WYNDHURST FAMILY MEDICINE, P.C.
102 Archway Court
Lynchburg, Virginia 24502
(434) 237-3664

Date:____________________

Patient:____SS#:____________________
Last First MI

Street Address:____

City:___________________________________ State:_____________________ Zip________________
_
Home Phone:_____________________________Cell Phone:__________________________________

Email Address:____________________________ Sex: M / F Birthdate:________________________

Place of Employment:______________________________Occupation:_________________________

Employer Address:_____________________________________Work Phone #____________________

Spouse:____________________________________Spouse SS#_________________________________

Spouse Employer and Address____

EMERGENCY CONTACT:
Name:____ Relationship:________________________
Phone:____________________________________Work Phone:________________________________

INSURANCE:
Primary:_________________________________ Member/ID #_________________________________
Group #____________________________Subscriber:____
Relationship to patent:________________________________Birthdate:________________________

I certify that I and/or my dependent(s) have insurance coverage with_________________________________
and I assign directly to Dr. Craig Petry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for ALL charges whether paid for by insurance or not. I agree that I am also fully responsible for ALL charges in the event that I have submitted incorrect insurance information, fail to give updated insurance information, or fail to provide insurance information or any other documentation that may be required by my insurance for payment. I understand that any failure to do so will result in my account being transferred to a collection agency and I will be fully responsible for all charges incurred by the agency as well. The above named physician may use my healthcare information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____ ___________________________________
Signature of Patient or Parent/Guardian Date

____ ___________________________________
Please Print Name Relationship to Patient

PRIVACY PRACTICES ACKNOWLEDGEMENT

WYNDHURST FAMILY MEDICINE
102 ARCHWAY COURT
Lynchburg, VA 24502
(434) 237-3664

I have received the Notice of Privacy Practices and have been given the opportunity to review it.

Name:________________________Birthdate____________

Signature:______________________

PATIENT RECORDS OF DISCLOSURES

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 also has the right to request confidential communications of their PHI.

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

____Home Telephone

____Written Correspondence

____Ok to leave message?

____Ok to Mail to home?

____Work Telephone?____________

____Other_______________

Ok to leave message on Voicemail_____________

I give permission for me protected health information to be shared with: (please list spouse, family, friends or any that apply

1____

2____

3____

4____

Signature:______________________________Date:_______________

Please note that uses and disclosures for TPO may be permitted without prior consent in an emergency.