BAY INTERNISTS, INC.
Your center of excellence for patient-focused healthcare
DR. STEVEN F. GLESSNER
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DR. PATRICIA K. MONGE-MEBERG
DR. JUNE B. DAFFEH
JACKIE L. OREN, RN, FNP
SHEILA A. BRANSON, ACNP-BC

Dear Valued Patient,

We would like to welcome you to Bay Internists, Inc. We are pleased that you have chosen our office to provide you with all of your medical needs.

Enclosed is a New Patient Packet. This includes a **Demographic Sheet**; **Written Acknowledgement Form** (Notice of Privacy Practice is located in our office and you may sign this form the day of your appointment); **Consent to HIV testing**; **Record Release Authorization**; **Financial Policy and Portal Authorization Form. P**lease review, sign and date these forms.

We ask that if you are taking any medications to please bring them with you to your appointment so that the physician may note your chart and refill any medications at that time.

Please bring your insurance card(s) and photo identification to each visit.

All co-payments are due at the time of service. For your convenience, we accept Visa/MasterCard, cash, or checks.

If you have any questions, please feel free to contact our office Monday-Friday 8:30am – 4:30pm at (804) 435-3103. Again, we would like to thank you for selecting Bay Internists, Inc. We look forward to serving you.

Sincerely,

Jennifer Hodges
Office Manager

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DEMOGRAPHIC INFORMATION		
Name:		Date of Birth:
Social Security #:	Legal Gender: ☐ M ☐ F	Preferred Pronouns:
Physical Address: City, State, Zip:		
Mailing Address: City, State, Zip:		
Home Phone:		Cell Phone:
E-mail Address:		
Marital Status: ☐ Married/Partnered ☐ Single ☐ Widowed ☐ Divorced ☐ Separated		
Employer:		Work Phone:
Preferred Contact Method: ☐ Home phone ☐ Cell phone ☐ E-mail		
Race: ☐ American Indian / Alaskan Native ☐ Asian ☐ Black / African American ☐ Native Hawaiian / Other Pacific Islander ☐ White ☐ Other Race ☐ Decline to answer		
Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Declined to answer		
Emergency Contact Name:		
Emergency Contact Phone Number:		
Emergency Contact Relationship:		
Preferred Pharmacy:		
How did you hear about us?		

INSURANCE INFORMATION	
Primary Insurance Company:	
Policy Holder:	Relationship:
Policy Holder's Date of Birth:	Policy Number:
Group Number:	Copay Amount:
Secondary Insurance Company:	
Policy Holder:	Relationship:
Policy Holder's Date of Birth:	Policy Number:
Group Number:	Copay Amount:

Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM
HIPAA AUTHORIZATION FORM

Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may request a revised copy.

- I, _____ have been provided a copy of the Bay Internists Inc. Notice of Privacy Practices.
- I have had an opportunity to read the Notice of Privacy Practices.
- I understand that I may ask questions if I do not understand any information contained in the Notice of Privacy Practices.
- I authorize my doctor to speak with the following regarding my health status:

NAME	RELATIONSHIP	PHONE

_____ _____
Patient's Signature Date

_____
Authorized Representative of Patient / Relationship

NOTICE OF DEEMED CONSENT TO HIV BLOOD TESTING

A law was enacted in Virginia in 1989 which authorizes health care providers to test their patients for HIV antibodies when the health care provider is exposed to the body of fluids of a patient in a manner which may transmit human immunodeficiency virus (HIV). Pursuant to this law, in the event of an exposure, you will be deemed to have consented to such testing, and the release of the test results to the health care provider who may have been exposed. However, you would be informed before your blood is tested for HIV antibodies, the testing would be explained to you and you would be given the opportunity to ask questions you might have.

I have read and understand the above "Notice if Deemed Consent to HIV Blood Testing."

_____ _____

Date Patient Signature

_____

Patient Name (Printed)

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FINANCIAL POLICY

The following are our conditions of registration as well as our policies with respect to the billing and collections of your account. By signing below, you are agreeing to be bound by these terms.

- **Basic Financial Policy:** Payment is due and payable at the time of service is provided unless other arrangements have been made.
- **For Patients with Insurance:** All co-payments and deductibles are due at the time of service. We may bill insurance carriers for you if we have a current contract with your carrier. Given that the agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, our fees are due and payable in full from you. We will call your insurance to verify coverage and eligibility.
- **For Patients with Medicare:** All co-payments and deductibles are due and payable at the time of service. We will bill Medicare for you. We may also bill secondary insurance carriers for you.
- **Non-Covered Services:** Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or immediately upon notice of insurance claim denial.
- **Returned Checks:** In addition to the face value of the check, for each check returned to us by your bank, you will be assessed a "bank returned check fee" equal to the amount charged to us by our bank, plus a $35 processing fee.
- **Missed Appointments:** In fairness to other patients and the doctor, we require at least 24 hours' notice to cancel an appointment. We reserve the right to charge you $25 for each appointment that was missed or not canceled within 24 hours' notice.
- **Unpaid Balances:** Charges reflected on billing statements are agreed to be correct and reasonable unless disputed in writing within (30) days of the billing date. If your unpaid balance is turned over to an attorney or collection agency for collection, you agree to pay all costs associated with collection, to include attorney fees equal to 33.33% of the unpaid balance.

MEDICARE PATIENTS: SIGNATURE ON FILE. I request and authorize payments of Medicare benefits be made to Bay Internists, Inc. for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Service and its agents any information needed to adjudicate these benefits for services. I understand my signature requests that payment be made and authorizes release of all information necessary to adjudicate the claim. If "other health insurance" is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of all information to the insurer or agency that is necessary to adjudicate the claim. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and that I am responsible for the deductible, coinsurance, and any noncovered services.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans to, Bay internists, Inc. This assignment will remain in effect until revoked by me in writing. I understand I remain financially responsible for all charges whether or not the charges are paid by said insurance to the extent permitted by law. I hereby authorize said assignee to release all information necessary to adjudicate all claims and secure payment for services rendered.

I have read, understood, and agree to be bound by the terms of this financial policy.

Patient Name:_____ D/O/B:_____

Signature:_____ Date: _____

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, _____

Physical Street: _____ *D/O/B:* _____
City, State, Zip: _____ *SSN:* _____
Home Phone: _____ *Previous Name:* _____

Authorize and request from:

Provider/Hospital: _____
Address: _____
_____
Phone: _____
Fax: _____

Release the following information

☐ Complete medical record
☐ Only the following records or types of health information (including any dates)

_____
_____

To:

Bay Internists, Inc.
Provider: _____
PO Box 1599
107 DMV Drive
Kilmarnock, VA 22482
Phone: (804) 435-3103
Fax: (804) 435-6695

Signature: _____ Date: _____

Relationship if Representative: _____

Witness Signature: _____

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI) VIA ELECTRONIC MEDIA

(Please Print)

Patient Name: _____ Chart # _____

E-mail Address: _____ Date of Birth: _____

Patient's Provider: _____

By signing this form, I authorize Bay Internists, Inc. to communicate via personal, secured access Patient Portal with me for my medical care and treatment. Bay Internists, Inc. will provide notices via your personal e-mail. That information can be found in your Patient Portal. No personal health information is transmitted via or into your personal e-mail. I understand that the following types of protected health information may be used, disclosed, and retained by health care providers of Bay Internists, Inc. as a result of the communications:

- My personal health information;
- Electronic display of radiological images (x-rays)
- Laboratory test results
- Pathology reports
- Other diagnostic test results

Patients and/or personal representatives who want to communicate with their health care providers by clinic Portal should consider all of the following issues before signing this Authorization.

- Portal communication is a convenience and not appropriate for emergencies or time-sensitive issues.
- Portal message received at Bay Internists, Inc. can be forwarded, printed and/or read, stored by Bay Internists, Inc. staff members.
- We advise caution when communicating highly sensitive or personal information via Portal messages (i.e. HIV status, mental illness, chemical dependency, and worker compensation issues.)
- Clinically relevant messages and responses will be documented in the medical record.
- Bay Internists, Inc. will not be liable for information lost or misdirected due to technical errors or failures.
- Bay Internists, Inc., does not own or have any interest in Portal website. E-MDS Portal is a secure conduit in which communication with our database is managed.

I understand that I have the right to revoke this Authorization at any time. If I want to revoke this Authorization, I must do so in writing, and address it to Bay Internists, Inc. I understand that if I revoke this Authorization, it will not apply to any information already released as a result of this Authorization.

I understand that I may refuse to sign this Authorization. I also understand that Bay Internists, Inc. cannot deny or refuse to provide treatment, payment, or medical records if I refuse to sign this Authorization.

I have read and understand the information in this authorization form.

_____ _____

Signature Date

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PATIENT HISTORY FORM- MALE

Name: _____ D/O/B: _____ Today's Date: _____

What brings you here today? _____

Primary Physician: _____

Preferred Pharmacy Name: _____ Phone: _____

CURRENT MEDICATIONS: None ☐

Instructions: Please list all medications, including strength and dosing instructions.

_____ _____

_____ _____

_____ _____

Multi-vitamin ☐ Omega 3/fish oil ☐ Aspirin ☐

Calcium ☐ Vitamin D ☐ Other vitamins or herbs ☐ _____

ALLERGIES: No known drug allergy ☐

Penicillin ☐ Sulfa ☐ Codeine ☐

Latex ☐ Iodine ☐ Other ☐ _____

SURGICAL HISTORY: None ☐

Instructions: Please indicate the year when surgery was done.

Vasectomy _____ Gall Bladder _____

Laparoscopy _____ Blood Transfusion _____

Cryosurgery/laser _____ Breast surgery/or biopsies _____

Appendectomy _____ Other surgeries _____

Colonoscopy _____

Have you ever received a blood transfusion? Yes ☐ No ☐

Have you had a blood test for Hepatitis C? Yes ☐ No ☐ (Recommendation is for all 'baby boomers' be screened)

Have you had a blood test for HIV? Yes ☐ No ☐ (Recommendation is for anyone who desires be screened)

PAST MEDICAL HISTORY/GENITOURINARY HISTORY/CURRENT PROVIDERS/
PREVENTATIVE HEALTH MAINTENANCE: No known medical problems ☐

Heart disease	☐	Autoimmune (lupus, MS, etc.)	☐	Arthritis	☐
Stroke	☐	Bleeding disorder/anemia	☐	Osteopenia/Osteoporosis	☐
Blood clots in legs/lungs	☐	Kidney disease/stones	☐	Migraine headaches	☐
High cholesterol	☐	Bowel disease/IBS	☐	Depression/Anxiety	☐
High blood pressure	☐	GERD	☐	Alcohol/Drug abuse	☐
Asthma	☐	Gallstones	☐	Gout	☐
Lung/TB	☐	Hepatitis	☐	Cancer (type)_____	☐
Diabetes	☐	Neurologic Issues	☐		
Thyroid issues	☐	COPD/Emphysema	☐		

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PATIENT HISTORY FORM- MALE (CONTINUED)

Name:_____ D/O/B: _____ Today's Date: _____

GENITOURINARY HISTORY:

Date of last prostate exam _____ Normal? Yes ☐ No ☐

Date of last PSA blood test _____ Normal? Yes ☐ No ☐

Date of last DEXA-bone density _____ Normal? Yes ☐ No ☐

Location of last DEXA-bone density _____

Have you ever had any of the following (check yes if applicable)

Genital herpes	☐	Current pain with intercourse	☐	Concern with sexual function	☐
Genital warts/HPV	☐	Current penile discharge or odor	☐		
Chlamydia	☐	Frequent yeast or bacterial infections	☐	Breast lump	☐
Gonorrhea	☐	Frequent urinary infections	☐	Breast pain	☐

What is your current method of contraception?

No need ☐ Condoms ☐ Vasectomy ☐

HEALTH MAINTENANCE

Date of last eye exam _____ Provider _____ Phone

Date of last dental exam _____ Provider _____ Phone _____

Date of last skin/dermatology exam _____ Provider _____ Phone _____

VACCINATION HISTORY

1. Tetanus vaccination — Date Received _____
2. Whooping cough/pertussis vaccination (Adacel) — Date Received _____
3. Pneumonia vaccination (Pneumovax) — Date Received _____
4. Prevnar vaccination (the "new" pneumonia vaccine) — Date Received _____
5. Shingles vaccination (Zostavax) — Date Received _____
6. Hepatitis A vaccination — Date Received _____
7. Hepatitis B vaccination — Date Received _____
8. Other vaccination _____ — Date Received _____

CURRENT PROVIDERS

Physician Name	Specialty
_____	_____
_____	_____
_____	_____
_____	_____

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FAMILY HEALTH HISTORY:

Instructions: Please mark if there is a family history of the illnesses following, indicate their relationship to you (i.e. M - mother, F - father, B - brother, S - sister, MGM - maternal grandmother, PGM - paternal grandmother).

Name: _____ D/O/B: _____ Today's Date: _____

Alcoholism	_____	Glaucoma and/or macular degeneration	_____
Alzheimer/ dementia	_____	Heart Disease	_____
Anemia	_____	High blood pressure	_____
Asthma	_____	High cholesterol	_____
Birth defects	_____	Hip Fracture	_____
Blood clots in legs/lungs	_____	Osteoporosis	_____
Depression/Anxiety	_____	Stroke	_____
Diabetes	_____	Thyroid disease	_____
Digestive problems	_____	Other	_____

LIVING			**CURRENT AGE OR AGE AT DEATH**	**CAUSE OF DEATH**
Mother	Yes ☐	No ☐	_____	_____
Father	Yes ☐	No ☐	_____	_____
Sister	Yes ☐	No ☐	_____	_____
Brother	Yes ☐	No ☐	_____	_____

SOCIAL HISTORY:

Tobacco use Yes ☐ (packs/day) _____ No ☐ Formerly ☐ (year quit/# of years) _____

Alcohol use Yes ☐ (type/quantity/day) _____ No ☐ Formerly ☐ (year quit) _____

Caffeine use Yes ☐ (cups/day) _____ No ☐

Exercise Yes ☐ (days/week) _____ No ☐

Education High school ☐ College ☐ Graduate ☐ Professional ☐

Working Retired ☐ Employed ☐ Previous/Current Employer _____ Not Working ☐

Birth Place _____ Religion _____

Military _____

Travel _____

Who else lives at home? _____

Do you have a smoke detector in your home?	Yes ☐	No ☐
Do you have a propane gas stove/fireplace or use propane?	Yes ☐	No ☐
If so, do you have a carbon monoxide detector?	Yes ☐	No ☐
Do you feel safe?	Yes ☐	No ☐
Can you talk to your spouse openly and honestly without reprimand or disagreement?	Yes ☐	No ☐
Do you have a medical power of attorney?	Yes ☐	No ☐
Do you have a living will/advanced medical directive?	Yes ☐	No ☐
Do you have a Do Not Resuscitate Order (DNR)?	Yes ☐	No ☐

Other _____

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CANCER FAMILY HISTORY QUESTIONNAIRE

PERSONAL INFORMATION

Patient Name: _____ Date of Birth: _____ Age: _____

Gender (M/F): _[___ Today's Date (MM/DD/YY):_____ Health Care Provider:_____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.
You and the following close blood relatives should be considered: You, Parents, Brothers, Sisters, Sons, Daughters, Aunts, Uncles, Nephews, nieces, Half-Siblings, First-Cousins, Grandparents, Grandchildren, Great-Grandparents and Great-Grandchildren.

YOU and YOUR FAMILY'S CANCER HISTORY (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS/ SIBLINGS/ CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
☑Y ☐N	*EXAMPLE: BREAST CANCER*	*45*	____	____	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐Y ☐N	BREAST CANCER							
☐Y ☐N	OVARIAN CANCER (Peritoneal/Fallopian Tube)							
☐Y ☐N	UTERINE/ENDOMETRIAL CANCER							
☐Y ☐N	COLON/RECTAL CANCER							
☐Y ☐N	10 or more LIFETIME COLON POLYPS (Specify #)							
☐Y ☐N	OTHER CANCER(S) (Specify cancer type)	Among others, consider the following cancers: Melanoma, Pancreatic, Stomach/Gastric, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid						

☐Y ☐N	Are you of Ashkenazi Jewish descent?
☐Y ☐N	Are you concerned about your personal and/or family history of cancer?
☐Y ☐N	Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? (Please explain/include a copy of result if possible)

HEREDITARY CANCER RED FLAGS (To be completed with your healthcare provider- Check all that apply)

Your PERSONAL History – Red Flags	Your FAMILY History – Red Flags
Hereditary Breast and Ovarian Cancer Syndrome	Hereditary Breast and Ovarian Cancer Syndrome
Breast cancer diagnosed at age 50 or younger	Close relative with breast cancer less than age 50
Ovarian cancer at any age	Close relative with ovarian cancer at any age
Two primary occurrences of breast cancer	Two or more breast cancer occurrences, in one relative or in two or more relatives on the same side of the family, one under age 50
Male breast cancer	A male relative with breast cancer
Triple Negative Breast Cancer	Combination of breast, ovarian, and/or pancreatic cancer on the same side of the family
Pancreatic cancer with a breast or ovarian cancer	Three or more relatives with breast cancer at any age
Ashkenazi Jewish ancestry with an HBOC associated cancer*	A previously identified BRCA1 or BRCA2 mutation in the family
Lynch Syndrome** (see cancer list below)	Lynch Syndrome** (see cancer list below)
Colorectal cancer under age 50	Two or more relatives with a Lynch syndrome cancer**, one before the age of 50
Endometrial/uterine cancer under age 50	Three or more relatives with a Lynch syndrome cancer** at any age
MSI High histology*** before age 60	A previously identified Lynch syndrome mutation in the family
Abnormal MSI/IHC tumor test result (colon/rectal/endometrial/uterine)	
Two or more Lynch syndrome cancers** at any age	
YOU and one or more relatives with a Lynch syndrome cancer**	

*HBOC associated cancer includes: Breast, ovarian, and pancreatic cancer
**Lynch syndrome cancer includes: Colon, endometrial/uterine, gastric/stomach, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain and sebaceous adenomas
***MSI High histology includes: Mucinous, signet ring, tumor infiltrating lymphocytes, crohn's-like lymphocytic reaction histology, or medullary growth pattern