Joan Helena Rose, M.D., F.A.C.S.

Patient Information

Patient Name: _____ SSN: _____

Street Address: _____ City: _____ State: ____

Zip: _____Home Phone #: _____ Cell Phone#:_____ Gender: M F

Date of Birth: _____Age: _____ Email:_____ Marital Status: _____

Patient Employment Information

Employer: _____

Street Address: _____ City: _____ State: ____ Zip: _____

Work Phone #: _____ Job Title: _____

Patient's Spouse Information

Spouse's Name: _____ SSN: _____

Spouse's Employer: _____ DOB:_____

Street Address: _____ City: _____ State: ____ Zip: _____

Work Phone #: _____ Job Title: _____

Patient's Legal Guardian Information/If Applicable

Mother's Name:	**Father's Name:**
Social Security #:	Social Security #:
Employer:	Employer:
Street Address:	Street Address:
City/ST/Zip:	City/ST/Zip:
Work Phone #:	Work Phone #:
Job Title:	Job Title:

Patient's Contact Person (in the event of an emergency)**:**

Name: _____Relationship: _____Phone#_____

Street Address: _____ City: _____ State: ____ Zip: _____

Patient's Physician Information

Family Physician/Primary Care Doctor: _____Phone#_____

MD who Referred Patient to Dr. Rose: _____Phone#_____

Was the Patient seen in the emergency room? **Yes** **No**/ VBGH / CHESAPEAKE/ LEIGH/PA/ Other

Is there anyone you would like us to release to or share with your medical and billing information?

Name_____**Relationship**_____**Phone#**_____

Patient Insurance Information

Primary Insurance Carrier: _____

Insured Party Member #/I.D. #: _____ Group #: _____
Who is the Subscriber? Self Mother Father Spouse

Secondary Insurance Carrier: _____

Insured Party Member #/I.D. #: _____ Group #: _____
Who is the Subscriber? Self Mother Father Spouse

Worker's Compensation Information

Is this a job-related injury/condition that should be filed as Worker's Compensation? Yes No

If yes, date of injury: _____ Has the employer been informed? Yes No

Person who can verify W/C claim: _____ Phone #: _____

Treatment/Financial Responsibility/Privacy Practices Acknowledgements

I hereby apply for treatment by the above physician and associates. Such treatment may include injections, minor surgery, drawing of blood, and other such procedures as deemed necessary. I understand that payment for professional services is expected at the time of the visits. I accept responsibility to pay for all services rendered including appropriate deductibles and co-payments at the time of service. I further understand that I will fully pay for any non-covered service rendered by Hand Associates, P.C. I authorize release of any and all information – including medical records – necessary for collection of my account. I agree to pay, in addition to the outstanding fees, all costs of collection including attorney's fees (33% of balance due), court costs, and any and all legal fees to bring my account to solution. I understand that there is a $25 fee for any check returned from my bank if there are non-sufficient funds to cover the check. I agree to pay interest on any unpaid charges. I understand that it is not the policy of Hand associates, P.C. to file insurance for care unless the office participates with the contracted insurance company or if a hospital or office procedure is done. If insurance is filed by Hand Associates, P.C., it will be done with the understanding that I assign payment directly to Hand Associates, P.C. and not myself. I understand that my insurance policy is a contract between my insurance company and me and that I am ultimately financially responsible for any fees.

I concede that the information I have here provided is true and correct, and I agree to the terms stated above.

A law was enacted in Virginia in 1989 which authorizes health care providers to test their patients for HIV antibodies when the health care provider is exposed to the body fluids of a patient in a manner which may transmit human immunodeficiency virus (HIV). Pursuant to this law, in the event of such an exposure, you will be 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. However, you would be informed before and of your blood would be tested for HIV antibodies pursuant to this provision, the testing would be explained and you would be given the opportunity to ask any questions you might have. I have read and understand the notice "Notice of Deemed Consent to HIV Blood Testing"

I hereby acknowledge receipt of Hand Associates, PC.'s Notice of Privacy Practices.

Signature: _____ **Date:** _____
Signature of parent or legal guardian if patient is a minor or covered by parent's insurance

The receptionist will need to make a copy of your insurance and ID cards

Please be prepared to remit your copay before you are seen today.