MAHONEY FAMILY MEDICINE
100 College Drive
Martinsville, VA 24112
PHONE (276)666-0500 FAX (276) 666-0400

REGISTRATION FORM

Date _____

PATIENT NAME: _____ **SSN:** _____

DATE OF BIRTH: _____ **SEX:** Male / Female **MARITAL STATUS:** _____

MAILING ADDRESS: _____ **CITY:** _____

STATE: _____ **ZIP:** _____ **HOME PHONE:** (_____)_____

WORK PHONE: (_____)_____ **CELL PHONE:** (_____)_____

EMPLOYER: _____ **TITLE/DEPT:** _____

GUARANTOR INFORMATION (Person Financially Responsible):

NAME: _____ **RELATIONSHIP:** _____

MAILING ADDRESS (If different from above): _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: (_____)_____ **CELL PHONE:** (_____)_____

EMPLOYER: _____ **WORK PHONE:** (_____)_____

IN CASE OF AN EMERGENCY:

CONTACT #1: _____ **RELATIONSHIP:** _____

HOME PHONE: (_____)_____ **CELL/WORK PHONE:** (_____)_____

CONTACT #2: _____ **RELATIONSHIP:** _____

HOME PHONE: (_____)_____ **CELL/WORK PHONE:** (_____)_____

PRIMARY INSURANCE (Please present card for copying):

INSURANCE COMPANY: _____ **POLICY #:** _____

GROUP #: _____ **INSURED NAME:** _____

RELATIONSHIP: _____

SECONDARY INSURANCE (Please present card for copying):

INSURANCE COMPANY: _____ **POLICY #:** _____

GROUP #: _____ **INSURED NAME:** _____

RELATIONSHIP: _____

****PLEASE KEEP US UPDATED ON ANY CHANGES IN YOUR PERSONAL DATA****
– Name, Address, Phone Numbers, or Insurance Carriers, etc.—

REGISTRATION FORM CONTINUED:

***** PAYMENTS ARE EXPECTED WHEN SERVICE IS RENDERED, UNLESS ARRANGEMENTS HAVE BEEN MADE PRIOR TO YOUR APPOINTMENT. ALL CO-PAYS ARE DUE AT THE TIME OF SERVICE. IF WE ACCEPT YOUR INSURANCE WE WILL AUTOMATICALLY FILE IT FOR YOU, HOWEVER, YOU ARE RESPONSIBLE FOR YOUR PORTION. IF YOUR DEDUCTIBLE HAS NOT BEEN MET, YOU WILL HAVE TO PAY IN FULL. *****
(We accept Cash, Check, Visa, Mastercard, and Discover Credit Cards)

ABN NOTICE: Medicare and some insurances can deny payment for certain services rendered if they are a non-covered service (ex: B-12 Shots.) Our staff may be of some assistance in this, but it is ultimately the patient's responsibility to know what their specific policy covers. Please sign stating you have been made aware and that if Medicare/Insurer denies payment, you agree to be personally and fully responsible for allowable charges.

PATIENT/LEGAL GUARDIAN SIGNATURE: _____

DATE: _____

PRIVACY PRACTICE ACKNOWLEDGEMENT

I have received/reviewed the Notice of Privacy Practices and I am signing stating that I acknowledge and understand the meaning of its content. (This is posted in the waiting area and printout available upon request.)

NAME: _____ BIRTHDATE: _____

SIGNATURE: _____ TODAY'S DATE: _____

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTH CARE INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

THIS AUTHORIZES Mark T. Mahoney, D.O., P.C. / Karen Garrett, PA-C / Susan Weeks, NP-C TO REQUEST AND RECEIVE, FROM THE VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS, ANY AND ALL RECORDS HELD BY THE DEPARTMENT, RELATING TO SCHEDULE II-V CONTROLLED SUBSTANCES DISPENSED TO THE PATIENT NAMED ABOVE.

I UNDERSTAND THAT THIS AUTHORIZATION PERMITS THE DEPARTMENT OF HEALTH PROFESSIONS TO DISCLOSE CONFIDENTIAL HEALTH CARE RECORDS TO THE PRESCRIBER NAMED ABOVE. A COPY OF THIS AUTHORIZATION SHALL BE INCLUDED WITH MY ORIGINAL RECORDS. THERE IS A POTENTIAL FOR ANY INFORMATION DISCLOSED PURSUANT TO THIS AUTHORIZATION TO BE SUBJECT TO RE-DISCLOSURE AS PERMITTED OR REQUIRED BY LAW.

I UNDERSTAND THAT, IF NOT PREVIOUSLY REVOKED, THIS CONSENT WILL EXPIRE ONE YEAR AFTER THE DATE OF MY SIGNATURE, UNLESS OTHERWISE SPECIFIED.

_____ _____

PATIENT/LEGAL GUARDIAN SIGNATURE **DATE**

(Please list relationship if you are not the patient)

***NOTE*: This authorization form is in addition to, and separate from, any other disclosure forms that you may have signed.**

* AUTHORIZATION FOR TREATMENT *

MAHONEY FAMILY MEDICINE
100 College Drive
Martinsville, VA 24112
PHONE # (276) 666-0500 FAX # (276) 666-0400

Authorization for Medical Treatment

I hereby authorize and consent to the rendering of such medical care, including diagnosis and treatment as may be necessary in connection with my condition, by authorizing the treating physician and his/her designees or agents to perform such medical, surgical, and/or other procedures as deemed advisable by my physicians.

Deemed consent for blood-borne pathogens testing

I understand that in all confirmed cases where a health care provider or any person employed by or under the direction of a health care provider is directly exposed to blood or other body fluids in a manner which may transmit Human Immunodeficiency Virus (HIV), the virus that causes Acquired Immunodeficiency Syndrome (AIDS), and Hepatitis B or C to the release of such test results to the person who was exposed. Positive test results also may be disclosed as medically necessary in connection with the patients' medical treatment and as required or permitted by Virginia Law.

I understand that the HIV blood test is not a direct test for the virus. The sample of blood is tested in two ways to confirm a positive test result. I further understand that a positive test result does not mean that I have AIDS and that in order to diagnose AIDS, other means must be used in conjunction with the blood test. I understand that tests for antibodies to HIV may not be 100% accurate and may sometimes produce false positive or false negative results.

Insurance Authorization and Assignment

I hereby authorize the above stated physician to furnish information to insurance carriers concerning my illnesses and treatments, and I hereby assign to the physician all payments for medical services rendered to myself and/or my dependents.

***** I understand that my insurance will be filed as a courtesy to me, but after 60 days if payment has not been made, I will be responsible for the entire balance unless other arrangements have been made. *****

Parental/POA Authorization for Treatment of Minors/Elderly

Should any of my minor children or elderly relatives need immediate medical attention and I am unavailable to give my consent for treatment, this signed statement will serve as my authorization for you to proceed with whatever medical care you deem advisable until I can be reached.

I have read and understand all the information as stated above…

_____
INDICATE RELATIONSHIP, If other than patient

_____
Date

_____
Witness

_____
Signature

MAHONEY FAMILY MEDICINE
100 COLLEGE DRIVE
MARTINSVILLE, VA 24112
PHONE (276)666-0500 FAX (276)666-0400

INFORMED CONSENT & WRITTEN AGREEMENT FOR NARCOTIC TREATMENT

- I understand that narcotic drugs include pain medications such as *opoids* and *opiates.* Examples include Lorcet, Darvocet, Hydrocodone, Oxycodone, Propoxyphene, Morphine, and others. Certain anxiety medications called *Benzodiazepines* are also considered narcotics for the purposes of this agreement. Examples include Xanax, Valium, Ativan, Alprozalam, Diazepam, Lorazepam, and others.
- I understand there are significant risks to the use of narcotics. These include but are not limited to:
    - **Short term risks:** Drowsiness, dizziness, poor judgment, slow reaction, time, forgetfulness, nausea, constipation.
    - **Long term risks:** Depression, memory loss, chronic constipation, addiction (compulsive use of a drug in spite of adverse consequences), tolerance (requiring more drug to achieve the same effect), dependence (withdrawal symptoms when the medication is discontinued abruptly.)
- I understand that, in general, I may have narcotic drugs prescribed ***only*** by **Dr. Mark Mahoney / Karen Garrett, PA / Susan Weeks, NP.** (Schedule appointments well in advance. ***Do Not*** wait until the last minute before your medication runs out to find that you cannot get an appointment with your physician.)
- I will have my narcotic prescriptions filled at only one pharmacy.
- **PHARMACY** _____

  LOCATION _____

  PHONE/FAX # _____
- I understand that narcotics generally ***WILL NOT*** be refilled early, even if they are lost or stolen.
- I understand that I ***will not*** use any illegal controlled substances. Examples include marijuana, cocaine, acid, and others. Proven use of the substances voids our Physician-Patient relationship.
- I understand that narcotics ***WILL NOT*** be refilled by phone. Plan ahead – ***Do Not*** call to have narcotic prescriptions refilled. An office visit is required for this.
- I understand that Dr. Mark Mahoney/Karen Garrett/Susan Weeks reserves the right to refuse prescriptions of narcotic medications or terminate medical care entirely to any patient for reasons including, but not limited to, the following:
    - **a)** The patient is suspected or proven of filling narcotic prescriptions by other physicians.
    - **b)** The patient is suspected or proven of improper use of the narcotics. This may mean that the medications are being lost, stolen, taken for recreational use, or taken in a different manner than they were prescribed, or used for any purpose other than pain control.
    - **c)** The patient is suspected or proven of forging or tampering with any prescription –A felony crime.
    - **d)** The patient is not benefiting or has developed side effects from the medications.
- I understand that I may be requested to undergo periodic drug testing, and that refusal to undergo such testing may lead to refusal of narcotic prescriptions or termination of medical care.
- I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered.

****

This agreement is entered into on this_____ day of _____, _____.

Patient signature _____

Physician/Witness signature _____

PATIENT'S RIGHTS & RESPONSIBILITIES

STATEMENT OF PATIENT RIGHTS:

- **PATIENTS HAVE THE RIGHT TO BE TREATED WITH DIGNITY AND RESPECT.**
- **PATIENTS HAVE THE RIGHT TO FAIR TREATMENT REGARDLESS OF RACE, RELIGION, GENDER, ETHNICITY, AGE, DISABILITY OR SOURCE OF PAYMENT.**
- **PATIENTS HAVE THE RIGHT TO HAVE THEIR TREATMENT AND OTHER INFORMATION KEPT PRIVATE.**
- **ONLY IN LIFE-THREATENING SITUATIONS, OR IF REQUIRED BY LAW, CAN RECORDS BE RELEASED WITHOUT A SIGNED CONSENT FROM PATIENTS.**
- **PATIENTS HAVE THE RIGHT TO INFORMATION FROM STAFF/PROVIDERS IN A LANGUAGE THEY CAN UNDERSTAND.**
- **PATIENTS HAVE THE RIGHT TO AN 'EASY TO UNDERSTAND' EXPLANATION OF THEIR CONDITIONA ND TREATMENT.**
- **PATIENTS HAVE THE RIGHT TO KNOW ALL ABOUT THEIR TREATMENT CHOICES REGARDLESS OF COST COVERAGE.**
- **PATIENTS HAVE THE RIGHT TO GET INFORMATION ABOUT SERVICES OFFERED BY THEIR PROVIDERS AND THE PATIENT ROLE IN TREATMENT PROCESS.**
- **PATIENTS HAVE THE RIGHT TO REQUEST PROGESSIONAL INFORMATION ABOUT THEIR PROVIDER.**
- **PATIENTS HAVE THE RIGHT TO KNOW THE CLINICAL GUIDELINES USED IN PROVIDING AND/OR MANAGING THEIR CARE.**
- **PATIENTS HAVE THE RIGHT TO PROVIDE SUGGESIONS ON OFFICE POLICIES AND PROCEDURES.**
- **PATIENTS HAVE THE RIGHT TO KNOW ABOUT THE COMPLAINT, GRIEVANCE, AND APPEALS PROCESS.**
- **PATIENTS HAE THE RIGHT TO KNOW ABOUT FEDERAL AND STATE LAWS GOVERNING THEIR RIGHTS AND RESPONSIBILITES.**
- **PATIENTS HAVE THE RIGHT TO PARTICIPATE IN THE FORMATION OF THEIR CARE PLAN.**

STATEMENT OF PATIENT RESPONSIBILITIES:

- **PATIENTS ARE RESPONSIBLE FOR PROVIDING THEIR MEDICAL PROVIDER WITH INFORMATION NEEDED TO DELIVER QUALITY CARE.**
- **PATIENTS ARE RESPONSIBLE FOR INFORMING THEIR PROVIDER WHEN/IF THEIR TREATMENT PLAN IS NO LONGER EFFECTIVE.**
- **PATIENTS ARE RESPONSIBLE TO FOLLOW THEIR TREATMENT PLANS AND TO INFORM THEIR PROVIDER OF ANY CHANGES TO THE TREATMENT PLAN MADE BY OTHER PROVIDERS, INCLUDING ANY CHANGES IN THEIR MEDICATIONS.**
- **PATIENTS ARE RESPONSIBLE FOR REVIEWING THEIR CARE AND TREATMENT PLANS CONTINUOUSLY AND REPORTING EFFECTIVENESS OR INEFFECTIVENESS OF THE CARE PLAN TO THEIR PROVIDER.**
- **PATIENTS ARE RESPONSIBLE FOR TREATING THOSE GIVING THEM CARE WITH DIGNITY AND RESPECT.**
- **PATIENTS SHOULD NOT BE INVOLVED IN ANY CONSCIOUS BEHAVIOR THAT COULD HARM THE LIVES OF THEIR PROVIDER, OFFICE STAFF, AND OTHER PATIENTS.**
- **PATIENTS ARE RESPONSIBLE FOR KEEPING THEIR APPOINTMENTS, ARRIVING ON TIME, AND NOTIFYING THE OFFICE OF ANY CANCELLATIONS AT LEAST 24 HOURS PRIOR TO THE APPOINTMENT.**
- **PATIENTS ARE RESPONSIBLE FOR ADDRESSING QUESTIONS ABOUT THEIR CARE TO THEIR PROVIDER AND ENSURE UNDERSTANDING OF THEIR CARE AND THEIR ROLE IN THE TREATMENT PROCESS.**
- **PATIENTS ARE RESPONSIBLE FOR NOTIFYING THEIR PROVIDER OF ANY CONCERNS REGARDING PAYMENT OR INSURANCE COVERAGE.**

PERMISSION FOR RELEASE OF INFORMATION FORM

I give my permission for the staff of *MAHONEY FAMILY MEDICINE* to release information regarding my healthcare to the following:

NAME	RELATIONSHIP	PHONE/FAX #

PATIENT SIGNATURE _____

DATE SIGNED _____

I *DO NOT* give my permission for the staff of *MAHONEY FAMILY MEDICINE* to release information regarding my healthcare. I am rather requesting to staff to NEVER release my medical information to the following:

NAME	RELATIONSHIP	PHONE/FAX #

PATIENT SIGNATURE _____

DATE SIGNED _____