PHYSICIAN ASSOCIATES OF VIRGINIA, P.C.
1421 Third Street, SW
Roanoke, VA 24016
(540) 345-4946 • (540) 345-8896
FAX (540) 343-7693

DANIEL V. BAUER, M.D., PhD — INTERNAL MEDICINE
CAROLYN CLARK, M.D. — FAMILY MEDICINE
BONNIE CULKIN, M.D. — GERIATRICS
JAMES GARDNER, M.D.
ANNE JAEGER, M.D.
EZEKIEL N. JONES, II, D.O.
SON NGUYEN, M.D.

Patient: _____

Date: _____

Appointment time: _____ *(Please arrive 30 minutes early)*

Doctor: _____

Welcome to Physician Associates of Virginia, P.C.!

Enclosed with this letter are several forms. Please complete the patient information and health history forms prior to your visit. When filling out the health history form, specific dates are not necessary. If you have any questions about these forms, the receptionist will be happy to help you when you come in for your appointment.

Please be sure to bring your Co-Pay (if applicable) and insurance cards with you so that we can verify your coverage. The Business Office will be happy to complete any insurance forms you may need. If you do not have health insurance, please call our Business Office before your scheduled appointment at 540-345-4946 or 540-345-8896. A brochure has been enclosed to tell you about our office. If you have any questions, please do not hesitate to call.

We look forward to meeting you.

Thank you,

The Physicians and Staff
Physician Associates of Virginia, P.C.

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PATIENT INFORMATION FORM

Cell Phone:
Email:

			ACCOUNT #		CLASS
PATIENT NAME (LAST, FIRST, MIDDLE)					
ADDRESS			CITY, STATE AND ZIP CODE		
SSN	SEX M F	MARITAL STATUS S M W Div	DATE OF BIRTH / /	PHONE NUMBER	
EMPLOYER AND ADDRESS			PHONE NUMBER		RELIGION

PLEASE COMPLETE SECTION BELOW IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR BILL

BILL TO NAME (LAST, FIRST, MIDDLE)			
ADDRESS		CITY, STATE AND ZIP CODE	
PHONE NUMBER	SSN	EMPLOYER	
IN CASE OF EMERGENCY NOTIFY NAME		PHONE NUMBER	RELATION

INSURANCE

BLUE SHIELD			**INS CODE**
SUBSCRIBER'S NAME			RELATION TO PATIENT (CHECK ONE) SELF__ SPOUSE __ DEP __ OTHER __
SUBSCRIBER ID #	GROUP	EFFECTIVE DATE	SUBSCRIBER'S DATE OF BIRTH (IF NOT PATIENT)
BLUE SHIELD PRIMARY YES ___ NO ___	MEDICARE POLICY YES ___ NO ___	EMPLOYEE SUPPLEMENTAL POLICY YES ___ NO ___	SUBSCRIBER'S EMPLOYER (IF DIFFERENT FROM PATIENT)

MEDICARE			**INS CODE**
SUBSCRIBER'S NAME (LAST, FIRST, MIDDLE)			POLICY #
EFFECTIVE DATE	COVERAGE (PLEASE CHECK) PART A ___ PART B ___	MEDICARE RAILROAD YES ___ NO ___	MEDICARE PRIMARY COVERAGE YES ___ NO ___

MEDICAID		**INS CODE**
NAME ON CARD (LAST, FIRST, MIDDLE)		MEDICAID CARD #
ORIGINAL DATE	EFFECTIVE DATE	END DATE

OTHER INSURANCE				INS CODE
NAME OF COMPANY	ADDRESS			POLICY #
SUBSCRIBER NAME			RELATION TO PATIENT (CHECK ONE) SELF __ SPOUSE __ DEP __ OTHER __	GROUP #
EFFECTIVE DATE	INSURANCE PRIMARY YES ___ NO ___	MEDICARE POLICY YES ___ NO ___	EMPLOYEE SUPPLEMENTAL POLICY YES ___ NO ___	
SUBSCRIBER'S DATE OF BIRTH (IF NOT PATIENT)			SUBSCRIBER'S EMPLOYER (IF NOT PATIENT)	

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Virginia State Law requires that should ANY EMPLOYEE of Physician Associates of Virginia be directly exposed to any of my blood or body fluids that my blood will be tested for HIV (AIDS test.). This is a way of protecting our employees and you as our valued patient.

Furthermore, if sufficient blood is not available for this test, I may be asked to return to this office to have my blood drawn for this AIDS test at no cost to me (the patient.)

This is pursuant to Virginia State Law, Code Section 32.1 - 36.1.

SIGNED: Patient_____

Responsible Party_____

(if minor or unable to sign)
Relationship_____

Date:_____

Witness: _____

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PERMISSION TO ACCESS ELECTRONIC MEDICATION HISTORY

I give permission to Physician Associates of Virginia to access my medication history. This information will be used to meet my medical needs.

SIGNED: Patient _____
DATE: _____

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGMENT FORM

I have received a copy of Physician Associates of Virginia, P.C.'s Notice of Privacy Practices.

SIGNED: Patient_____

Responsible Party_____

(if minor or unable to sign)
Relationship_____
Date:_____

Patient's Name: _____ DOB: _____

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FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

I authorize any applicable insurance carrier to make payments of insurance benefits directly to Physician Associate of Virginia (PAV) for services or supplies furnished to me by PAV. I authorize PAV to release to my insurance carrier such information as needed to determine and pay these insurance benefits. At PAV'S request, I will cooperate fully in filing and processing claims with my insurance carrier. I understand Federal regulations require such information to be kept confidential by the insurance carriers.

I understand and agree that I will remain responsible to PAV for payment of all fees and expenses charged by PAV for its services and supplies furnished to me or to the patient listed below. I will be financially responsible for any amounts not covered or paid (including annual deductible amounts) by the insurance carrier. I understand that I may feel free to discuss separate or total charges for these services with my physician or his agent.

I understand that PAV reserves the right to pursue delinquent accounts and may employ a collection agency after PAV's own collection efforts have failed. To communicate with you or to service your account or to collect any amounts you may owe, you may be contacted by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. You may also be contacted by text message or e-mail, using any e-mail address you have provided. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Patient's Name (Print):_____

DOB:_____

Signature:_____

Date:_____

Relationship to patient:_____

DIET/MEDICATION INSTRUCTIONS FOR CPE APPTS:

A.M. Appt (Non Diabetic): No breakfast
Drink water
Take meds as prescribed

A.M. Appt (Diabetic): If on insulin: Take medications as prescribed and eat as usual

If not on insulin and can skip breakfast with no problems:
No breakfast
Take meds as prescribed
Drink water

If unable to skip breakfast: Take medications as prescribed and eat as usual

P.M. Appt (Non Diabetic): Eat a light breakfast (toast, fruit, or cereal) and no lunch
Drink water
Take meds as prescribed

P.M. Appt (Diabetic): Take meds as prescribed and eat as usual

Offer patient with P.M. appointment option of coming in fasting for A.M. labs day of appt.

Inform nurse if patient chooses to do so and therefore the physician may enter lab orders if desires.