FINANCIAL POLICY

If you are covered by an insurance carrier we will file a claim for you at no cost. Any balance remaining after insurance payment will be due immediately.

You are responsible for all charges regardless of any pending insurance. If your insurance plan does not pay because it is an HMO plan (a plan where you must see a physician in your network), whether commercial insurance or Medicare, you will be held responsible. We accept payment by cash, personal check, VISA or MasterCard. Payment is due at the time of service.

There will be a $25 charge for missed appointments if you do not notify our office at least 24 hours in advance of the appointment time.

All account balances are considered past due after 60 days.

There is a $10.00 charge for disability forms related to loan repayments, payable in advance.

We accept Virginia and NC workman's compensation, but the patient is required to provide us with the billing information. WE DO NOT ACCEPT OTHER STATE'S WORKMAN'S COMPENSATION.

In the event that your account shall have to be placed with an attorney or collection agency, you will be responsible for an attorney or collection fee of 25% of the balance due.

AUTHORIZATION TO RELEASE & RECEIVE INFORMATION AND TO PAY BENEFITS TO PHYSICIANS:

I, the undersigned, request and authorize the payment of Medicare and/or other insurance in whole or in part, services rendered to me, or one or more of my dependent(s), by SPECTRUM MEDICAL (CLINIC) to be made directly to the CLINIC, notwithstanding Section 38.2-2201 (B) of the Code of Virginia, 1950, as amended. If my treatment or the treatment of my dependent(s) relates to an injury for which I am entitled to recover for my personal injury from a third party, I hereby assign to the CLINIC such portion of my recovery sufficient to cover all charges for services rendered to me with respect to such injuries by CLINIC. I authorize any holder of medical information about me to release to the Healthcare Financing Administration and/or other insurance companies, and its agents, any information needed to determine these benefits or the benefits payable for related services.

I will allow Spectrum Medical and subsidiaries to release to any health care facility any medical records deemed necessary for my continued care. I will also allow them to obtain any medical records from my previous healthcare providers necessary for my current treatment.

SUBROGATION NOTIFICATION

Your plan may contain a Subrogation clause. It is necessary that we advise you that as a Participant in the plan (or your dependent), you must reimburse the plan for benefits paid by the plan from any monies you (or your dependent) receive, in whole or in part, from a judgment or settlement, made by a third party from any recovery. You, as the participant or the dependent, must also take action to assist the plan in recovering this reimbursement. You (or your dependent) must sign and deliver all necessary documents that the plan may need to enforce its rights to obtain reimbursements.

By signing below I indicate that I have read this financial policy and agree to its terms and authorizations.

Signed _____ Date _____

Responsible Party (if under 18) _____ Date _____

PATIENT INFORMATION

125 Executive Drive, Suites A & B
Danville, Virginia 24541

800 Memorial Drive
Danville, Virginia 24541

800 Memorial Drive, Suite D
Danville, Virginia 24541

PLEASE PRINT

LAST NAME | FIRST NAME | MIDDLE | NAME YOU LIKED TO BE CALLED

SEX | BIRTHDATE | SOCIAL SECURITY NUMBER

ADDRESS (location address if P. O. Box) | Apt.. # | CITY | STATE | ZIP CODE

( ) | ( ) | WORK HOURS
AREA CODE | HOME PHONE | AREA CODE | CELL PHONE

( )
REFERRING PHYSICIAN'S NAME & ADDRESS (Including CITY, STATE, and ZIP CODE) | AREA CODE | PHONE NUMBER

RACE | MARITAL STATUS | EMAIL ADDRESS

EMPLOYER | FT / PT | SHIFT | BUSINESS PHONE NO./EXT. | ARE YOU A STUDENT | FT / PT

EMPLOYER'S ADDRESS (Including City & State)

SPOUSE'S NAME | SPOUSE'S SOCIAL SECURITY NUMBER | SPOUSE'S BIRTHDATE

SPOUSE'S EMPLOYER'S NAME & ADDRESS | PHONE # | EXT.

PLEASE FILL IN YOUR MEDICAL INSURANCE INFORMATION, AND GIVE YOUR CARDS TO THE RECEPTIONIST.

A. Primary Ins. _____

ID# _____

B. Secondary Ins. _____

ID# _____

*** MUST SHOW CARD ***

COMPLETE ONLY IF PATIENT IS UNDER AGE 18 OR FULL-TIME STUDENT

FATHER'S NAME | DOB | ADDRESS (Including CITY, STATE, and ZIP CODE) | SOC. SEC. NO.

FATHER'S EMPLOYER | ADDRESS (Including CITY, STATE, and ZIP CODE) | PHONE NO. & EXT.

MOTHER'S NAME | DOB | ADDRESS (Including CITY, STATE, and ZIP CODE) | SOC. SEC. NO.

MOTHER'S EMPLOYER | ADDRESS (Including CITY, STATE, and ZIP CODE) | PHONE NO. & EXT.

PERSON TO BE NOTIFIED IN CASE OF ACCIDENT OR EMERGENCY **(NOT LIVING AT SAME RESIDENCE.)**

NAME: _____ TELEPHONE: _____

RELATIONSHIP TO PATIENT: _____ ADDRESS _____

OVER →

_____

PRIVACY POLICY ACKNOWLEDGEMENT

125 Executive Drive, Suites A & B
Danville, Virginia 24541

800 Memorial Drive Suite D
Danville, Virginia24541

1075 Spruce Street
Martinsville, Virginia 24112

By signing below I acknowledge I have been offered a copy of Spectrum Medical's Privacy Policy.

Patient Name _____

_____ _____
Signature Date

The following person or persons are authorized to obtain my medical information when needed:

Name	**Relationship To Patient**

HEALTH HISTORY FORM

Chart #_____

NAME _____ **DOB** _____ **TODAY'S DATE** _____

HEIGHT _____ **feet** _____ **inches** **WEIGHT** _____ **pounds**

IF FEMALE, ARE YOU OR COULD YOU BE PREGNANT?_____

PRIMARY CARE PROVIDER/FAMILY DOCTOR _____

REASON FOR TODAY'S VISIT AND DATE OF INJURY: _____

_____

HAVE YOU BEEN SEEN BY ANOTHER MEDICAL PROVIDER FOR THIS PROBLEM? ☐ Yes ☐ No

WHO? _____ **WHEN?** _____ **WERE XRAYS TAKEN?** ☐ Yes ☐ No

PAST MEDICAL HISTORY (If no medical problems please check here ____)

___Acute Bronchitis
___Acute Juvenile Rheumatoid Arthritis
___Anemia
___Anxiety/Depression
___Arthritis
___Asthma
___Blood Clot
___Cancer
___Cerebrovascular Accident (STROKE)
___Chronic Bronchitis
___Chronic Renal Failure (Kidney disease)
___COPD
___Coronary Artery Disease (Heart Disease)
___Diabetes Mellitus, Type I
___Diabetes Mellitus, Type II
___Fibromyalgia
___GERD (Acid Reflux)
___Gout
___Hepatitis
___HIV-positive
___Hyperlipidemia (High Cholesterol)
___Hypertension (High Blood Pressure)
___Hypoparathyroidism
___Multiple Sclerosis
___Myocardial Infarction (Heart Attack)
___Osteoporosis
___Rheumatoid Arthritis
___Seizure Disorder
___Thyroid Disease
___Tuberculosis
OTHER_____
_____

PAST SURGICAL HISTORY (If no previous surgeries please check here ____)

Have you ever had any problems with anesthesia?_____ Explain: _____

_____

CARDIAC SURGERY
___Coronary Angioplasty
___CABG (Bypass)
___Heart Surgery
___Heart Valve Surgery

DENTAL SURGERY
___Oral Surgery

EYE SURGERY
___Cataract Surgery
___Glaucoma Surgery

GENERAL SUGERY
___Abdominal Surgery
___Appendectomy
___Breast Surgery
___Gallbladder Surgery
___Hemorrhoidectomy
___Herniorrhaphy (Hernia)

GI SURGERY
___Hiatal Hernia Surgery
___Ulcer Surgery

HEENT SURGERY
___Deviated Septum Surgery
___Sinus Surgery
___Tonsillectomy

NEURO SURGERY
___Brain Surgery

OB/GYN SURGERY
___Hysterectomy

ORTHOPEDIC SURGERY
___Ankle Surgery
___Arthroscopy of Knee
___Arthroscopy of Shoulder
___Carpal Tunnel Surgery
___Femoral Rodding
___Foot Surgery
___Hand Surgery
___Hip Fracture Surgery
___Humeral Rodding
___Shoulder Surgery
___Tibia Rodding
___Total Hip Replacement
___Total Knee Replacement

PULMONARY SURGERY
___Lung Surgery

SPINE SURGERY
___Back Surgery
___Neck Surgery

UROLOGICAL SURGERY
___Bladder Surgery
___Prostate Surgery

VASCULAR SURGERY
___Carotid Artery Surgery
___Leg Circulation Surgery

OTHER SURGERY (That Is Not Listed Above) _____

_____

NAME _____ **Chart #**_____

SOCIAL HISTORY

Occupation _____

Do you drink alcohol? ☐ Yes ☐ No How much and how often? _____

Do you smoke tobacco? ☐ Yes ☐ No How much and how long? _____

If you smoked previously and quit, when did you quit? _____

Do you have a history of substance abuse/recreational drug use? ☐ Yes ☐ No What drug(s)? _____

FAMILY HISTORY

___No Pertinent Family History
___Asthma
___Bleeding Disorder
___Blood Clots
___Cancer
___COPD
___Diabetes Mellitus
___Heart Disease
___Hypertension (High Blood Pressure)
___Kidney Disease
___Mental Illness
___Osteoarthritis
___Osteoporosis
___Rheumatoid Arthritis
___Seizure Disorder
___Stroke
___Thyroid Disorder

OTHER MEDICAL PROBLEMS NOT LISTED _____

ALLERGIES

CONTACTANTS
___Adhesive Tape
___Detergents
___Latex
___Metal
___Nickel
___Soaps

ENVIRONMENTAL
___Animal Dander
___Dust
___Insect Bites
___Insect Stings
___Poison Ivy
___Pollen
___Trees

FOODS
___Eggs
___Milk
___Nuts
___Shellfish

MEDICATIONS
___Aspirin
___Betadine
___Codeine
___E-mycin
___Iodine
___Morphine
___NSAIDS
___Penicillins
___Sulfa
___Keflex
___Ampicillin
___Cipro

OTHER ALLERGIES NOT LISTED_____

MEDICATIONS

Pharmacies you use:

Local _____ Mail Order _____

** Please list all medicines (prescription and non-prescription), vitamins, home remedies, birth control pills, herbs, etc. Include dosages and frequency that medicines are taken.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

REVIEW OF SYSTEMS – Are you currently having any difficulty with the following:

___Chills
___Fatigue
___Fever
___Bruising
___New Skin Lesions
___Skin Color Changes
___Skin Ulcers
___Head Injury
___Neck Pain
___Neck Stiffness
___Cough
___Difficulty Breathing
___Chest Pain
___Fainting/Blacking Out
___Rapid Heart Rate
___Abdominal Pain
___Change in Bowel Habits
___Change in Bladder Habits
___Decreased Range of Motion of a Joint
___Joint Pain
___Joint Redness
___Joint Stiffness
___Joint Swelling
___Muscle Pain
___Muscle Weakness
___Swelling of Extremities
___Numbness
___Unusual Sensation
___Tingling
___Anxiety
___Depression
___Abnormal Bleeding

OTHER (please explain) _____

INJURY INFORMATION QUESTIONNAIRE

We **must** have the following information filled out for your insurance claim to be processed. If the following information is not filled out completely, we will have to ask you to pay your bill in full each visit, because insurance companies now require this information.

1. Patient's Name _____

   If under 18, Responsible Party _____

2. Date of Birth _____ SS# _____

3. Date of injury and body part being effected _____

   _____

4. How did the injury occur? _____

   _____

5. Is this a school related sports injury? _____

6. Where did the injury occur? (If school, name of school) _____

   _____

7. Did this happen at work? ☐ Yes ☐ No
   (if Yes, please fill out the Workman's Compensation Information sheet)

8. Is this related to an automobile accident? ☐ Yes ☐ No
   (if Yes, please fill out the Auto Accident Information sheet)

9. Is there any other insurance involved? ☐ Yes ☐ No

   (if Yes, what insurance company?_____)

Signature _____ Date _____

_____

WORKMAN'S COMPENSATION INFORMATION

We **must** have the following information filled out for your insurance claim to be processed. If the information is not filled out completely, you will be asked to pay your bill in full each visit. Insurance companies now require this information.

1. Patient's Name _____
2. Date of Birth _____ SS# _____
3. Date of Injury _____
4. How and where did the injury occur? _____
5. Name of Employer _____
6. Address of Employer _____
7. Phone Number of Employer _____
8. Workman's Comp Insurance Carrier _____
9. Workman's Comp Address _____
10. Workman's Comp Phone Number _____
11. Claim # _____

The information provided on this Statement of Workman's Compensation is complete and true to the best of my knowledge.

Signature _____ **Date** _____

125 Executive Drive, Suite A ◆ Danville, VA 24541 ◆ Phone 434/793-4711 ◆ Fax 434/797-5448
spectrummed.com

AUTO ACCIDENT INFORMATION

125 Executive Drive, Suites A & B
Danville, Virginia 24541

800 Memorial Drive Suite D
Danville, Virginia 24541

1075 Spruce Street
Martinsville, Virginia 24112

Date of your accident _____

In your own words give your account of the accident: _____

_____

_____

Was your own personal car involved? ☐ Yes ☐ No

If YES give the name of your car insurance company

Address _____

Policy # _____

Were you a passenger in someone else's car? ☐ Yes ☐ No

Were you hit by another person's car? ☐ Yes ☐ No

Name of other person's car insurance company _____

Address _____

Claim # _____

If you have hired an attorney, please provide us with that information:

Name _____

Address _____

Phone # _____

The information provided on this Auto Accident statement is complete and true to the best of my knowledge.

Signature _____ **Date** _____