, our office **will not** reschedule your appointment, which means you will not become our patient. If you have any questions about these forms, please feel free to contact our office.

Sincerely,
Monica Hott
Office Manager

Hours:
By Appointments Only
Monday- Friday: 7:00 am- 5:00pm
Closed for lunch 12:00pm – 1:30pm

FINANCIAL POLICY

This form requires an electronic signature and will be obtained at your first appointment.

Payment Responsibility: Patients or their legal representative are ultimately responsible for all charges for services rendered. Payment is expected at time of service for all co-pays as well as any prior balance. We will NOT bill any co-pays as we are contractually required by insurance carriers to collect co-pays at the time of service. Claims will be submitted to your insurance carrier(s) and you are responsible for any deductible, coinsurance, and/or non-covered services. Per contractual obligations we cannot waive co-pays, coinsurance or deductibles. Statements are generated on a 28 day cycle. Balances are due from the patient/legal representative in full upon receipt of statement unless other arrangements have been made. Patients with an outstanding balance for more than 90 days may be referred to an outside collection agency and will be responsible for collection/attorney's fees in addition to the balance owed.

*For Physical Exams/Annual Wellness Visits for which you require additional services for health problem(s) beyond the scope of the physical/wellness exam, an additional charge will be incurred, and you will be asked to pay any co-pays or patient responsibility amounts.

Self-pay: If you are uninsured or have an insurance we do not participate with, you are responsible for remitting payment in full at the time of service. A deposit for services will be required at check-in and the difference for charges incurred will be settled at check-out.

- New Patients: $225 deposit
- Established Patients: $140 deposit

Liability/Motor Vehicle Accident: We will file Motor Vehicle Accident (MVA) claims to health insurance carriers only for reimbursement. In the event the claim is not paid in full by the health insurance carrier, it is the patient's responsibility to pay the claim within 30 days. Per the patient's request, a receipt can be provided to the patient for direct reimbursement from the car accident carrier or legal representative.

Late Arrivals, Cancellations and No-Shows: The following fees are not covered by your insurance.

- If an appointment is not cancelled at least 24 hours in advance you will be charged a $25 fee;
- If you fail to show to an appointment, you will be charged a $50 fee;
- If you arrive late to an appointment, we have the right to reschedule the appointment. If you continue to arrive late to appointments, you will be charged a $50 fee.

Insurance Authorization and Assignment: I authorize and give permission to Stephens City Family Medicine, LLC to release billing and medical information, to include the transcript of my medical records to my insurance carrier(s) upon their request, for the purpose of determining benefits payable under the contract. I assign to Stephens City Family Medicine, LLC any and all benefits incurred for the services provided by them. I request that payment of authorized insurance benefits be made on my behalf to Stephens City Family Medicine, LLC for any services furnished to me.

I request that payment of authorized Medicare Benefits be made on my behalf to the provider for any services rendered to me by the physician. I authorize any holder of medical information about me to be released to the Centers for Medicare and Medicaid Services, and its agents, any information needed to determine these benefits payable for related services.

I have read and/or been advised to read the entire Financial Policy.

_____ _____

Signature of Patient or Responsible Party Date

STEPHENS CITY
FAMILY MEDICINE, LLC

Authorization for Disclosure of Protected Health Information

I Authorize The Use / Disclosure Of Health Information About Me As Described Below

Patient Name:_____ Date of Birth:_____
(Please Print)

Contacts:

Name	Relationship to Patient
Home Phone #	**Mobile Phone #**

Name	Relationship to Patient
Home Phone #	**Mobile Phone #**

Name	Relationship to Patient
Home Phone #	**Mobile Phone #**

1) I understand that this authorization will expire one (1) year from today's date.
2) I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Stephens City Family Medicine, LLC in writing.
3) I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4) I may inspect or copy any information used or disclosed under this agreement.
5) I understand that, if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations.

The receptionist wil input the above information upon completion and obtain an electronic signature from the patient or legal guardian.

Notice Of Deemed Consent To HIV Blood Testing

I have been informed by this notice that a law was enacted in Virginia in 1989 and 1993 which authorizes the hospital to test me for Human Immunodeficiency Virus (HIV) and Hepatitis B or C antibodies when any health care provider is exposed to my body fluids in a manner which may transmit HIV and Hepatitis B or C. Pursuant to this law, in the event of such an exposure, I am deemed to have consented to such testing, and to have consented to the release of the test results to the health care provider who may have been exposed.

IF PATIENT IS UNABLE TO SIGN OR IS A MINOR, COMPLETE THE FOLLOWING:

_____
Signature of closest relative or guardian

_____
Signature of Witness

_____
Relationship to Patient

STEPHENS CITY
FAMILY MEDICINE, LLC

CONFIDENTIAL PATIENT INFORMATION

Stephens City Family Medicine
160 Warrior Drive, Stephens City, VA 22655 Today's Date:
____/____/____
540-868-4100 New Patient___ Established Patient___

PLEASE PRINT CLEARLY

PATIENT INFORMATION:

Name:_____ Birth Date: ___/___/_____ Social Security #:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Cell Phone Carrier: _____

E-mail:_____

Male____ Female____ Marital Status: Single_____ Married_____ Divorced_____ Widowed _____

Mailing Address:_____
Street City State Zip Code

Race: American Indian___ Asian___ African American ___ Native Hawaiian or Pacific Islander ___ White___ Declined___

Ethnicity: Hispanic or Latino ___ Not Hispanic or Latino ___ Declined ___

Preferred Language: _____

Place of Employment: _____ Address:_____ How Long:_____
(Patient) Company Name Company Address

Nearest Relative not living with you: Name:_____ Phone:_____

Spouse Name: _____ Birth Date: ___/___/_____ Social Security#: _____

Place of Employment: _____ Address:_____ How Long:_____
(Spouse) Company Name Company Address

RESPONSIBLE PERSON'S INFORMATION (This section only needs to be filled out if patient is a minor, under age 18):

Name:_____ Birth Date: ___/___/_____ Social Security #:_____

Mailing Address:_____
Street City State Zip Code

Home Phone:_____ Work Phone:_____ Cell Phone: _____

Place of Employment: _____ Address:_____ How Long:_____
Company Name Company Address

Place of Employment: _____ Address:_____ How Long:_____
(Other Parent) Company Name Company Address

INSURANCE INFORMATION:

Insurance Company:_____ Policy Name Under:_____ Birth Date: ___/___/_____

Policy #:_____ Group Name or #:_____

Secondary Insurance Company:_____ Policy Name Under:_____

Policy #:_____ Group Name or #:_____

PATIENT AND RESPONSIBLE PARTY AUTHORIZATION

I authorize Stephens City Family Medicine for _____ (patient) to apply for benefits on my behalf for the covered services rendered and request that payments from the above named insurance company(ies) be made directly to Stephens City Family Medicine for the treated person named. 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 to be used in place of the original. IN ALL CASES, PROFESSIONAL FEES ARE THE PATIENT, SPOUSE, GUARDIAN AND/OR PARENTS' RESPONSIBILITY. Finance Charge (no charges if paid in 30 days of billing date) may be computed by a "Periodic Rate" of 1 1/2% 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 past due debts.

Print Name:_____ Signature:_____ Date:____/____/_____

Signature from Stephens City Family Medicine:_____ Date: ____/____/_____

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Pediatric patients under the age of 18 years

All sections of this form must be completed. If a section is not applicable, please indicate "N/A."

Name: _____ Birthdate: _____ Today's date: _____

Why is your child coming in to be seen? _____

Who does your child see for medical care now? _____

Why are you changing practices (if applicable)? _____

Is your child up to date on vaccinations? (PLEASE NOTE: SCFM is not accepting new pediatric patients who have/will not receive routine vaccinations as recommended by the CDC.) If not fully up to date, please explain: _____

Medical Problems

(Include birth history if pertinent.)

Medication	Dose	Frequency

(Include prescriptions, supplements, vitamins, etc. Attach list if necessary)

Preferred Pharmacies	
Local	
Mail away	

Allergies	Reaction

Surgeries	Dates

Other Doctors/Providers	Specialty

Social History	
Others living at home	
Parental marital status	
Smoke-free home	
Smoke detectors	
Pets	
Daycare	
Activities	

Family History	Age at death
Mother	
Father	
Siblings	
Maternal GM	
Maternal GF	
Paternal GM	
Paternal GF	

By signing below, I certify all information is true and correct to the best of my knowledge.

Parent/Guardian signature: _____ Today's date: _____

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Cancellation Policy and No-Show Policy

Effective June 2, 2017

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed medical care. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty-five-dollar ($25) fee; this will not be covered by your insurance.

If you fail to show to an appointment you will be charged a fifty-dollar ($50) fee; this will not be covered by your insurance.

We understand that delays can happen, however we must try to keep the other patients and doctors on time.

If a patient arrives late to an appointment we have the right to reschedule the appointment. If a patient continues to arrive late to appointments then a fifty-dollar ($50) fee will be charged; this will not be covered by your insurance.

By signing this cancellation policy and no-show policy, you are indicating that you understand and agree to the terms of service explained above. You are also indicating that you have given your permission to be charged and will be responsible for paying the charge in full within thirty days if any of the above stipulations apply to you.

Name of Patient: _____DOB:_____

Patient or Legal Guardian Signature: _____

Date: _____

If you are under the age of 30 we want a copy of your immunization record. Please complete so we can request your immunizations only.

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO STEPHENS CITY FAMILY MEDICINE.

Directions: Type or Print all requested information with exception of signatures on page 2.

Individual's Name: _____ Individual's ID Number: _____

Street Address: _____ Individual's Date of Birth: _____

City:_____ State: _____ Zip:_____ Phone: _____

I authorize the name or person/organization listed below to disclose the above-named individual's health information as described below to:

Stephens City Family Medicine, LLC, 160 Warrior Drive, Stephen's City, VA 22655

_____

Name of Person/Organization authorized to release the protected health information.

_____

Street Address

_____

City, State, ZIP

Phone Number: _____ Fax Number: _____

❑ Immunization Record Only

❑ Other: _____

_____

I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV Infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex) and any other communicable disease. It may also include information about behavioral or mental health services, and referral and/or treatment for alcohol and drug abuse.

This disclosure and use is for the following purpose(s):*

_____

_____

(*Note: The statement "at the request of the individual" is sufficient when the individual initiates an Authorization and does not, or chooses not to, state the purpose.) I understand that if I give permission, I have the right to change my mind and revoke it. This must be in writing to Stephen's City Family Medicine, LLC that maintains the individual's records that I authorized on Page 1 of this form. I also understand that any uses or disclosures already made with my permission cannot be taken back. If this authorization is needed as a condition to obtain health care coverage and I revoke it, then I understand that the above person/organization who would have received the information may have the right to contest health care coverage claims. Unless otherwise revoked, this authorization will expire on the following date, event or condition. (If I fail to specify an expiration date, event or condition, this authorization will expire one year from the signature date.)

Date, Event or Condition _____

I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or eligibility for benefits unless the information is necessary to demonstrate that I meet eligibility or enrollment criteria. By signing this Authorization, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. I further understand I may request a copy of this signed Authorization. I may inspect or copy any information used or disclosed under this agreement. I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be disclosed and would no longer be protected by these regulations.

_____

Patient's Signature or Patient's Representative **Date**

_____

Printed Name of Patient's Representative **Relationship to Patient**

Our Privacy Officer can be contacted as follows:

Monica Hott
Stephens City Family Medicine
160 Warrior Drive
Stephens City, VA 22655
540-868-4100 • 540-868-0888 fax

Stephens City Family Medicine Use Only

This authorization was revoked:

_____

Signature **Date**