INOVA

1PAND

Patient Information:
Name (last, first, middle initial): _____ Email Address: _____

Address: _____ Apt # _____ City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Age: ____ Sex: ☐ Male ☐ Female Social Security Number: _____ Preferred Language: _____

Phone Number (mobile): _____ Phone Number (alternate): _____ ☐ home ☐ work

To minimize disruption to your daily life but also keep you informed, Inova uses SMS text message to communicate non-clinical messages like appointment reminders and surveys. If you would prefer that we contact you via another method, please let us know.

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired Employer: _____
☐ Student ☐ Other _____

Emergency Contact: _____ Relationship to Patient: _____

Address: _____

Phone Number (home): _____ Phone Number (alternate): _____ ☐ cell ☐ work

Demographics: Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Race: ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native
☐ More than one race ☐ Hispanic ☐ Native Hawaiian or other Pacific Islander
☐ Decline to say ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to say

Insurance Information – We will request to scan your ID and insurance card.

Primary Insurance: _____ Patient is Subscriber/Policy Holder: ☐ Yes ☐ No

Member ID # _____ Provider/Insurance Services Phone Number _____

Secondary Insurance: _____ Patient is Subscriber/Policy Holder: ☐ Yes ☐ No

Member ID # _____ Provider/Insurance Services Phone Number _____

Insured Information (if other than patient):

Subscriber/Policy Holder: _____ Relationship to Patient: _____

Address: _____

Social Security Number: _____ Date of Birth: _____ Subscriber Employer: _____

Please indicate your referring provider in addition to other providers who will need your treatment information.

Primary Care Provider Name: _____

Address: _____ Phone Number: _____ Fax Number: _____

Specialty Care Provider Name: _____ Specialty: _____

Address: _____ Phone Number: _____ Fax Number: _____

Specialty Care Provider Name: _____ Specialty: _____

Address: _____ Phone Number: _____ Fax Number: _____

Patient/Parent/Guardian (signature): _____ Date: _____ Time: _____

Patient/Parent/Guardian (print name): _____ Relationship: _____

Interpreter Information (To be completed by Inova staff, if applicable):

☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) _____

☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ☐ Male ☐ Female

Inova Medical Group
Patient Registration Form

IMG Location: _____

CAT # 20806DT/R050620 • PKGS OF 100

INOVA®

1PROD

The Health Insurance Portability and Accountability Act (HIPAA) **Privacy Rule** gives you the right to request how and where your healthcare provider communicates with you. We invite you to share your preferred place and manner of communication. You may change, update or revoke this information at any time, though it must be done in person. The information on this form will remain in effect for one year. You may revoke it at any time.

Print Name:_____ **Date of Birth:** _____

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

☐ **Patient Portal:** MyChart
☐ **Phone Contact:** Use the following numbers to contact me:

Home Phone: _____	☐ Leave message with detailed information	☐ Leave message with a call back number only
Cell Phone: _____	☐ Leave message with detailed information	☐ Leave message with a call back number only
Work Phone: _____	☐ Leave message with detailed information	☐ Leave message with a call back number only

☐ **Written Communication:** ☐ Mail to my home address ☐ Other: _____

☐ **Other:** _____

Preferred Contacts:

We respect your right to indicate who you prefer to involve in your treatment decisions and/or with whom your information is shared. Please note, however, that we may also share your information as set forth in our Notice of Privacy Practices.

Please indicate the person (s) you prefer we share your information with below:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Patient (signature): _____ Date: _____ Time: _____

Patient (print name): _____

Parent or Guardian (if patient is a minor or otherwise not competent):

(signature): _____ Date: _____ Time: _____

(print name): _____ Relation to Patient: _____

Interpreter Information (To be completed by Inova staff, if applicable):
☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) _____
☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ☐ Male ☐ Female

Inova Medical Group

Patient Record of Disclosure-Preferred Contacts

☐ Specialty (location): _____
☐ Primary (location): _____

CAT # 20749DT/R013020 • PKGS OF 50

INOVA

1PMTREV

Department/Location: _____

1. For Medicare Recipients:
I certify that the information provided to me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to Inova (or its affiliates) for any services furnished to me during the applicable periods of medical care.

2. Assignment and Coordination of Insurance Benefits:
I agree to provide information regarding all health insurance benefits to which I/the patient may be entitled. I hereby assign payment(s), if any, from insurance carrier(s) health benefit plan to Inova (or its affiliates) for services rendered to the patient. I hereby authorize payments directly to Inova, including any benefits otherwise payable to me under the terms of my policy, but not to exceed the balance due to Inova (or its affiliates) for services rendered to me during the applicable periods of medical care.

3. Unauthorized, Non-covered, or Out of Plan Services:
I understand and acknowledge:

- If my insurance carrier or administrator of benefits does not consider any services rendered covered services, or has not authorized these services, they will not pay and I agree to pay for these services.
- **One or more of my physicians may not accept insurance or may be out of network with my health insurance.**
- In the case of out of plan/network physician or services, there may be reduced benefits and I may be required to pay a higher co-pay, deductible or co-insurance amount.

4. Responsibility for Payment:
In my capacity as patient, legal representative or representative payee for the patient, I agree to pay all charges for which I may be legally responsible including but not limited to health benefit deductibles, copayments, co-insurance and non-covered services. In the event my account must be placed with an attorney or collection agency to obtain payment, I agree to pay reasonable attorneys' fees and other collection costs.

5. Automobile Accident Patients - Notice regarding the assignment of medical expense benefits will be provided to you in a separate document.

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered, and accept the above conditions and terms; and I agree to pay all charges for which I may be legally and/or contractually responsible, including but not limited to health insurance deductibles, co-payments, and non-covered services. **I understand that Inova, its affiliates, agents (including but not limited to debt collectors) or designees may contact me about outstanding balances through various methods including the use of manual representative outbound calls and voice messages and/or automated dialing services and pre-recorded artificial voice messages, at any telephone number I provide to Inova.** I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Inova. *I understand and agree this document will remain in effect for my present outpatient visit and any future outpatient or physician office visits to Inova, unless specifically cancelled in writing by me.* I understand that I will be asked to review and sign this form once per calendar year as long as I remain a patient of Inova.

Patient/Guardian/etc. (signature)	**Patient/Guardian/etc.** (print name)	Date	Time

Relationship to Patient (if not signed by patient) _____

Interpreter Information (To be completed by Inova staff, if applicable):
☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) _____
☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ☐ Male ☐ Female

Inova

Authorization for Claims, Payment, and Reviews - Ambulatory

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH
☐ IMG: _____ ☐ Other: _____

CAT # 20083DT/R050420 • PKGS OF 25

INOVA

1HIPAA

I certify that I have been made aware of Inova Health System's **Notice of Privacy Practices** and that I have a right to receive a copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Inova Health System's health care operations. The Notice also describes my rights and Inova Health System's duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the registration areas of each facility and on Inova Health System's web site at www.inova.org. I may request that a copy be mailed to me by calling **703-204-3342.**

Inova Health System reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices.** I may obtain a revised **Notice of Privacy Practices** by calling the above number and requesting a revised copy be mailed to me, by asking for one at the time of my next appointment, or by accessing Inova Health System's web site listed above to view the most current version.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE _____ DATE _____ TIME _____

PRINTED NAME OF PATIENT OR PERSONAL REPRESENTATIVE _____

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY _____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ☐ Male ☐ Female

Inova Health

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

CAT #84498 / R081015
PKGS OF 100

INOVA

1HEAR

Inova Staff:
1. **If accommodations are requested, page interpreter services at 98824 within 15 minutes of completing this form.**
2. **A new form should be used at every visit and any time a change in accommodations is requested.**

Name of Person Requesting/Declining Accommodations: _____

Relationship to Patient: ☐ Self ☐ Parent ☐ Family Member ☐ Friend ☐ Other _____

Do you and/or your companions have any special needs that require accommodations? ☐ **YES (complete boxes A and B)** ☐ **NO (complete box B)**

A. If you require special accommodations, please check as appropriate:

Deaf and Hard of Hearing:
☐ Sign language interpreter ☐ Notepad and pen ☐ Speak loudly
☐ Sound amplifier (ex. PockeTalker® or disposable Posey®)
☐ Uses hearing aid(s): ☐ Left ☐ Right ☐ Bilateral
☐ Amplified phone with flasher (if admitted)
☐ Video Remote Interpreter (VRI) (where available)
☐ Other: _____

Vision:
☐ Magnifying sheet ☐ Request an escort
☐ Braille phone ☐ Documents read out loud
☐ Other: _____

Mobility:
☐ Uses service animal ☐ Walking escort
☐ Wheelchair escort ☐ Extra-wide wheelchair escort
☐ Accessible exam table ☐ Accessible weight scale
☐ Other: _____

Speech:
☐ Point-to-Speak cards ☐ Point-to-Speak alphabet ☐ Notepad and pen
☐ Other: _____

Other or Special Instructions: _____

B. All Patients, Representatives and Companions, please read and sign:

By my signature below I hereby certify that: (1) I have been given an opportunity to communicate whether I and/or my companions have any special needs; (2) I have had the opportunity to select appropriate accommodations; (3) I have reviewed the above selections; (4) those selections are true, accurate and complete; (5) those selections reflect my and/or my companions' choices; and (6) I have received or can request a copy of the process for filing a complaint if I am unsatisfied with my own and/or my companions' accommodations. I understand that if my and/or my companions' needs change during my visit, I can request service changes from my caregiver free of charge.

☐ Patient's medical condition does not allow completion at this time.

Patient/Representative/Companion (signature)	**Patient/Representative/Companion** (print name)	Date	Time

Relationship to Patient: ☐ Self ☐ Parent ☐ Family Member ☐ Friend ☐ Other: _____

Staff Witness (signature)	**Staff Witness** (print name)	Date	Time	Contact #	Department

Interpreter Information (To be completed by Inova staff, if applicable):
☐ In person ☐ Telephonic ☐ Video Interpreter name/ID# (if applicable) _____
☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver Signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ☐ Male ☐ Female

Inova

Americans with Disabilities Act (ADA)/ Special Needs Assessment

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH
☐ IMG: _____ ☐ Other: _____

CAT # 20328DT/R022420 • PKGS OF 50

INOVA

2PSMHX

Date of Visit: _____
Reason for Visit: _____
Allergies: _____

Past Medical History (list all prior medical diagnoses)

_____ _____
_____ _____
_____ _____

Past Surgical History (list all surgeries and dates)

Surgery	Date	Surgery	Date

Significant Medical Conditions in Your Family

Condition	Family Member	Condition	Family Member

Medications (include over-the-counter medications)

Medication	Dose	Frequency

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? _____
Do you vape? ☐ Yes ☐ No Do you use smokeless tobacco (ex. chew, snuff)? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week? _____
Do you currently or have you ever used illicit drugs? ☐ Yes ☐ No If yes, please list: _____
Do you exercise? ☐ Yes ☐ No If yes, how often? _____

Age at first menstrual period:	First day of last menstrual period:
Number of days between menstrual periods:	Number of days menstrual period lasts:
Are you having any menstrual problems? ☐ Yes ☐ No If yes, describe:	
Are your periods: ☐ Regular ☐ Irregular	**Number of pads or tampons/day:**
Flow: ☐ Light ☐ Moderate ☐ Heavy	**Cramps:** ☐ Mild ☐ Moderate ☐ Severe

Are you menopausal? ☐ Yes ☐ No If yes, age at which you started menopause: _____
If you are menopausal, are you having any vaginal bleeding? ☐ Yes ☐ No If yes, describe: _____
When was your last Pap Test? _____ Was it normal? ☐ Yes ☐ No
Have you ever had an abnormal Pap Test? ☐ Yes ☐ No If yes, when? _____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____
Date of Birth: _____ Medical Record # _____
Gender: ☐ Male ☐ Female

Inova Medical Group
OB/GYN
Medical Condition & History

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH

CAT # 20857DT/R030420 • PKGS OF 50

INOVA

2PSMHX

Date of last: Mammogram: _____ DEXA (bone density scan): _____
Colonoscopy: _____ Tdap/Tetanus vaccine: _____

Have you received the Human Papillomavirus (HPV) vaccine? ☐ Yes ☐ No

What type(s) of birth control have you used in the past? ☐ Intrauterine Device (IUD) ☐ Oral Contraceptives
☐ Depo Provera ☐ Other _____

Current Contraception: _____ Do your partners use condoms? ☐ Yes ☐ No

Are you currently sexually active? ☐ Yes ☐ No Are your partners: ☐ Male ☐ Female ☐ Both

Number of sexual partners over your lifetime: _____ Number of times you have sex per month: _____

Do you want to be tested for sexually transmitted diseases (STDs)? ☐ Yes ☐ No

Have you ever had an sexually transmitted disease (STD)? ☐ Yes ☐ No

If yes, check any of the STDs which you have had: ☐ Chlamydia ☐ Gonorrhea ☐ Venereal Warts
☐ Genital Herpes ☐ HPV ☐ Human Immunodeficiency Virus (HIV) ☐ Other: _____

Pregnancies

Pregnancy Date	Type of Delivery (vaginal or c-section)	Complications	Pregnancy Dates	Type of Delivery (vaginal or c-section)	Complications
Number of:	Miscarriages:	Terminations:		Living Children:	

Current Medical Conditions (please check all that you are currently experiencing):

☐ Blood in stool
☐ Blood in urine
☐ Breast pain
☐ Chest pain
☐ Constipation
☐ Cough
☐ Decreased sexual drive
☐ Diarrhea
☐ Difficulty concentrating
☐ Dizzy spells/fainting
☐ Domestic violence
☐ Excess body/facial hair
☐ Fever
☐ Frequent bruising
☐ Hair loss
☐ Headaches
☐ Heartburn/indigestion
☐ Heat/cold intolerance
☐ Hot flashes/night sweats
☐ Irregular heartbeat
☐ Nausea
☐ Pain or bleeding with sex
☐ Pelvic pain
☐ Premenstrual symptoms
☐ Severe joint/muscle pain
☐ Skin lesions
☐ Trouble breathing
☐ Trouble sleeping
☐ Trouble with balance
☐ Unexplained weight change
☐ Unusual fatigue
☐ Urination-frequency increase
☐ Urination-incontinence
☐ Urination-pain
☐ Vaginal discharge/odor
☐ Vaginal dryness
☐ Vulvar itching/rash
☐ Victim of sexual abuse
☐ Vomiting
☐ Other: _____

☐ Check here if more space is needed. Continue on back of page.

My signature verifies that the information provided is correct to the best of my knowledge.

_____ _____ _____
Patient or Designated Decision Maker (signature) Date Time

_____ _____
If Designated Decision Maker (print name) Relationship

Reviewed by Physician (signature): _____ Date: _____ Time: _____

Physician (print name): _____

Interpreter Information (To be completed by Inova staff, if applicable):
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☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ☐ Male ☐ Female

Inova Medical Group
OB/GYN
Medical Condition & History

CAT # 20857DT/R030420 • PKGS OF 50