DMV MEDICAL CONCIERGE

Physician House Call Service

(571) 484 4000 | info@dmvmedicalconcierge.com
8280 Willow Oaks Corp Drive Fairfax VA 22031

PATIENT INFORMATION FORM

FIRST NAME: _____ LAST NAME: _____

CONTACT NUMBERS:

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: (____) _____

ADDRESS:_____

CITY: _____ STATE: _____ ZIP CODE: _____ SEX: M____ F____

BIRTH DATE: _____/_____/_____ SS#: _____-_____-_____

Emergency Contact – Name_____Phone #_____

EMPLOYER: _____

Insurance Details (Primary Insurance)

PRIMARY INSURANCE COMPANY: _____

CLAIM'S ADDRESS: _____
STREET OR PO BOX CITY STATE ZIP CODE

INSURED'S NAME: _____ INSURED'S ID#: _____

INSURED'S GROUP #: _____ RELATIONSHIP TO INSURED: _____

INSURED'S DATE OF BIRTH: _____ INSURED'S SS#:_____

Secondary Insurance

SECONDARY INSURACE COMPANY: _____

CLAIM'S ADDRESS:

_____ STREET OR PO BOX

CITY STATE ZIP CODE

INSURED'S NAME: _____ INSURED'S ID#: _____

INSURED'S GROUP #:_____ RELATIONSHIP TO INSURED: _____

INSURED'S DATE OF BIRTH: _____ INSURED'S SS#: _____

Payment Guarantee and Assignment of Insurance Benefits

Consent to obtain medical services, allocation of benefits authorization, payment obligation, and Receipt of Notice of Privacy Practices I give my consent to receive medical treatment from practitioners affiliated with DMV Medical Concierge, and I accept that, regardless of insurance coverage, I am financially responsible for the services given to me by DMV Medical Concierge. For any services given to me by DMV Medical Concierge, I request that payment of approved Medicare or other health benefits be rendered on my behalf to DMV Medical Concierge. I allow and guide any holder of medical information or documents about me to release it to the Centers for Medicaid and Medicare Services, as well as its carriers and agents and Right to Know.

DMV Medical Concierge

Any details or documents required by DMV Medical Concierge and its billing officers, as well as any other payers or insurers, to assess these benefits or benefits payable for any services given to me by DMV Medical Concierge, now or in the future. I consent to immediately remit all payments received from any source for the services given to me to DMV Medical Concierge, and I transfer all rights to such payment to DMV Medical Concierge. The undersigned agrees to pay all charges incurred to DMV Medical Concierge, and if the account is handed over for collection, he/she agrees to pay all collection costs, including a collection fee equal to 33.3 percent of the total amount due and payable. On all outstanding balances, the undersigned here agrees to pay interest at a rate of 18% annually.

I also accept that DMV Medical Concierge handles the doctors' house calls and charges $65 per visit (management fee). This fee, I understand, is not covered by your medical benefits and must be paid out of pocket.

I, _____, also acknowledge DMV Medical Concierge has given me a copy of the Notice of Privacy Practices. For additional information and/or questions, I am aware that I may contact the privacy officer of DMV Medical Concierge.

_____ Patient Signature

_____ Date

_____ Patient Representative's

_____ Signature Relationship to Patient

HIPAA Notice of Privacy Practices

THIS NOTICE SPECIFIES HOW YOUR MEDICAL INFORMATION CAN BE USED AND DISCLOSED, AS WELL AS HOW YOU CAN GET ACCESS TO IT. PLEASE TAKE TIME TO READ IT CAREFULLY.

This Notice of Privacy Practices specifies how we can use and reveal your protected health information (PHI) for treatment, payment, or health-care operations (TPO), as well as for other legal purposes. It also demonstrates how you can get access to and monitor your safe health information. Protected health information refers to information about you, such as demographic data, that can be used to classify you and is relevant to your past, current, or potential physical or mental health or illness, as well as related health care services.

Uses and Disclosures of Protected Health Information

Your confidential medical information may be used and reported by your doctor, our office staff, and those interested in your care and treatment outside of our office for the purposes of offering medical services to you, paying your medical bills, supporting the physician's practice, and any other use permitted by law.

Treatment: Your confidential health records will be used and disclosed to provide, arrange, or administer your medical care and any associated services. This involves working with a third party to coordinate or administer the medical care. For example, if possible, we will report our protected health information to a home health provider that offers cares for you. Your confidential health records, for example, can be shared with a doctor to whom you have been referred so that the doctor has all of the information required to diagnose or treat you.

Payments: Your protected health information will be utilized to collect payment for your medical services as requested. For instance, acquiring approval for a stay in the hospital may necessitate disclosing your related protected health information to the health plan in order to obtain hospital admission approval.

Healthcare Operations: We can use or reveal your protected health information as required to support your doctor's practice's business operations. Quality assessment activities, employee evaluation activities, educating medical students, licensing, and conducting or planning for other business activities are all examples of these activities. We can, for example, share your protected health information with medical students who see patients at our clinic. When your doctor is ready to attend to you, we can address you by name in the waiting room.

We may contact you to notify you of your appointment using or disclosing your protected health information as required. Without your permission, we can use or reveal your protected health information in the following circumstances. These circumstances include: as required by law, public health problems as required by law, communicable diseases: health oversight: abuse or negligence: food and drug administration requirements: legal proceedings: law enforcement: coroners, funeral directors, and organ donation: research: criminal activity, military activity, and national security: compensation for employees: inmates: use and disclosure requirements: We are required by law to make reports to you and when the Secretary of the Department of Health and Human Services demands them to review or assess our compliance with Section 164.500. Unless allowed by statute, all permitted and authorized uses and disclosures will be rendered only with your consent, authorization, or opportunity to object. Except to the degree that your doctor or the doctor's practice has taken action in reliance on the use or disclosure stated in the authorization, you may revoke this authorization at any time in writing.