PATIENT INFORMATION

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Jr. ☐ Sr. ☐ Other_____

Name(last)_____(First)_____(M.I.)_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐Widowed ☐Legally Separated ☐ Other

Address_____

City, State, Zip _____ Social Security No. _____

E-Mail_____ Are you interested in having access to your records online? _____

☐ Male ☐ Female Date of Birth_____

Phone Numbers:
Home_____Work_____Cell_____Other_____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Decline to Specify

Race: ☐ American Indian or Alaska Native ☐ Black or African American ☐ Other Race: _____

☐ Native Hawaiian or Other Pacific Islander ☐ White or Caucasian ☐ Asian☐ Decline to Specify

Employer_____ Occupation_____

Emergency Contact_____Phone#_____

PRIMARY INSURANCE

Insurance Company / Phone_____

Subscriber's Name: _____Relation to Patient_____

Subscriber's Social Security No_____Subscriber's Date of Birth_____

Effective Date_____ ☐ Male ☐ Female

Subscriber's ID_____Group ID_____ Copay Amount_____

SECONDARY'INSURANCE

Insurance Company / Phone_____

Subscriber's Name: _____Relation to Patient_____

Subscriber's Social Security No_____Subscriber's Date of Birth_____

Effective Date_____ ☐ Male ☐ Female

Subscriber's ID_____Group ID_____Copay Amount_____

PHARMACY INFORMATION

Whenever possible, we will electronically transmit your prescription(s) directly to your pharmacy.

Pharmacy Name_____Phone Number_____

Pharmacy Address _____City/State/Zip_____

**I consent to electronic transmitting of prescriptions to and/or from my pharmacy over a secure pathway.

Patient Signature: _____ Date: _____

PRIMARY CARE PHYSICIAN

Primary Care Physician:_____Phone Number_____

Address_____City, State, Zip_____

PATIENT CONSENT

I, the undersigned, hereby consent to and authorize the following:

- the administration and performance of all treatments
- the administration of any needed anesthetics
- the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- the use of prescribed medications
- the performance of diagnostic procedures/test and cultures
- the performance of other medically accepted laboratory tests that may be considered physician or their assigned designees

I fully understand that this consent is given in advance of any specific diagnosis or treatment and I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing. I understand that **Dominion Cardiology, P.C.** may include consent at satellite offices under common ownership.

I, the undersigned, authorize **Dominion Cardiology, P.C.** to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

PHYSICAN INSURANCE ASSIGNMENT: I hereby authorize **Dominion Cardiology P.C.** (PROVIDER) to release medical information to any healthcare provider or third-party insurance company for the purpose of treatment, payment or operations, which may pertain to my care. I hereby assign all insurance payments directly to **Dominion Cardiology, PC.** I permit a copy of this assignment of benefits to be placed in my original file at **Dominion Cardiology**. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for charges not covered by any third party carrier and in accordance with contractual terms and participatory agreements. Should this account become delinquent, I agree to pay any collection / attorney fees up to the legal limit.

I have reviewed and understand my patient rights and responsibilities. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature_____Date:_____

POLICIES AND PROCEDURES

Dominion Cardiology, P.C. is dedicated to making your experience here a good one. Please initial the following policies we have in place in order for us to concentrate on giving you the best care possible:

_____We require at least 24 hours' notice for cancellations so that we may accommodate other patients that may require our services. This will assist us in meeting the medical needs of the community that may require immediate attention. Failure to give 24 hours' notice will result in a $25.00 fee for missed new patient and follow-up appointments, and $100.00 fee will be assessed for all missed procedures.

_____if a referral is required for your office visit, it is the patient's responsibility to obtain this form from their primary care physician. Failure to obtain a referral could result in payment denial from the insurance company and would result in becoming the patient's responsibility.

_____if you need a prescription to be filled we will be happy to write it for you. However please allow 24 to 48 hours for refill requests.

_____it is the responsibility of the patient or guarantor to make sure that **Dominion Cardiology P.C.** has the correct insurance information on file. Failure of payment from your insurance company will result in patient billing and responsibility.

_____ there is a $20 fee for each medical form that needs to be completed.

Patient Signature_____Date_____

PRIVACY PRACTICIES ACKNOWLEDGMENT

I have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.

Signature_____Date of Birth_____
Name_____Date_____

Kwabena O. Agyeman, MD
Nadeem A. Faruqi, MD, FACC
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(804)520-1080 Fax: (804)520-1906
www.dominioncardiology.com

Permission to Disclose Protected Health Information to Family or Friends

Patient Name_____ Date of Birth_____ SSN: _____

By signing this paper below, I authorize **Dominion Cardiology, P.C**. to release my Protected Health Information (PHI) to the person(s) listed in the table below. This information may be oral or written information. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friend in order to assist with my continuing care. Any information requested that does not pertain to assisting with my healthcare and any requests for copies of medical records will require a signed HIPPAA compliant authorization.

I understand that once my PHI is disclosed pursuant to this Authorization, the federal privacy protections will no longer apply to the disclosed PHI, and thus, my authorized family/friends may re-disclose that PHI.

I understand that I have the right to revoke this authorization at any time by sending a letter to:

Dominion Cardiology, P.C.
2731 South Crater Rd.
Petersburg, VA 23805

I understand that the revocation will take effect on the date that it is received by the Privacy Officer.

Date of Permission	Name of Individual & Relationship to Patient	Comments/Instructions (ie may pick up meds, may disclose test results, etc)	Patient Initials

The physicians/staff have my permission to: (Please check all boxes that apply)

- ☐ Leave a message on cell phone — Cell phone number:_____
- ☐ Leave a message at work — Work phone number_____
- ☐ Leave a message on voicemail — Phone number:_____
- ☐ Leave a detailed message on answering machine — Phone number:_____

_____ _____
Signature of Patient Date

Informed Consent to use Patient Portal:

Patient Name: _____ Date of Birth: _____

Email Address: _____

Purpose: Dominion Cardiology offers a secure way for our patients to view parts of their records and communicate with our staff. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is, therefore, intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How it works: A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. **If you loose your password we cannot give it to you over the phone. You must come to the office to get a copy.**

How to participate: You can compose, pick up and reply to secure messages or view information sent to you through a web site hosted by our electronic health records company. Once this form is agreed to and signed, we will send you an email notification that tells you how to register for the first time. This notification will give you the URL (internet address) of the web site where you can log in. By clicking on the URL you will activate your internet browser, which will open the web site. You will then be able to log in using the user name and password provided. Next you will be able to look in your "message box" and see any new or old messages or view other parts of your electronic record. Because the connection channel between your computer and the web site uses "secure sockets layer" technology, you can read or view information on your computer, but it is still encrypted in transmission between the web site and your computer.

Privacy Protection and Risks: This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address and only the correct individual (or someone authorized by that individual) must be able to get access to it. Only you can make sure these two factors are present. We need you to make sure we have your correct email address and we are informed if it ever changes. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us. If you think someone has learned your password, you should promptly go to the web site and change it. We understand the importance of privacy in regards to your health care and will continue to strive to make all information as confidential as possible. We will never sell or give away any private information, including email addresses, without your written consent.

Conditions of Participation: Use of the Patient Portal and appendix is governed by the terms and conditions of this informed consent and the policies and procedures. Please read this agreement carefully before accessing or using the Patient Portal. Access to this secure site is an optional service, and we may suspend or terminate it at any time and for any reason. We reserve the right at any time and from time to time to modify the Patient Portal site or documents or any part thereof, with or without notice. Any modifications made to this document or its appendix will be effective immediately upon posting on the site. By accessing or using the Patient Portal, you agree to be bound by all of the terms and conditions of the Patient Portal as posted on the site at the time of your access or use. You agree to review the Patient Portal documents on the website each time you use the Patient Portal so that you are aware of any modifications made to the Patient Portal documents. You agree not to hold Initial Point Family Medicine or any of its staff liable for network infractions beyond its control. All site users represent and warrant that they are at least 18 years of age and that they possess the legal right and ability to agree to these terms of participation as set out in the Patient Portal documents and to use the site in accordance with these documents. We are offering this service free of charge until the end of the year at which time we reserve the right to charge an annual fee. We will provide adequate notice of such fees prior to them taking affect.

We have provided you with our policies and procedures for using the Patient Portal. We need you to understand and comply with these, and by signing this form below you will acknowledge that they were explained to you and that you agree to comply with them. If you do not understand or do not agree to comply with our policies and procedures, do not sign this form. If you have any questions we will gladly provide more information.

Patient Acknowledgement

Signature_____ Date_____