



Abingdon Internal Medicine
322 Valley Street NE, Abingdon, VA 24210
(276) 628-1106

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New Patient Information

Demographic Information:

Full Name: _____ Date of Birth: _____

Mailing Address: _____

Physical Address (If Different): _____

Social Security Number: _____ Telephone Number: _____

E-mail Address: _____

Emergency Contact:

Name: _____

Relationship: _____

Phone Number: _____

HIPPA Consent for Contact (Y/N): _____

Persons Authorized to Speak with Abingdon Internal Medicine Regarding HIPPA Confidential Information:

Name/Relationship/Telephone Number: _____

Name/Relationship/Telephone Number: _____

Insurance Information:

Insurance Carrier: _____

Member ID: _____

Group Number: _____

Policy Holder Name and Date of Birth: _____

Medical History:

Chronic conditions (e.g., diabetes, hypertension, heart disease): _____

Surgeries: _____

Allergies: _____

Medications:

Prescription medications (please list all, including dosages and frequency): _____

Over-the-counter medications, vitamins, or supplements (please list): _____

Family Medical History:

- Chronic conditions or diseases in mother: _____

- Chronic conditions or diseases in father: _____

- Chronic conditions or diseases in brother/sister: _____

Immunization Status (Date of Last Vaccine):

- Influenza: _____

- Pneumococcal Pneumonia: _____

- Shingles: _____

- Tetanus: _____

- RSV: _____

Preventive Screenings: When was your last?

- Mammogram (if applicable)? _____

- Pap smear (if applicable)? _____

- Colonoscopy? _____

- Bone density scan? _____

Lifestyle and Habits:

- Do you smoke or use any tobacco products? _____

- If yes, how much and how often: _____

- Do you drink alcohol? _____

- If yes, how much and how often: _____

- Do you use any recreational drugs? _____

Previous Primary Care Provider:

- Provider: _____

- Reason for Changing? _____

- Are you seeking treatment for Pain Management? _____

- Are you seeking treatment for Anxiety? _____

Authorization for Release of Confidential Health Care Information

This authorizes Abingdon Internal Medicine to request and receive confidential information regarding your past medical treatment. This includes a search of the Virginia Prescription Monitoring Program regarding prescribing of controlled substances and review of any Electronic Health Records (EHR) available to Abingdon Internal Medicine.

I understand that Abingdon Internal Medicine utilizes the Virginia Prescription Monitoring Program and that this authorization permits The Virginia Department of Health Professions to disclose such confidential health records to Abingdon Internal Medicine. A copy of this authorization will be included in my medical record. There is a potential for any information disclosed pursuant to this authorization to be re-disclosed as permitted or required by law.

Name: _____

Signature: _____

Date: _____

Financial Policy and Patient Responsibility

Abingdon Internal Medicine is committed to providing quality and affordable healthcare. Please read the following policies and sign in the space below. You may obtain a copy of this policy upon request.

Insurance: You are responsible for bringing your insurance card and I.D. to every appointment, and for notifying us of any changes. If you fail to provide insurance information, you will be responsible for the claim in full.

Payment: Payment for co-payment, balance and self-pay are due at the time of service. Payment for prior services is due upon receipt of the statement. Lack of payment or payment arrangement will result in your visit being re-scheduled until such payment is made.

Non-Covered Services: Some or all of the services provided may not be covered by insurance. Any non-covered services are patient responsibility. The patient is responsible for insurance provider appeals. Medication coverage is determined by insurance providers and may be denied. Medication costs are patient responsibility and prior authorization requests are not guaranteed.

Returned Checks: There is a \$35 service fee on all returned checks. This is payable before further services are provided.

Missed (No Show), Cancelled and Rescheduled Appointments: If you miss or cancel/reschedule an appointment without 24 hours' notice, you may be subject to a \$45 fee billed directly to you or your insurance guarantor. The \$45 fee must be paid prior to further services. After two no show appointments or cancelled/reschedule appointments without 24 hours' notice, your account will be reviewed for, and is subject to dismissal from Abingdon Internal Medicine.

Financial Dismissal: Patients who do not pay their balance or make arrangements for payment risk dismissal from our practice. We reserve the right to dismiss patients due to accounts being financially delinquent.

Other Fees: Copying records for transfer of care or for personal use are subject to the HIPPA Act reasonable costs for copying and mailing. All forms and fees must be paid prior to completion.

Yearly Evaluations: Abingdon Internal Medicine requests patients be seen at a minimum, once every 12 months. This may or may not be covered by your insurance policy. We reserve the right to deny service to patients who have not maintained regular appointments.

Billing Questions: Please contact our billing department at (276) 628-1106 to resolve any questions about your balance or coverage. They are available Monday through Thursday from 8:00 AM to 5:00 PM.

I acknowledge that I have read the Financial Policy and Patient Responsibility information above. I will follow all policies and acknowledge that I am financially responsible for all charges incurred. I also understand that I am subject to balance collection and/or dismissal from Abingdon Internal Medicine if I fail to comply with policies or financial responsibility.

Name: _____

Signature: _____

Date: _____

HIPAA Notice of Privacy Practices

Ver. 07.06.2024

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 (“Notice”) applies to all Protected Health Information (“PHI”) about you (the patient) held or transmitted by Abingdon Internal Medicine, PC. We are required by law to provide individuals with legal notice of our legal duties and privacy practices with respect to PHI. PHI is any individually identifiable information about your past, present, or future physical or mental health condition or payment for healthcare or about the provision of care to you. PHI may include information about your condition or treatment, diagnostic tests and images, and related health information.

Your Rights

When it comes to your PHI, you have the right to:

Obtain an electronic or paper copy of your medical record. You may ask to see or obtain an electronic or paper copy of your medical record, billing information or other health information we use to make decisions about you or direct us to send a copy of PHI stored in an electronic health record to another person designated by you in writing. We will respond usually within 30 days of your request. We may charge a reasonable fee to cover the costs of furnishing the copy or summary.

Request we make corrections to your medical record. You may request to correct PHI you feel is incomplete or incorrect. We may deny your request, but we will tell you why in writing within 60 days of your request.

Request confidential communications. You may ask us to contact you in a particular way (for instance, office or home phone) or to send mail to another address. We will comply with all reasonable requests.

Ask us to limit what we use or disclose. You may ask us not to use or disclose parts of your PHI for treatment, payment, or health care operations. We are not required to agree to your request, unless you payout-of-pocket in full for a medical service, your request is to not disclose PHI for the purpose of payment or operations with your health insurer and the disclosure is not required by law.

Obtain an accounting of disclosures of your PHI. You can ask for a list (accounting) of the times we have disclosed your PHI for six years prior to the date of your request. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting per year for free but will charge a reasonable, cost-related fee.

Obtain a copy of this Notice. You may request a paper copy of this Notice at any time, even if you agreed to receive the Notice electronically.

File a complaint if you feel your rights have been violated. You can file a complaint with our office if you feel we have violated your rights. We will not retaliate against you for filing a complaint. To do so, you may contact us using the information below:

Carolyn Kelly, 322 Valley Street NE, Abingdon, Virginia, 24210

You also have the right to file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

Select someone else to act for you. If you have granted someone medical power of attorney or if someone is your legal guardian, that person may exercise your rights listed above and make decisions about your PHI.

Uses and Disclosures

We may use and disclose your PHI without obtaining your authorization as described below. Not every use or disclosure in a category will be listed. Your PHI may be stored in paper, electronic or other form and may be disclosed electronically and by other methods.

For Treatment. We may use and disclose your PHI with other professionals and providers to treat you. For example, we may disclose your PHI to another physician involved in your care.

For Healthcare Operations. Abingdon Internal Medicine may use and disclose your PHI to run our businesses, improve your care, and contact you when necessary. For example: We may use or disclose your PHI: (1) to conduct quality or patient safety activities, population-based activities relating to improving health or reducing health care costs, case management and care coordination, and contacting your health care providers and you with information about treatment alternatives; (2) when conducting training programs or performing accreditation, licensing, or credentialing activities; (3) when conducting or arranging for medical review, legal services, and auditing functions; and (4) for our proper management and administration, including customer service, resolving complaints, strategic planning, etc.

For Payment. We may use and disclose your PHI to obtain payment for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections and claims management. These activities also include determinations of eligibility and coverage to obtain payment from you, an insurance company or another third party. For example, we disclose your PHI to your health insurance plan so it will pay for services provided to you.

For public health. We may use and disclose your PHI for public health activities, such as to prevent or control disease, injury or disability. For example, we can disclose PHI about you for specific situations, such as reporting adverse reactions to medications to the FDA; preventing the spread of disease; helping with product recalls; reporting suspected abuse, domestic violence or neglect; or preventing or reducing a serious threat to the health or safety of a person or the public.

For research. We may use or disclose your PHI for research in limited circumstances.

To comply with the law. We will share PHI about you if required by state or federal law, including with the U.S. Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

To report abuse, neglect or domestic violence. If we reasonably believe that you are a victim of abuse, neglect, or domestic violence, we may disclose your PHI to a government authority, including a social service protective agency, authorized by law to receive reports of abuse, neglect or domestic violence.

For health oversight activities. We may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure actions.

Additional Disclosures

For organ and tissue donation. We may disclose PHI about you to organ procurement organizations, which are entities involved in procuring, banking and transplanting organs, eyes, and tissues.

To a medical examiner, coroner, or funeral director. We may disclose PHI with a coroner, medical examiner, or funeral director when an individual dies.

To law enforcement. We may disclose your PHI for law enforcement purposes, as permitted by HIPAA, including in response to a subpoena or court order.

For lawsuits and legal actions. We may disclose PHI about you in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request or other lawful process.

To our business associates. We may disclose your PHI to one our service providers, known as “business associates,” in order for them to provide services to us or on our behalf. Our business associates are required by written agreement to safeguard your PHI and otherwise protect your privacy as required by law.

Incidental. We may make incidental disclosures of limited PHI, such as by mailing statements to you with your name on the envelope by calling your name in the waiting room to call you back to an examination room.

To individuals involved in your care or payment for your care. We may disclose your PHI to your family or friends, or any other individual identified by you when they are involved in your care or in the payment for your care. For example, when a family member or a friend comes with you into an exam room, we understand this to be your acknowledgment that you want this individual to be involved in your care.

To communicate with you. We may use your PHI to communicate with you in person, by phone, or by e-mail.

To a Health Information Exchange. We may participate in one or more Health Information Exchanges (HIEs) and may electronically share your PHI for treatment, payment, healthcare operations and other permitted purposes with other participants in the HIE. HIEs allow your healthcare providers to efficiently access and use your PHI as necessary for treatment and other lawful purposes.

For worker's compensation purposes. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs.

When data is limited or de-identified. We may remove most information that identifies you from a set of data and use and disclose this data set for research, public health and healthcare operations.

We are required by law to maintain the privacy and security of your PHI.

We will notify you promptly if a breach occurs that may have compromised the privacy or security of your information.

We must follow the duties and privacy practices described in this Notice and give you a copy of it. We may change the terms of this Notice, provided such changes are permitted by applicable law. Changes to this Notice will apply to all PHI we have about you. The new notice will be available upon request, in our office and on our website.

Notice of Privacy Practices Acknowledgement

I acknowledge that I have reviewed the Notice of Privacy Practices for Abingdon Internal Medicine, PC in its entirety and that I may receive a copy upon request.

Name: _____

Signature: _____

Date: _____