Dr. Roxanne Dietzler, PC
Occupational Medicine & Family Practice
732 Thimble Shoals Blvd, Suite 102
Newport News, Virginia 23606

Patient Information: PLEASE PRINT

*First Name*_____*MI*_____*Last Name*_____ _____

*SS#*_____*Date of Birth*_____*Address*_____ _____

*City*_____*State*_____*Zip*_____ *Marital Status S M D W O*

*Home #( )*_____*Work#( )*_____*Cell #( )*_____

Who can we thank for referring you to our office? _____

Is this a Workers Compensation Visit? Y N If so what type of injury? _____

- If you are here at a Companies request, no payment is required at this time
- *PAYMENT IS DUE PRIOR TO SERVICES BEING RENDERED* for all other patients. We only accept cash or credit card, no personal checks. We do not file insurance, nor do we guarantee that you will be reimbursed for your visit. We do not accept Medicaid or Medicare patients. If you have insurance and would like a 1500 (insurance form), please let the receptionist know, and we will be more than happy to fill one out for you for a $5.00 fee.
- Worker's Compensation patients are responsible for payment if their claim is denied. You will be sent a bill from us if your claim is denied. Payment is expected at the time the bill is received by cash or credit card.

PRIVATE PATIENTS

PATIENTS WHO ARE NOT HERE AT A COMPANIES DIRECTION ARE RESPONSIBLE FOR FEES FOR ALL SERVICES RENDERED, REGARDLESS OF INSURANCE COVERAGE. ALL PAYMENTS ARE DUE PRIOR TO SERVICES BEING RENDERED. THE PATIENT AND/OR THE PATIENT'S INSURANCE CARRIER MAY RECEIVE A SEPARATE BILL FOR LABORATORY SERVICES AND X-RAY INTERPRETATIONS. THESE PAYMENTS ARE DUE TO THE ENTITY PERFORMING THESE SERVICES. WE CAN NOT GUARENTEE REIMBURSEMENT FOR ANY SERVICES.

PATIENT CONSENT

I hereby give my consent for Dr. Roxanne Dietzler, PC and its representatives to obtain necessary historical information, perform physical examinations, medical evaluations, medical testing and to administer necessary treatment and or medications as may be necessary. I realize that this evaluation may be at my employer or future employer's request. I further authorize Dr. Roxanne Dietzler, PC to complete tests of examinations on me for drug and alcohol use pursuant to an agreement between my prospective or current employer and Dr. Roxanne Dietzler, PC. I understand that the tests may include the procurement and examination of urine, breath and or blood samples. Further, I understand that a Medical Review Officer not employed by Dr. Roxanne Dietzler, PC may be reviewing the drug test results and that the MRO may contact me.

I authorize the release of medical information obtained during my evaluation and/or test results to my prospective or current employer. I understand that if I decline to sign this consent and thereby decline to take the test or undergo and examination that has been requested by the employer, that the employer will be notified. I further understand that if Dr. Roxanne Dietzler, PC is performing these test(s) as a service to the employer or prospective employer that Dr. Roxanne Dietzler, PC assumes no responsibility for any actions taken by the employer as a result of the examination or test or refusal to consent to the test or examination. I consent to the release of protected health information that is required to carry out treatment and payment for healthcare services performed on my behalf. I also consent to all treatments as deemed appropriate by the treating physician and agree to pay for all such services rendered. I accept responsibility for payments of all charges incurred as well as all collection agency costs and or attorney fee up to 33 1/3% should such collection action become necessary. I further attest that I have received, read and understand the Notice of Privacy Practices at this office.

I understand that in accordance with Section 32.1-45.1 of the Code of Virginia, 1950, as amended, that if during the course of the provision of health care services at Dr. Roxanne Dietzler, PC any employed staff member or any individual under the direction of Dr. Roxanne Dietzler, PC or any other health care provider is exposed to my body fluids in a manner which according to the guidelines of the Center of Disease Control, could potentially transmit human immunodeficiency virus (HIV), Hepatitis B, and/or Hepatitis C that I shall be deemed to have consented to blood testing for infection with HIV, Hepatitis B and C. I further agree to the release of all related blood test results to the person who was exposed.

_____ _____ _____

Patient Name Printed | Patient Signature | Date

GENERAL MEDICAL HISTORY FORM

If none apply, please check N, write N/A or NONE

MEDICAL HISTORY: Check if you have *EVER* had any of these *DIAGNOSED*

	Y	N		Y	N		Y	N
Anemia			Diabetes			Liver disease		
Ankle injury			Glaucoma			Low back injury/pain		
Anxiety			Gout			Mid back pain		
Arthritis			Heart Disease			Migraines		
Asthma			Hepatitis			Neck injury/pain		
Bleeding Disease			High blood pressure			Reflux		
Cancer			High cholesterol			Shoulder injury/pain		
Depression			Kidney disease			Seizures/Stroke		
Dermatitis/Skin Ds			Knee injury			Stroke		

OTHER:_____

SURGICAL HISTORY

	Y	N	When		Y	N	When
Ankle surgery (R/L)				Knee surgery (R/L)			
Appendix removed				Low back surgery			
C-Section				Neck surgery			
Colonoscopy				Shoulder surgery (R/L)			
Gallbladder removed				Stress test			
Heart/stent/bypass				Tonsils removed			
Hernia repair				Tubal ligation			
Hysterectomy				Vasectomy			

OTHER:_____

CURRENT MEDICATIONS: (Name-Dose) _____

_____

Do you have any ALLERGIES TO MEDICATIONS? NO □ YES □ Please list _____

FAMILY HISTORY

Mother	□Alive □Deceased	Cause of Death-
Father	□Alive □Deceased	Cause of Death-
Brother & Sisters	#___Alive #____ Deceased	Cause of Death-

Do you have any family history of:

	Y	N	Who & What Type		Y	N	Who
Cancer				Heart disease			
Diabetes				Other			

Tobacco- Do you currently use: □Cigarettes □Cigars □Snuff □Chewing tobacco □ None

How much in a day:_____ How many months/years:_____

Alcohol- Do you drink? □Never □Rarely □Monthly □Weekly □Daily

Shots: Tetanus shot in last 10 year? □Yes_____(year) □No □Unknown

Hepatitis B series? □Yes_____(year completed) □No □Started not finished

Family Doctor:_____ ____ # Of Children_____

Occupation:_____ ____ Company:_____

Number of years/months with current company: _____

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ACKNOWLDGEMENT OF RECIEPT, NOTICE OF PRIVACY PRACTICES

The federal HIPPA privacy rule requires our office to comply with certain legal requirements designed to protect your personal health information (PHI). HIPPA gives individuals the right to request a restriction on uses and disclosures of PHI. The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home. We may need your written authorization to release PHI even if you are the one requesting the release.

Under certain conditions, for example worker's compensation, drug testing and employer directed examinations a release may not be required. If your employer has directed you to come to our office, your PHI may be released to the employer unless you indicate otherwise. Please let the office staff know if you have any questions about information that may be released at the time of your visit.

The goal of our office is to provide open communication with our patients. At your visit we provide you with the privacy information brochure, "We Care About Your Privacy" as well as have the information posted next to the receptionist desk. If you have any questions about the contents of the brochure please let us know.

Our usual methods for notifying patients are by way of mail or telephone. We will not leave confidential information on your voice mail unless it is deemed an emergency by the physician. We may leave you a reminder message about an upcoming appointment or information to call our office for results or to speak with the doctor. We make every attempt to keep your information confidential. We may also send post cards about upcoming appointments.

☐ *I have read and agree with all the above listed ways of communication*

☐ *I have read and do not agree with the above listed means of communication:*
Please explain below and notify the physician of your concerns:

_____
_____

If you would like to be contacted by other means please let us know by indicating below:

_____ _____
_____ _____

If you would like private information released to anyone other than yourself we must have their name and information in writing. You may list their information below. This release would authorize them to receive any and all information about the office visit, labs, etc.
I authorize release of private health care information to: Name / Address / Phone

_____ _____ _____
_____ _____ _____

*Signature*_____ *Date*_____

You May Refuse to Sign This Acknowledgement

OFFICE USE ONLY
We attempted to obtain written acknowledgement of the receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because ☐Individual refused to sign ☐Other: