

ALEXANDRIA PRIMARY CARE ASSOCIATES

PATIENT INFORMATION

FIRST NAME				MIDDLE INITIAL	LAST NAME		
STREET ADDRESS					CITY, STATE		ZIP CODE
HOME PHONE				WORK PHONE			
EMPLOYER				EMPLOYER ADDRESS			
DATE OF BIRTH		SOCIAL SECURITY NUMBER			SEX		MARITAL STATUS
					M F		S M D W

PRIMARY INSURANCE POLICY HOLDER INFORMATION

INSURED'S FIRST NAME				MIDDLE INITIAL	LAST NAME		
INSURED'S STREET ADDRESS					CITY, STATE		ZIP CODE
RELATIONSHIP TO PATIENT		INSURED'S HOME PHONE			INSURED'S WORK PHONE		
INSURED'S EMPLOYER				INSURED'S DATE OF BIRTH		INSURED'S SOCIAL SECURITY NUMBER	

SECONDARY INSURANCE POLICY HOLDER INFORMATION

INSURED'S FIRST NAME				MIDDLE INITIAL	LAST NAME		
INSURED'S STREET ADDRESS					CITY, STATE		ZIP CODE
RELATIONSHIP TO PATIENT		INSURED'S HOME PHONE			INSURED'S WORK PHONE		
INSURED'S EMPLOYER				INSURED'S DATE OF BIRTH		INSURED'S SOCIAL SECURITY NUMBER	

How did you hear about us?

Emergency Contact:	Tel:
Signature	Date

(Authorizes claims to be made with your insurance company)

CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE - PAST MEDICAL HISTORY

Name: _____ Nickname: _____ Date of Birth: _____ Age: _____ Date: _____

ALLERGIES
<div style="text-align: right;">None <input type="checkbox"/></div> <p><i>(List any allergies to medicines or other substances)</i></p>

SURGERY / HOSPITALIZATION		
DATE	REASON	None <input type="checkbox"/>

ILLNESSES
<div style="text-align: right;">None <input type="checkbox"/></div> <p><i>(List any chronic or recurrent illnesses - Date of onset)</i></p>

ACCIDENTS / INJURIES		
DATE	<i>(Please list)</i>	None <input type="checkbox"/>

List All Medications You Take Regularly (Prescription and Non-Prescription)		
Medicine	Dose	None <input type="checkbox"/>

(✓) CHECK ANY THAT YOU HAVE HAD OR NOW HAVE:	
<input type="checkbox"/> Abnormal Pap Smear	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> AIDS or HIV Disease	<input type="checkbox"/> Hodgkin's Disease, Lymphoma or Leukemia
<input type="checkbox"/> Alcohol Overuse or Abuse	<input type="checkbox"/> Irritable Bowel Syndrome
<input type="checkbox"/> Allergies or Hay Fever	<input type="checkbox"/> Kidney Disease or Nephritis
<input type="checkbox"/> Anemia (i.e. - low iron)	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Anxiety or Panic Attacks	<input type="checkbox"/> Liver Problems
<input type="checkbox"/> Arthritis or Gout	<input type="checkbox"/> Lung Problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Lupus
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Malaria
<input type="checkbox"/> Bladder Infection	<input type="checkbox"/> Meningitis
<input type="checkbox"/> Blood Clots or Bleeding Prob.	<input type="checkbox"/> Migraine Headache
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Muscle Disease or Weakness
<input type="checkbox"/> Boils or Cysts - Recurrent	<input type="checkbox"/> Nervous Breakdown
<input type="checkbox"/> Bone or Joint Disease	<input type="checkbox"/> Pancreatitis
<input type="checkbox"/> Bowel or Colon Disease	<input type="checkbox"/> Phlebitis
<input type="checkbox"/> Broken or Cracked Bones	<input type="checkbox"/> Pleurisy
<input type="checkbox"/> Breast Lumps	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Bronchitis - Recurrent	<input type="checkbox"/> Polio
<input type="checkbox"/> Bursitis or Tendonitis	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Cholesterol - Elevated	<input type="checkbox"/> Seizures, Convulsions, or Epilepsy
<input type="checkbox"/> Colitis	<input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> Concussion or Head Injury	<input type="checkbox"/> Sickle Cell Disease or Trait
<input type="checkbox"/> Depression or Suicide	<input type="checkbox"/> Skin Disease - Chronic
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Skin Infections - Recurrent
<input type="checkbox"/> Drug Overuse or Abuse	<input type="checkbox"/> Sleep Difficulties or Disorders
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Sprains or Dislocations - Severe
<input type="checkbox"/> Excessive Stress	<input type="checkbox"/> Stroke or Brain Attack
<input type="checkbox"/> Gallbladder Disease or Gallstone	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Tuberculosis (TB) or positive test
<input type="checkbox"/> Gonorrhea, Syphilis or Chlamydia	<input type="checkbox"/> Ulcer Disease or Gastritis
<input type="checkbox"/> Headaches - Severe	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Hearing Problem	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Vision Problem
<input type="checkbox"/> Heart Murmur or Heart Disease	<input type="checkbox"/> Yellow Jaundice
<input type="checkbox"/> Hepatitis or Cirrhosis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Herniated or Ruptured Disc	
<input type="checkbox"/> Herpes	

IMMUNIZATION HISTORY		
HAVE YOU HAD:		DATE OF LAST
Chickenpox or Shot	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Hepatitis B Series or Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Influenza Shot	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Pneumonia Shot	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Rubella Shot or Blood Test	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Tetanus Shot	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

ALEXANDRIA PRIMARY CARE ASSOCIATES

STEPHEN M. MINTON, MD

Diplomate, American Board of Internal Medicine

MA. CONCEPCION H. DE LUNA, MD

Diplomate, American Board of Internal Medicine

LEV L. BARATS, MD

Diplomate, American Board of Internal Medicine

SEEMA P. KUMAR, MD

Diplomate, American Board of Internal Medicine

LEESA M. MADSEN, PA-C

CHRISTOPHER M. GARRISON, ANP-C

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Alexandria Care Primary Associates. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosure require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use or disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Duties of Alexandria Primary Care Associates

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing.

Complaints and Contact Person

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Christopher M. Garrison, MSN, ANP-C
Alexandria Primary Care Associates
4660 Kenmore Avenue, Suite 710
Alexandria, VA 22304

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. Inquiries about our privacy practices can be made at the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

This notice is effective on or after March 17, 2003.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Alexandria Primary Care Associates reserves the right to modify the privacy practices outlines in the notice.

Signature

I have received a copy of the Notice of Privacy Practices

Name of Patient

Signature of Patient

Date

Signature of Patient Representatives *(Required if the patient is a minor or an adult who is unable to sign)*

Relationship of Patient Representative to Patient