Virginia Beach Premier Medical, P.C.

PATIENT INFORMATION

Name (Last, First, M.I.):

Date of Birth: **Age:** **Sex:** M / F **Marital Status:** [ ]Married [ ]Single [ ]Divorced [ ]Widowed

Address: (Street) (City) (State) (Zip)

Phone: **Cell:** **Social Security:**

Work: **Referral Source:**

Email Address:

Pharmacy Name: **Phone:**

Location of Pharmacy:

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Name: Relationship to

Address: Date of Birth:

Phone: Cell: Social Security:

Work:

Employer's Address:

Emergency Contact Name:

Phone:

PRIMARY INSURANCE INFORMATION

Insurance Co:

Insured's Name: Relationship to Patient:

ID #: Date of Birth: Sex:

SECONDARY INSURANCE INFORMATION

Insurance Co:

Insured's Name: Relationship to Patient:

ID #:

Virginia Beach Premier Medical, P.C.

PATIENT RECORD DISCLOSURE: ADDENDUM TO HIPAA FORM

Patient:_____ Date:_____

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

- ☐ Home Telephone _____
  - ☐ Okay to leave message w/ detailed info
  - ☐ Leave message with call-back number only
- ☐ Work Telephone _____
  - ☐ Okay to leave message with detailed info
  - ☐ Leave message with call-back number only
- ☐ Written Communication
  - ☐ Okay to mail to my home
  - ☐ Okay to mail to my work/office
  - ☐
- ☐ Cell Phone: _____
  - ☐ Okay to leave message with detailed info
  - ☐ Okay to send Text Message Appt Reminders
  - ☐ Okay to send detailed Text Messages

I give my written consent for the following person(s) to receive and/or discuss information pertaining to my medical care at/with Virginia Beach Premier Medical, P.C., with their staff in the following manner (s).

Name	Relationship to Patient	Contact Phone Number	Can be Discussed
			Appt's / Billing / Medical Info / ALL
			Appt's / Billing / Medical Info / ALL
			Appt's / Billing / Medical Info / ALL
			Appt's / Billing / Medical Info / ALL
			Appt's / Billing / Medical Info / ALL
			Appt's / Billing / Medical Info / ALL
			Appt's / Billing / Medical Info / ALL

By signing below, I am acknowledging that I have been provided with a copy of Virginia Beach Premier Medical, P.C. Privacy Notice pursuant to the Federal regulations known as the HIPAA Privacy Rule

_____ _____

Patient Signature Date

_____ _____

Print Name Date

_____ _____

Employee Acknowledgement Date

Authorization for Release of Patient Medical Information

Attn: _____ Phone: _____

_____ Fax: _____

I hearby authorize the above party to release the following medical information to:

Virginia Beach Premier Medical, P.C.

Barbara Parks, M.D. / Nir Horev, M.D. / L. Rob Cajulis, M.D. / Ohad Sheffy, M.D.

1860 Colonial Medical Court, Virginia Beach, VA 23454

Phone: (757)416-6750 Fax: (757)416-6830

Patient Name: _____ Date of Birth: _____

SSN: _____ Phone: _____

Former Name if applicable: _____

☐ **Please release all records, including but not limited to, progress notes, operative notes, laboratory test results, diagnostic test, and x-rays.**

☐ **Please release the following records:**

Note: _____

_____

I understand that the information in my health record might include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavior or mental health services, genetic testing, and treatment for alcohol and drug abuse. This information will be released unless otherwise indicated:
DO NOT RELEASE: (INITIALS)

This authorization expires exactly one year from the date which it is signed. The patient has the right to cancel this authorization at anytime. Cancellation of this authorization must be submitted in writing. Each Virginia Beach Premier Medical, P.C. patient is provided with a copy of full HIPAA privacy policy guidelines when they arrive as a new patient. If you have any questions and would like an additional copy of the HIPAA guidelines you may request one at anytime.

_____ _____

Patient Signature (Parent or Guardian of Minor) Date

_____ _____

Witness Date

VBPM

BARBARA L. PARKS, M.D.
L. ROB CAJULIS, M.D.
NIR HOREV, M.D.
OHAD SHEFFY, M.D.
GREGORY J. WARTH, M.D. EMERITUS

PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Virginia Beach Premier Medical, P.C. is required by federal law to provide patients with a Notice of Privacy Practices that describes how medical information about you may be used and disclosed and how you can access this information.

By signing below, you acknowledge that you have received or have been offered the opportunity to receive a copy of the Notice of Privacy Practices from Virginia Beach Premier Medical, P.C.

This acknowledgment confirms only that you have received or had the opportunity to review the Notice. It does not indicate that you agree with any particular use or disclosure described in the Notice.

Patient Information

Patient Name: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____

Email Address (optional): _____

Acknowledgment

I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices for Virginia Beach Premier Medical, P.C.

Patient Signature: _____

Date: _____

BARBARA L. PARKS, M.D.
L. ROB CAJULIS, M.D.
NIR HOREV, M.D.
OHAD SHEFFY, M.D.
GREGORY J. WARTH, M.D. EMERITUS

If Signed by Personal Representative

Name of Representative: _____

Relationship to Patient: _____

Signature of Representative: _____

Date: _____

Office Use Only

If the patient or personal representative refuses to sign this acknowledgment, please document the attempt to obtain acknowledgment below.

Reason acknowledgment not obtained (check one):

☐ Patient declined to sign
☐ Patient unable to sign
☐ Emergency situation
☐ Other: _____

Staff Member Name: _____

Staff Signature: _____

Date: _____

My Current Prescription Medications, Over-the-Counter (OTC) Medications, Vitamins, Supplements, Herbal Products, and Traditional Cultural Medicines

Name of Medication	Reason Taken	Dose and Directions	Prescribing Provider	Notes

2023