PLEASE BRING YOUR INSURANCE CARDS AND THIS COMPLETED FORM TO YOUR FIRST APPOINTMENT

JORDAN-YOUNG INSTITUTE
ORTHOPEDIC SURGERY • SPORTS MEDICINE
NEUROSURGERY • PHYSICAL MEDICINE & REHABILITATION

PATIENT INFORMATION

ACCOUNT # _____

PATIENT NAME_____ MAIDEN/OTHER NAME_____

ADDRESS _____

CITY _____ STATE _____ ZIP_____ EMAIL _____

AGE _____ DATE OF BIRTH _____ □ MALE □ FEMALE MARITAL STATUS _____

HOME PHONE _____ CELL PHONE _____

SOCIAL SECURITY NUMBER _____

EMPLOYER _____ EMPLOYER PHONE _____

OCCUPATION _____

PRIMARY CARE PROVIDER _____

REFERRING PHYSICIAN _____

RESPONSIBLE PARTY OR SPOUSE

NAME_____ MAIDEN/OTHER NAME_____

ADDRESS _____

CITY _____ STATE _____ DATE OF BIRTH _____

HOME PHONE _____ SOCIAL SECURITY # _____

CELL PHONE _____ OCCUPATION _____

EMPLOYER _____ EMPLOYER PHONE _____

PRIMARY HEALTH INSURANCE INFORMATION

COMPANY NAME _____ EFFECTIVE DATE _____

POLICY HOLDER NAME _____ POLICY NUMBER _____

POLICY HOLDER DATE OF BIRTH _____ SOCIAL SECURITY # _____

PATIENT'S RELATIONSHIP TO POLICY HOLDER: □SELF □SPOUSE □ CHILD □ OTHER

GROUP # _____

SECONDARY HEALTH INSURANCE INFORMATION

COMPANY NAME _____ EFFECTIVE DATE _____

POLICY HOLDER NAME _____ POLICY NUMBER _____

POLICY HOLDER DATE OF BIRTH _____ SOCIAL SECURITY # _____

PATIENT'S RELATIONSHIP TO POLICY HOLDER: □SELF □SPOUSE □ CHILD □ OTHER

GROUP # _____

EMERGENCY CONTACT INFORMATION

NAME OF CONTACT _____

TELEPHONE _____ RELATIONSHIP _____

SIGNATURE ON BACK →

I HEREBY CONSENT TO TREATMENT by Jordan Young Institute physicians, their associates, and/or assistants and accept responsibility for fees for such medical services. I understand that treatment may include x-rays, injections, medical appliances and/or other procedures as deemed necessary.

DEEMED CONSENT

I understand that, in accordance with Section 32.1-45.1 of the Code of Virginia, 1905, as amended, if a Jordan-Young Institute, P.C. healthcare provider is exposed to my blood or other bodily fluids in a manner which may transmit disease, I may be tested for infection with Human Immunodeficiency Virus (HIV), the virus which causes Acquired Immune Deficiency Syndrome (AIDS) or Hepatitis B or C viruses. I further understand that the results of any such test will be shared with me and the exposed healthcare provider; that the Virginia Department of Health will be notified; and that appropriate counseling shall be provided if the results are positive.

DISABILITY / FMLA FORM INFORMATION

Jordan-Young Institute, P.C. staff will complete all disability and/or FMLA forms that you require, within two weeks of the date requested. We are unable to complete forms while you wait. We require a fee of $35 for completion of all disability and FMLA forms.

PATIENT AUTHORIZATION

I authorize Jordan-Young Institute, P.C. to release medical information necessary to submit my health insurance or Worker's Compensation Claims. I request that my health insurance or Worker's Compensation claims be paid directly to Jordan-Young Institute,P.C. In consideration of the services rendered, I/we agree and understand that each person(s) signing this document jointly and severable agrees to pay for all services rendered by Jordan-Young Institute, P.C. If this account is referred to an outside collection agency or attorney, then the undersigned person(s) agree and promise to pay all collection costs including attorney fees of 33 1/3 % of the principal amount due and owing when turned over for collection and do further agree to pay interest on the unpaid balance at the legal rate from the date services were last rendered. I authorize photocopies of this form to be valid as the original.

POLICY FOR FORMS COMPLETION AND THE COPYING OF MEDICAL RECORDS AND X-RAYS

Any request for medical records require a medical release to be completed. Medical records will be filled within two weeks of date requested. Please see medical release form for all charges that may apply. Please allow one week for any request of x-ray films. There will be a charge of $5 per x-ray film.

PRESCRIPTION REFILL POLICY

To request a prescription refill, please call us Monday through Friday, from 9:00a.m. to 4:00 p.m .. Please allow 24 hours for us to process your prescription refill request. Prescriptions for narcotics cannot be ordered after hours or on weekends. Please remember to call us in advance so that we can assist you in a timely manner.

CLINICAL RESEARCH ACTIVITY

The physicians of Jordan-Young Institute are involved in clinical research studies and trials and work closely with Jordan Research Foundation. The companies sponsoring these studies and trials provide financial support for research staff as well as for activities the physicians perform outside of clinical practice. These activities may include consulting, advisory boards, giving speeches and/or presentations, or writing reports. If you would like more information please ask to speak with the Jordan Research Foundation's Research Coordinator.

Patient Signature: _____ Date: _____

Patient or Guardian's Signature: _____ Date: _____

Relationship to Patient _____

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MEDICAL QUESTIONNAIRE

Dr. Parker W. Babington

NAME_____ BIRTH DATE _____ TODAY'S DATE_____

IF YOU HAVE BEEN SEEN BY DR. BABINGTON BEFORE, PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. DO YOU HAVE A NEW PROBLEM THAT WAS NOT EVALUATED AT YOUR LAST VISIT? Y N
   IF SO, WHAT IS IT? _____
2. HOW LONG HAS IT BEEN SINCE YOUR LAST VISIT (APPROXIMATELY)? _____ DAYS WEEKS MONTHS
3. SINCE YOUR LAST VISIT, ARE YOU: BETTER WORSE SAME
4. ON A SCALE OF 0-100%, HOW MUCH BETTER ARE YOU NOW? IF NO BETTER, PUT 0%. _____

ALL PATIENTS, PLEASE COMPLETE THE FOLLOWING:

WHAT IS YOUR PAIN LEVEL TODAY? _____
(0=NONE, 10= WORST PAIN IN YOUR LIFE)

1. WHAT IS THE QUALITY OF THE PAIN?

SHARP DULL STABBING THROBBING ACHING BURNING

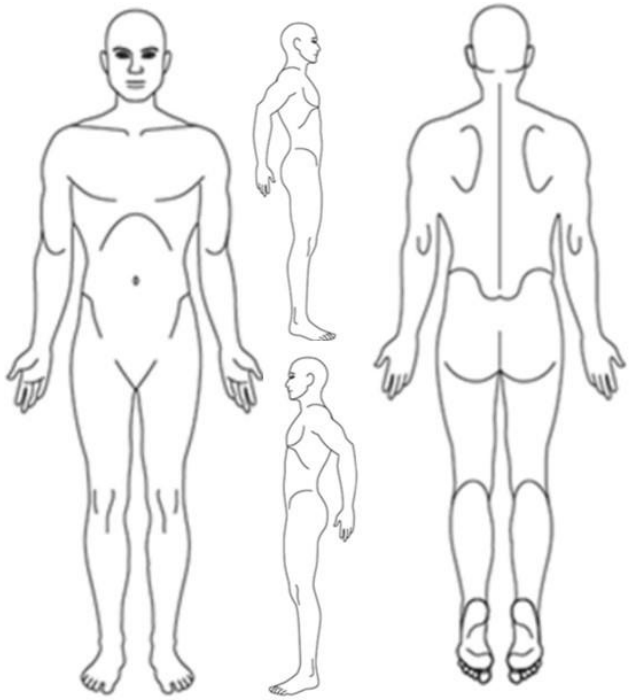
2. THE PAIN IS: CONSTANT COMES AND GOES
3. DOES IT WAKE YOU FROM SLEEP? Y N
4. DO YOU HAVE: NUMBNESS TINGLING WEAKNESS
   LOSS OF BOWEL OR BLADDER NONE
5. WHAT MEDICATIONS ARE YOU TAKING FOR THIS CONDITION? NONE

ANTI-INFLAMMATORY _____(NAME)
PAIN KILLER (NARCOTIC) _____(NAME)

6. INDICATE ANY PRIOR TREATMENT IN THE BOX BELOW:

TREATMENT	DID IT HELP?
ANTI-INFLAMMATORIES	Y N
PHYSICAL THERAPY	Y N
HOME EXERCISE PROGRAM	Y N
INJECTION	Y N
SURGERY	Y N

PLEASE DRAW THE LOCATION OF YOUR PAIN ON THE DIAGRAM. INCLUDE ANY RADIATION TO ARMS OR LEGS.



HISTORY	
CIRCLE ANY PROBLEM AREAS AND DESCRIBE	ALLERGIES NERVES LUNGS EYES SKIN STOMACH/BOWELS OTHER JOINTS DIABETES EARS PSYCHIATRIC WEIGHT LOSS/FEVER HEART URINE ANEMIA
DESCRIBE ANY PROBLEMS:	
ARE YOU PRESCRIBED ANY MEDICATIONS BY ANY OTHER PHYSICIAN? Y N DESCRIBE: _____	
HAVE YOU RECENTLY BEEN HOSPITALIZED? Y N DESCRIBE: _____	
WHAT IS YOUR CURRENT JOB STATUS? REGULAR JOB LIGHT DUTY NOT WORKING DUE TO THIS CONDITION DO NOT WORK RETIRED	
DO YOU HAVE ANY QUESTIONS YOU WOULD LIKE THE DOCTOR TO ANSWER AT THIS VISIT? _____ _____	
PATIENT SIGNATURE _____ MD/PA SIGNATURE _____DATE _____	

PATIENT HISTORY

PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOUR FIRST APPOINTMENT

PATIENT NAME_____ TODAY'S DATE _____
LAST FIRST MIDDLE

DATE OF BIRTH _____ AGE _____ HEIGHT_____ WEIGHT_____

PRIMARY CARE PHYSICIAN'S NAME/ADDRESS _____

REFERRING PHYSICIAN'S NAME/ADDRESS _____

YOUR PRIMARY PROBLEM/COMPLAINT_____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

WHAT IS THE SEVERITY OF YOUR PAIN (CIRCLE ONE) NONE 1 2 3 4 5 6 7 8 9 10 Unbearable

IS YOUR PAIN: ☐ IMPROVING ☐ WORSENING ☐ STAYING THE SAME

WHAT IMPROVES YOUR SYMPTOMS OR MAKES THEM WORSE?_____

_____

IS THIS A PROBLEM DUE TO AN ACCIDENT? ☐ **YES** ☐ **NO**

IS THIS A WORKERS COMP CLAIM? ☐ **YES** ☐ **NO**

HOW DID THE INJURY OCCUR (SPORTS, WORK, MOTOR VEHICLE ACCIDENT)?_____

_____

WHERE DID THE INJURY OCCUR? _____ **DATE OF INJURY**_____

HAVE YOU HAD X-RAYS, MRIs, or CTs PERFORMED ELSEWHERE RELATED TO THIS PROBLEM? ☐ YES ☐ NO
IF YES, PLEASE EXPLAIN _____

HAVE YOU BEEN EXAMINED BY A PHYSICIAN FOR THIS COMPLAINT BEFORE? ☐ YES ☐ NO
IF YES, LIST PHYSICIAN _____

HAVE YOU BEEN TOLD THAT YOU NEED SURGERY, OR EVER HAD SURGERY RELATED TO THIS? ☐ YES ☐ NO
IF YES, LIST PHYSICIAN _____

DO YOU SMOKE? ☐ YES ☐ NO IF YES, HOW OFTEN/HOW LONG: _____

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO IF YES, HOW MUCH/OFTEN: _____

HAVE YOU EVER HAD A DRUG ADDICTION? ☐ YES ☐ NO IF YES, HOW LONG AGO: _____

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MEDICAL AND SURGICAL HISTORY

HAVE YOU EVER BEEN DIAGNOSED WITH:	YES	NO	LIST ANY OTHER MEDICAL CONDITIONS OR TREATMENTS BELOW:
DIABETES TYPE 1 OR TYPE 2			
HYPERTENSION			
ASTHMA			
KIDNEY DISEASE			
ULCERS			
GASTRITIS			
HEPATITIS			
HIV			
SEIZURES			
BLEEDING DISORDERS			
CANCER			

PLEASE LIST ANY PREVIOUS SURGERIES AND THE APPROXIMATE YEAR

SURGERY	YEAR	SURGERY	YEAR

PLEASE LIST ALL MEDICATION ALLERGIES

MEDICATION	REACTION

PLEASE LIST ALL MEDICATIONS (PRESCRIPTION AND OVER-THE-COUNTER) THAT YOU ARE CURRENTLY TAKING

MEDICATION	DOSE	FREQUENCY

FAMILY HISTORY
PLEASE INDICATE THE HEALTH STATUS OF YOUR FAMILY MEMBERS

MOTHER _____ ☐ ALIVE ☐ DECEASED
FATHER _____ ☐ ALIVE ☐ DECEASED
BROTHER _____ ☐ ALIVE ☐ DECEASED
SISTER _____ ☐ ALIVE ☐ DECEASED
CHILD _____ ☐ ALIVE ☐ DECEASED
CHILD _____ ☐ ALIVE ☐ DECEASED
RELATIVE _____ ☐ ALIVE ☐ DECEASED
RELATIVE _____ ☐ ALIVE ☐ DECEASED

REVIEW OF SYSTEMS

CONSTITUTIONAL					GENITOURINARY				
Excessive Fatigue		Yes		No	Difficult Urination		Yes		No
Exercise Intolerance		Yes		No	Kidney stones		Yes		No
Chills		Yes		No	Frequency		Yes		No
Fever		Yes		No	Urgency		Yes		No
Unexpected weight loss		Yes		No	Flank pain		Yes		No
Unexpected weight gain		Yes		No	Bleeding		Yes		No
EYES					Painful urination		Yes		No
Glaucoma		Yes		No	Bladder infection		Yes		No
Cataracts		Yes		No	**SKIN**				
Blurred/double vision		Yes		No	Lesion color change		Yes		No
Redness		Yes		No	Rash		Yes		No
Pain		Yes		No	Itching		Yes		No
ENT					Redness		Yes		No
Infected or painful teeth		Yes		No	Skin changes		Yes		No
Headache		Yes		No	Poor healing		Yes		No
Difficulty swallowing		Yes		No	**NEUROLOGICAL**				
Nose bleeds		Yes		No	Head injury		Yes		No
Ringing/Pain in ears		Yes		No	Seizures		Yes		No
CARDIOVASCULAR					Numbness/tingling		Yes		No
Chest pain		Yes		No	Stroke		Yes		No
Heart murmurs		Yes		No	Dizziness		Yes		No
High blood pressure		Yes		No	Tremors		Yes		No
Palpitations		Yes		No	**HEMATOLOGIC**				
Irregular pulse		Yes		No	Easy bleeding/bruising		Yes		No
Fainting		Yes		No	Blood clots		Yes		No
Vascular disease		Yes		No	Blood transfusion		Yes		No
RESPIRATORY					**ENDOCRINE**				
Asthma		Yes		No	Heat/cold intolerance		Yes		No
Snoring		Yes		No	Excessive thirst/urination		Yes		No
Cough		Yes		No	**ALLERGIC**				
Pulmonary edema		Yes		No	Reaction to foods		Yes		No
Shortness of breath		Yes		No	Reaction to environment		Yes		No
Wheezing		Yes		No	**PSYCHIATRIC**				
Pain with a deep breath		Yes		No	Nervousness		Yes		No
GASTROINTESTINAL					Anxiety		Yes		No
Heartburn		Yes		No	Depression		Yes		No
Nausea		Yes		No	Hallucinations		Yes		No
Vomiting		Yes		No					
Constipation		Yes		No					
Diarrhea		Yes		No					
Bloody/Tarry Stools		Yes		No					

Patient Signature _____ **Date** _____

Reviewed with patient

Physician Signature _____ **Date** _____

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FINANCIAL POLICY

Thank you for choosing Jordan-Young Institute. We are committed to providing you with the best patient care experience possible. As part of this goal, we would like to explain our payment policies before your treatment begins so you have the chance to ask questions before any payment obligation occurs. We feel that helping you understand your payment expectations and obligations ahead of time will help us provide you with the quality of compassion and care you expect from our practice.

For your convenience, we have answered a variety of commonly asked questions about payment policies. If you do not find the answer to your specific questions, please ask to meet with appropriate staff who can help.

DO YOU ACCEPT MY INSURANCE AS PAYMENT IN FULL?

We are participating providers with Medicare, Cigna, Sentara Optima, Blue Cross Blue Shield and Healthkeepers, Aetna, Humana, Tricare Standard, United Healthcare, VHN, and PHCS. This means that we will accept the insurers allowable as payment in full. **You, however, are still responsible for payment of any deductibles, co-insurance or co-pays as defined by your insurance coverage. Your office visit will be rescheduled if you are unable to pay your co-pay or provide a referral (if necessary) before you are seen.**

We do not participate with Aetna HMO, Today's Option Medicare Advantage or any of the Medicare-Medicaid dual-eligibility programs, however, we will assist you in determining your benefit coverage. We do not offer payment plans but we can refer you to an external agency should you need to make such arrangements.

We do not participate with Healthkeepers Plus and Sentara Family Care.

WHEN DO I HAVE TO PAY FOR SERVICES?

You are expected to pay all co-pays, co-insurance and unmet deductibles on the day of your visit. We accept VISA, MasterCard, Discover, and American Express as well as payment by cash or check. **If you are unable to pay, your appointment will be rescheduled.**

You are expected to pay for all non-covered services and DME Cash and Carry Items at the time of issue. We will gladly hold an item for you until you are able to pay.

MAY I STILL BE SEEN IF JORDAN-YOUNG DOES NOT PARTICIPATE WITH MY INSURANCE?

If you do not carry insurance we participate with, your policy may have out-of-network benefits. It is your responsibility to call your insurance carrier to determine and understand your benefit coverage. Jordan-Young will file a claim to your insurance as a courtesy to you; however, we are not obligated to accept your insurance's payment as payment in full. **You may be balance billed for the difference between our charge and the amount your insurance pays.**

DO I NEED A REFERRAL TO BE SEEN?

Many insurance plans now provide open referral networks; however, **it is your responsibility to determine and understand if your individual insurance coverage requires a referral.** If your insurance requires a referral, you must have the referral available at the time of your appointment. If you do not have the referral with you, you will be asked to either 1) Reschedule your appointment to give you time to obtain the referral or 2) Sign a waiver that will make you responsible for payment in full of the charges incurred on the day's visit.

Tricare Prime patients must obtain a referral before being scheduled for an appointment.

DO I HAVE TO PAY IF I HAVE BEEN INJURED IN AN ACCIDENT?

Jordan-Young does not accept legal cases or attorney liens. If you have been injured in a non-work-related accident for which you are seeking legal remedy, you will be required to pay 100% of your billed charges before being seen. **Your medical insurance cannot be billed.**

If you have been injured in a work-related accident, **it is your responsibility to obtain an award number from the state Workers' Compensation Commission** in order to ensure that your claim will be paid in full. If you are treated without the award number from the state and your payment of your claim is denied or only paid in part by your employer, you will be held responsible for the balance of your bill.

Jordan-Young accepts fee schedule payments for injured workers covered under the United States Department of Labor, Jones Act, Longshoreman's Act and Sentara Health Systems.

MAY I SET UP A PAYMENT PLAN?

Payment is expected in full at the time services are rendered. **If you are not able to pay the patient responsible balance of your bill at the time of service, Jordan-Young retains the right to refer your account to AMC for collection. AMC will attempt to negotiate reasonable payment terms with you and will accept most forms of payment. If you fail to keep the agreed payment terms, further collection activities will ensue. You will be responsible for fees and any other associated costs incurred in collecting on your account.**

Co-insurance and deductible balances after insurance are expected to be paid within 30 days of receiving your first patient statement. If your account balance is still unpaid after 31 days, **your account will be referred to Account Management Company AMC for collections. AMC is not a collection agency, but rather an external bill paying service. However, if you default on your payment arrangements or do not pay your outstanding bill, your outstanding account will be immediately transferred to a collection agency. You will be responsible for the balance due on your account plus any non-negotiable fee assigned by the collection agency in satisfying the payment of your account balance.**

You will be responsible for contacting Credit Control Corporation and AMC at either (757)873-3332 or 1-(800)723-5431 for making time-based payment arrangements or collections payments.

WHAT HAPPENS IF I MISS AN APPOINTMENT OR HAVE A CHECK RETURNED?

Jordan-Young reserves the right to charge a NO SHOW fee of $50 for any missed appointment. This fee must be paid before another appointment is scheduled.

Jordan-Young reserves the right to charge a RETURN CHECK fee of $35 for any payment by check that is returned for insufficient funds.

I have read and fully understand the policies of this office regarding payment. I agree to pay any known patient responsible obligations at the time of service or any obligations identified as my responsibility within 30 days of notification by my insurance or Jordan-Young. I understand that collection of my patient responsible balances outside these terms may be handled by an outside collection agency and I will be responsible for both the balance of the bill and any non-negotiable fees assigned for collection. I understand that I am personally responsible for following the regulations, policies and procedures of my insurance plan.

_____ _____

Patient Signature Date

_____

Printed Name

Consent and Acknowledgement of Receipt of Notice of Privacy Practices for Purposes of Payment and Healthcare Operations (HIPAA)

I consent to the use or disclosure of my protected health information by Jordan Young Institute for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Jordan Young Institute.

I have the right to revoke this consent, in writing, at any time, except to the extent that Jordan Young Institute has taken action in reliance on this consent.

My "protected health information" (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Jordan Young Institutes' Notice of Privacy Practices (NPP) prior to signing this document. The Notice of Privacy Practices has been offered to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Jordan Young Institute. The Notice of Privacy Practices for Jordan Young Institute is also provided in the lobby and on the group website at www.jordan-younginstitute.com. This Notice of Privacy Practices describes my rights and responsibilities and Jordan Young Institutes' duties and actions with respect to my protected health information.

Jordan Young Institute 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 accessing the group's website, calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment. I acknowledge I have been told about and offered to receive a copy of the Notice of Privacy Practices.

Release of Information: I hereby give Jordan Young Institute permission to release information on my medical condition to the following people:

_____

Name and Relationship

_____

Name and Relationship

_____

Name and Relationship

I understand that the areas discussed with these people could include treatment options, side effects, prescriptions, financial information, test results, etc.

_____ _____

Patient Signature Date

_____

Printed Name

Parent or Personal Representative refused to sign acknowledgment

_____ Staff Initials

_____ Date

I would like to **RESTRICT DISCLOSURES** "to the insurance company" for services paid for out of pocket.

Patient Signature _____

Date of Service _____