Abingdon Internal Medicine, PC
322 Valley St. NE
Abingdon, VA, 24210
Phone: (276)-628-1106 Fax: (276)-623-2150
JENNIFER JONKERS, MD JOE RUPE, MD
AMY ALMANY, FNP EMORY ROBINETTE, MD

Patient Information

Name: _____ **Preferred Name:** _____

(Last, First, M. Initial)

D.O.B: _____ **Social Security:** _____

(Required)

Mailing Address: _____

Physical Address: _____
(if different)

City: _____ **State:** _____ **Zip Code:** _____

Contact Information

Primary Number: _____ **Secondary:** _____

Cell □ *Home* □ *Cell* □ *Home* □

Work: _____ **Email Address:** _____

Preferred Method of Appointment Reminders Phone Call □ *Text Message* □

(Primary Phone Number)

Emergency Contact

Name: _____ **Relationship:** _____

Phone: _____ **HIPAA Consent** □

Address: _____

HIPAA Consent

Concerning matters of my health, I give permission for Abingdon Internal Medicine to speak with:

Name: _____ **Name:** _____

Relationship: _____ **Relationship:** _____

Phone: _____ **Phone:** _____

Name: _____ **Name:** _____

Relationship: _____ **Relationship:** _____

Phone: _____ **Phone:** _____

Insurance Information

Insurance Carrier: _____

Name of Policy Holder: _____

Social Security of Policy Holder: _____

D.O.B of Policy Holder: _____

Health Information

Former Primary Care Provider: _____

Reason for Changing: _____

Are you currently seeking an appointment to treat pain or anxiety, **OR** currently a patient of a pain clinic? _____

Current Medication

Please list all prescription medications.

_____

_____

_____

_____

_____

Authorization for Release of Confidential Health Care Information

This authorizes Abingdon Internal Medicine to request and receive from the Department of Health Professions all records held relation to scheduled II-IV controlled substances dispensed to above name patient.

I understand that this authorization permits the Department of Health Professionals to disclose confidential health records to the physicians named above. A copy of this authorization shall be included with my original records. There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure as permitted or required by the law.

Patient Name: _____

Patient Signature: _____

Guardian Signature: _____

Date: _____

Abingdon Internal Medicine, PC
322 Valley St. NE
Abingdon, VA. 24210
Phone: (276)-628-1106 Fax: (276)-623-2150
JENNIFER JONKERS, MD JOE RUPE, MD
AMY ALMANY, FNP EMORY ROBINETTE, MD

Financial Policy and Patient Responsibility

Abingdon Internal Medicine is committed to providing you quality and affordable health care. Please read the following policies and sign below in the space provided. A copy will be provided to you upon your request.

1. INSURANCE: You are responsible for bringing your insurance and prescription cards to every appointment and notifying us of any insurance changes. If you fail to provide us with the correct insurance information within 30 days, you will be responsible for the balance of the claim in full.
2. PAYMENT: Payment is due at the time of services provided and/or upon receipt of statement from our billing office. This applies to co-pays, balances, self pay, etc. Not paying or making payment arranges for these will result in having to reschedule your appointment until payment can be made.
3. NON-COVERED SERVICES: Please be aware that some or all, of the services provided to you during your visit may not be covered by your insurance company. Any non-covered charges are patient responsibility. You will need to call your insurance carrier to appeal any non-covered charges.
4. Returned Checks: There will be a $35.00 service charge for returned checks.
5. Missed (No Show), Cancelled, and Rescheduled Appointments: If you fail to reschedule or cancel your appointment with at least 24-hour notice or no show for your appointment, you may be charged a $45.00 fee billed directly to you or responsible guardian. The $45.00 must be paid prior to receiving additional services through our facility. After two missed (no show) appointments or cancellations/reschedules without at least 24-hour notice, your account will be reviewed for possible discharge from the practice.
6. Financial Dismissal: Patients who do not pay their balances or make payment arrangements risk being dismissed from the practice. Abingdon Internal Medicine reserves the right to dismiss patients due to personal balances or accounts being financially delinquent.
7. Billing Questions: We will be happy to help you resolve your balance and answer questions you may have. We can be reached at (276)-628-1106, Monday-Thursday 8:00am-5:00pm.

8. **Other Fees:** Copying of records for transferring care to another facility or for personal use, completion of forms for equipment, services, and etc. All requests and forms must be prepaid prior to completion.
9. **Yearly Health Checks:** Physicians may require yearly physicals, which may or may not be covered under your health insurance policy.

I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND WILL FOLLOW ALL POLICIES AND RESPONSIBILITIES STATED IN THE "FINANCIAL POLICY AND PATIENT RESPONSIBILITY". I ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED. I ALSO UNDERSTAND IF I DO NOT FOLLOW THE POLICIES ABOVE THAT ABINGDON INTERNAL MEDICINE WILL TAKE FURTHER ACTION TO COLLECT ANY BALANCE.

_____

Patient Name (print)

_____ _____

Patient or Legal Authorized Representative Signature | Relationship to Patient

_____ _____

Legal Authorized Representative (print) | Date

Abingdon Internal Medicine, PC
322 Valley St. NE
Abingdon, VA, 24210
Phone: (276)-628-1106 Fax: (276)-623-2150
JENNIFER JONKERS, MD JOE RUPE, MD
AMY ALMANY, FNP EMORY ROBINETTE, MD

HIPAA Acknowledgement

I, _____, acknowledge that I have read over the Notice of Privacy Practices for Abingdon Internal Medicine, PC, and that I may get a copy upon request.

_____ _____

Print Name of Patient Signature of Patient

_____ _____

Relationship to Patient Date