8650 SUDLEY ROAD SUITE 206
MANASSAS, VIRGINIA 20110
703-368-9234
FAX# 368-0505

DRS. FARR, WAMPLER, HENSON & WILLIAMS, LTD
JOSEPH G. FARR, M.D. G. BENJAMIN WAMPLER, M.D. KENNETH I. HENSON, M.D.
JOHN P. WILLIAMS, M.D. CYNTHIA A. DOUGHERTY, M.D.
TAX ID No. 54-0923918

432 HOSPITAL DRIVE
WARRENTON, VIRGINIA 20186
(540) 347-2805

PATIENT REGISTRATION - *Please Print Clearly*

DATE					
PATIENT NAME First	Middle	Last		DATE OF BIRTH	AGE
HOME ADDRESS	APT. NO.	CITY		STATE	ZIP
OCCUPATION	SOCIAL SECURITY NO.	MARITAL STATUS ☐S ☐M ☐D ☐W	SEX ☐M ☐F	HOME PHONE	
EMPLOYER OR SCHOOL	FULL TIME ☐ PART TIME ☐	ADDRESS		WORK PHONE	
SPOUSE'S NAME (OR PARENT)	SPOUSE'S EMPLOYER (OR PARENT)			SPOUSE'S WORK PHONE (OR PARENT)	
IN CASE OF EMERGENCY, CONTACT:	RELATIONSHIP	WORK PHONE		HOME PHONE	
REFERRED BY	ANY DRUG ALLERGIES? IF SO, LIST				

BILLING INFORMATION

FINANCIALLY RESPONSIBLE PERSON ☐PATIENT ☐SPOUSE ☐PARENT ☐ OTHER _____	NAME IF DIFFERENT FROM PATIENT	HOME PHONE
FINANCIALLY RESPONSIBLE PERSON'S ADDRESS (IF DIFFERENT FROM PATIENT)		
FINANCIALLY RESPONSIBLE PERSON'S EMPLOYER	EMPLOYER ADDRESS	WORK PHONE

INSURANCE INFORMATION

POLICY HOLDER SELF ☐ SPOUSE ☐ PARENT ☐	PRIMARY INSURANCE CO. NAME	SUBSCRIBER'S NAME	SOCIAL SECURITY NO.	DATE OF BIRTH
INSURANCE CO. ADDRESS		ID/POLICY NO.		GROUP NO.
SECONDARY POLICY HOLDER SELF ☐ SPOUSE ☐ PARENT ☐	SECONDARY INSURANCE CO. NAME	SUBSCRIBER'S NAME	SOCIAL SECURITY NO.	DATE OF BIRTH
INSURANCE CO. ADDRESS		ID/POLICY NO.		GROUP NO.

The undersigned agrees to promptly pay all charges when billed for medical services rendered and the persons listed below agree and do hereby become legally responsible for any and all charges incurred for the patient named above. SIGN _____

WORKMAN'S COMPENSATION AND ACCIDENT INFORMATION

☐ WORKMAN'S COMPENSATION ☐ ACCIDENT CASE

DATE OF ACCIDENT	CLAIM/FILE NO.	EMPLOYERS NAME	
EMPLOYERS ADDRESS		PHONE #	CONTACT PERSON OR SUPERVISOR
INSURANCE CARRIER NAME		ADDRESS	

Patient's Authorization

I, _____, hereby authorize Drs. Farr and Wampler, Ltd. to apply for benefits on my behalf for covered services rendered I request payment from BC/BS of National Capital area. Blue Shield of Virginia, Medicare and/or _____
(OTHER INSURANCE COMPANY NAME)
be made directly to the above-named Practice (or in case of Medicare Part B benefits, to myself or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to BC/BS of National Capital Area, Blue Shield of Virginia, the above named billing agent, (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and/or _____
(OTHER INSURANCE COMPANY NAME)
I permit a copy of this authorization to be used in place of the original. This authorization may be revolked by either me or above-named carrier at any time in writing.

Signature of Subscriber or Beneficiary *Identification No.* *Date*

PATIENT ACCOUNT NO.: _____

CONCERNING INSURANCE

I HEREBY AUTHORIZE THIS PHYSICIAN TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED.

I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT. I FURTHER AUTHORIZE THE RELEASE OF ANY NECESSARY INFORMATION, INCLUDING MEDICAL INFORMATION FOR THIS OR ANY RELATED CLAIM, TO MY INSURANCE CARRIER, (OR, IN THE CASE OF MEDICARE PART B BENEFITS TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION). A COPY OF THE AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL.

THIS AUTHORIZATION MAY BE REVOKED BY EITHER ME OR MY INSURANCE CARRIER AT ANY TIME IN WRITING.

X _____ _____

SIGNATURE OF PATIENT, INSURED, BENEFICIARY, PARENT/LEGAL GUARDIAN **DATE**

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE PAYMENT OF ALL MEDICAL INSURANCE BENEFITS WHICH ARE PAYABLE TO ME UNDER THE TERMS OF MY INSURANCE POLICY TO BE PAID DIRECTLY TO THIS PHYSICIAN FOR SERVICES RENDERED. I FURTHER AUTHORIZE THE RELEASE OF ANY INFORMATION NEEDED FOR PROCESSING MY INSURANCE CLAIMS. A COPY OF THIS AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL.

I UNDERSTAND AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT PAID BY MY INSURANCE COMPANY.

X _____ _____

SIGNATURE OF PATIENT, INSURED, BENEFICIARY PARENT/LEGAL GUARDIAN **DATE**

I, _____, UNDERSTAND THAT IF IN THE EVENT MY ACCOUNT BECOMES PAST DUE (OVER 30 DAYS) AND ALL ATTEMPTS TO ARRANGE PAYMENT HAVE FAILED, IT WILL BE TURNED OVER FOR COLLECTION. I ALSO UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ALL APPLICABLE COLLECTION OR ATTORNEY'S FEES AND ALL OTHER COSTS EXPENDED TO COLLECT SAID AMOUNT. I ALSO UNDERSTAND IF IN THE EVENT I PAY BY CHECK AND IT IS RETURNED FOR INSUFFICIENT FUNDS, I WILL BE CHARGED A FEE OF $25.00.

I HAVE READ AND UNDERSTAND THE FOREGOING.

X _____ _____

SIGNATURE OF PATIENT, INSURED, BENEFICIARY, PARENT/LEGAL GUARDIAN **DATE**

I, _____, THE UNDERSIGNED, HEREBY AUTHORIZE AND REQUEST DRS. FARR, WAMPLER, HENSON, & WILLIAMS, LTD. TO RELEASE INFORMATION REGARDING MY PROFESSIONAL CARE AND TREATMENT TO:

MYSELF **OTHER** _____ _____

NAME **RELATIONSHIP**

X _____ _____

SIGNATURE OF PATIENT, PARENT/LEGAL GUARDIAN **DATE**

PATIENT'S MEDICAL HISTORY FORM

DRS. FARR, WAMPLER, HENSON, WILLIAMS & DOUGHERTY

Patient's Name:_____Date:_____

What is the reason for your visit today?_____

_____

Please List all of your Medical Problems (current & old)_____

_____

_____

Please List all of your Previous Surgeries_____

Do any of these Medical Problems apply to you? Please Check box to the right of those that do.

Heart Disease		Diabetes		Depression		Diarrhea	
Chest Pain		Thyroid Disease		Stroke		Constipation	
Heart Murmer		Arthritis		Nervous Disorder		Stomach Ulcers	
High Blood Pressure		Kidney Stones		Back Pain		Heartburn	
Shortness of Breath		Blood in your Urine		Blood Transfusion		Hernia Repairs	
Asthma/Emphysema		Frequent Urination		HIV or Hepatitis		CANCER: list type(s)	
Blood with Coughing		Pain with Urination		Bleeding Tendency			
Anesthetic Reaction							

Please list **ALL** the **MEDICATIONS** you are presently taking._____

_____

_____

Are you **ALLERGIC** to any **MEDICATIONS**? (Please list)_____

_____

SOCIAL HISTORY:

Do you Smoke? Yes_____ No_____

If Yes, how much a day?_____ If you stopped, When?_____

Do you Drink Alcohol? Yes_____ No_____

If Yes, how much?_____ If you stopped, When?_____

MARITAL STATUS: Single_____Married_____Separated_____Divorced_____

Widowed_____ How Many Children?_____

FAMILY MEDICAL HISTORY:

Please list any close relatives that have a history of the following diseases: Heart Disease, Stroke, Diabetes, Cancer? If there are other diseases that run in your family, please list.

_____

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services that I may need.

X_____

Signature of Patient or Guardian Date

Office use only:
Date:

Breast History Information:

Drs. Farr, Wampler, Henson, Williams, Dougherty & Brown
www.novasurgery.com

Name: **Date:**

Who Referred you to us? _____

What is the Reason for your visit today? (Please Circle)

[Right] or [Left] or [Both] breasts?

Abnormal Mammogram or Ultrasound?
Breast Lump?
Nipple Discharge?
Breast Pain?
OTHER REASON? _____

Has anyone in your family ever had Breast or Ovarian Cancer?
(Please list their age at diagnosis.)

	"Mother's side"	**"Father's side"**
Grandmother	_____	
Mother	_____	
Daughter	_____	
Sister	_____	
Aunt	_____	

Birth Control Pills: Have you ever taken them? **Yes** **No**
If yes, How many total years did you take them?_____
Have you taken hormone replacement? **Yes** **No**
If yes, name of drug? _____ **For how many years?** _____

Menstrual ("Period") History:
At what age did you begin your "Period"? _____
How old were you when you had your 1st child? _____
How many children have you had? _____

Previous Breast Procedures: (Please circle)

Cyst Aspirations:	**None**	**Left**	**Right**
Breast Biopsy:	**None**	**Left**	**Right**
Breast Cancer Surgery:	**None**	**Left**	**Right**

Did you Breastfeed your children? **Yes** **No**
Have you had a Hysterectomy? **Yes** **No**
(Removal of your uterus or "womb")
Have you had your ovaries removed? **Yes** **No**
(ie: sometimes performed with a hysterectomy)

HIPAA Notice of Privacy Practices

Drs. Farr, Wampler, Henson & Williams, Ltd.
8650 Sudley Road, Suite #206
Manassas, Virginia 20110
(703) 368-9234

432 Hospital Drive
Warrenton, Virginia 20186
(540) 347-2805

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____Date_____

Drs. Farr, Wampler, Henson, & Williams, Ltd.
General, Vascular, Thoracic & Breast Surgery
www.NOVASURGERY.com

Breast Care Responsibility Agreement

WHAT YOU NEED TO KNOW:

It is common that patients do not return for office visits or breast imaging studies as recommended. Return visits and breast imaging studies (ie: mammograms) are frequently recommended 6 to 12 months in advance. Unfortunately, we are not equipped to track every patient's follow-up plan. We will not call to remind you when to return to see your surgeon…or for every test result. DO NOT ASSUME THAT IF YOU DO NOT HEAR FROM US, EVERY THING IS O.K.! A delay in the diagnosis and treatment of breast cancer may occur if you do not follow our recommendations.

We rely on you to help us provide good care by implementing our recommended treatment and follow-up plan.

OUR COMMITMENT TO YOU:

Your surgeon will outline a detailed plan for your care. You will leave our office with the appropriate order forms and follow-up visit recommendations. We typically see you in our office after follow-up imaging studies and review the results in person with you. Even we can miss or overlook aspects of your care. If you ever recognize this, please call and bring it to our attention. Our practice does not coordinate general breast cancer screening (see reverse for guidelines). We recommend you coordinate this with your primary care physician.

YOUR RESPONSIBILITY:

1. **Keep track of your return visits and breast imaging orders at home. (Place a reminder in your calendar.)**
2. **Coordinate these visits and imaging studies yourself.**
3. **Call us for any questions or concerns.**
4. **Call us if you feel we have not done our job well.**

******ONLY TOGETHER CAN WE ACHIEVE THE BEST IN BREAST CARE******

I acknowledge that I have received a copy of this sheet for my review and records.

Name:_____ **Date:**_____

Breast Care Responsibility Statement Cont'd
(Additional Information)

A Few Important Reasons for Breast Surgeon Follow-up Visits and Imaging Studies:

1. **"Indeterminante" imaging results**
   - When a mammogram or ultrasound or MRI suggests that there is a tiny risk of a cancer (usually less than 3%). A repeat exam is often recommended in 3 – 6 months by the radiologist to detect any change that would more strongly suggest there is a cancer present.
2. **If you have had Breast Cancer**
3. **Women deemed a "High Risk" for developing breast cancer**
4. **After a Stereotactic Breast Biopsy**
5. **Often after an breast surgery**
6. **A repeat surgeon breast exam is suggested**

Breast Cancer Screening Guidelines

[American Cancer Society]

- **Yearly mammograms are recommended starting at age 40 and continuing for as long as a woman is in good health.**
- **Clinical breast exam (CBE) should be part of a periodic health exam, about every 3 years for women in their 20s and 30s and every year for women 40 and over.**
- **Women should know how their breasts normally feel and report any breast change promptly to their health care providers. Breast self-exam (BSE) is an option for women starting in their 20s.**
- **Women at high risk (greater than 20% lifetime risk) should get an MRI and a mammogram every year. Women at moderately increased risk (15% to 20% lifetime risk) should talk with their doctors about the benefits and limitations of adding MRI screening to their yearly mammogram. Yearly MRI screening is not recommended for women whose lifetime risk of breast cancer is less than 15%.**