WYNDHURST
FAMILY MEDICINE
102 Archway Court Lynchburg, Virginia 24502

Patient Name:

____Date:______________
(Last) (First) (Middle)

Street Address:____

City:_______________________________State:__________Zip_______________

Home Phone:__________________________ Cell Ph:_________________________

Email Address:______________________________Sex: M/F Birthdate:__________

Patient SS#:__________—__________—__________

Place of Employment:__________________________Occupation:_________________

Employer Address:_________________________________Work Phone:____________

Spouse:_________________________________ SpouseSS#:_________________

Spouse Employer and Address:____

Emergency
Contact:____Relationship____________

Phone:___________________________

Primary Insurance:________________________Member ID #____________________

Group#:________________________Policy Holder:____________________________

Relationship to Patient:____________________Policy Holder DOB:________________________

I certify that I and/or my dependent(s) have insurance coverage with ______________________
and I assign directly to Craig J Petry, M.D. and Wyndhurst Family Medicine all insurance benefits, if any, otherwise payable to me for services rendered. The above named office will 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.

PLEASE INITIAL THE FOLLOWING AND THEN SIGN BELOW:

_____I understand that I am financially responsible for ALL charges whether paid by my 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 update my insurance information should it change, or fail to provide any other documentation required by this office or my insurance company for payment.

_____I understand that the medical providers at Wyndhurst Family Medicine order lab tests to diagnose, treat or as part of your yearly wellness exam. I am FULLY responsible for any lab charges not covered by my insurance.

_____I understand that my failure to do so will result in my account being assigned to a collection agency. I will be FULLY responsible and agree to pay ALL interest, agency fees, court costs and attorney fees. I agree that this authorization shall be valid until rescinded in writing or replaced by an updated agreement.

____ ____________________
(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

____Ok to leave message?

____Work Telephone?____________

____Written Correspondence

____Ok to Mail to home?

____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.

Wyndhurst Family Medicine
102 Archway Court
Lynchburg, Virginia 24502

I____understand that I am here today for a complete physical exam (Wellness Exam) and that I will have lab tests as part of my physical. I also understand that my insurance company may not pay for every lab test that is performed. In the event that my insurance company does not cover every lab test, I may receive a bill from LabCorp and I will be responsible for that bill. Wyndhurst Family Medicine is not responsible for these charges as LabCorp files your insurance and receives the payment.

If I have additional health concerns or symptoms that I discuss with my provider during my physical, I understand that I may be charged a “problem visit” in addition to my physical. Blood work done to evaluate my complaints may also not be covered by my insurance company.
A copay WILL be due for visits that address a health concern.

____ __________________________
signature Date

____
Print Name