OLD DOMINION
Osteopathic Medicine, LLC

A Hands-On Approach to Helping You Heal

Welcome to Old Dominion Osteopathic Medicine!

Enclosed you will find the following forms:

- Patient Registration Form
- Insurance Information
- Consent for Treatment
- Disclosure Authorization, Confidentiality Agreement, and HIPAA Notice
- Medical History

We know that you prefer to be seen at your scheduled time, so please plan on arriving **30minutes prior to your scheduled appointment time**, as well as taking a few minutes to complete the following forms prior to your first appointment with us, if at all possible. Having these forms completed upon arrival will keep your waiting time to a minimum.

For your first appointment, please come prepared with the following items:

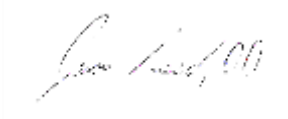
- Any lab work completed within the last 6 months.
- The attached forms, completed as fully as possible.
- Your Insurance Card
- A Picture ID (Military ID or Driver's License)
- If possible, a bag containing all current medications, including over-the-counter and vitamin supplements, or a complete list if you cannot bring the items with you.
- Payment for your specialist office visit co-pay. We accept checks, cash, Master Card, and Visa. If you do not know how much your co-pay will be, feel free to call us ahead of time and we can look it up for you.

If possible, please wear loose, comfortable clothing and drink plenty of water the day of your appointment.

Also, please note: if you are **more than 10 minutes late** for your scheduled appointment time, you will have to be rescheduled. Unfortunately, due to time constraints, there will be no exceptions to this rule.

Thank you for selecting Old Dominion Osteopathic Medicine. We look forward to meeting you soon.

Sincerely,



Jason A. Sneed, D.O.
540-322-5040

OLD DOMINION
Osteopathic Medicine, LLC

A Hands-On Approach to Helping You Heal

Patient Information:

First Name _____ MI ___ Last Name _____

Date of Birth: _____/_____/_____ Sex: **M / F** Social Security #:_____-____-_____

Address: _____

City: _____ State: ____ Zip:_____

Home Phone: _____-_____-_____ Cell/Work Phone: _____-_____-_____

Which number would you prefer we contact you on? _____

Email: _____

We will never sell, share, trade, or use your information for anything other than what you have explicitly granted us permission for. Please note that all emails are unencrypted and thus vulnerable to third-party interception.

May we email you reminders for your appointments? **Y / N**

May we email you our monthly newsletter and practice notifications? **Y / N**

How did you hear about us? _____

Emergency Contact Information:

Name: _____ Relationship: _____

Phone: _____-_____-_____ or _____-_____-_____

Do you have a Power of Attorney? **Y / N**

If YES, please provide: Name: _____ Date Effective: ___/____/_____

(For Patients Under Age 18) Responsible Party Information:

Last Name _____ First Name _____ MI ___

Date of Birth: _____/_____/_____ Social Security #:_____-____-_____

Address: _____

City: _____ State: ____ Zip:_____

Home Phone: _____-_____-_____ Cell/Work Phone: _____-_____-_____

Meaningful Use Information:

Disclosure of meaningful use information is completely voluntary. Choosing not to disclose the following information will not in any way effect your medical treatment.

Language:

☐Decline to Answer	☐English	☐Spanish
☐French	☐German	☐Chinese
☐Italian	☐Japanese	☐Korean
☐Portuguese	☐Russian	☐Other: _____

Race:

☐Decline to Answer	☐Unknown
☐Black or African American	☐Black Hispanic or Latino
☐American Indian or Alaskan Native	☐Native Hawaiian
☐Filipino	☐Guamanian
☐Samoan	☐Tongan
☐Other Pacific Islander	☐Vietnamese
☐Chinese	☐Japanese
☐Korean	☐Other Asian
☐White	☐White Hispanic or Latino

Ethnicity: ☐Decline to Answer ☐Hispanic or Latino ☐Not Hispanic or Latino

Student Shadows:

Old Dominion Osteopathic Medicine is an Osteopathic Rotation site for future DO physicians, both those in the process of applying to medical school as well as those completing their medical education at accredited Osteopathic medical schools. As such, we may have students shadowing Dr. Sneed to learn about his holistic approach to medicine using OMM.

Initial here if you agree to allow students to participate in your care, realizing that if at any point you become uncomfortable you can ask the student to leave, or let Dr. Sneed or his staff know, with no ramifications upon your care.

_____

OR

Initial here if you decline to allow students to participate in your care, knowing that this in no way will affect the care you receive.

_____

OLD DOMINION
Osteopathic Medicine, LLC

A Hands-On Approach to Helping You Heal

Authorization to Use or Disclose Protected Health Information:

Old Dominion Osteopathic Medicine, PLLC, its physicians and staff are hereby authorized to disclose protected health information with those listed below. Permission may be revoked at any time in writing.

Name	Relationship	Phone

Pharmacy:

Name: _____ Phone: _____-_____-_____

Address: _____

City: _____ State: ____ Zip:_____

Primary Care Physician:

Name: _____ Phone: _____-_____-_____

Practice Name: _____

Address: _____

City: _____ State: ____ Zip:_____

While Dr. Sneed can handle many of your medical needs, similar to those of a primary care physician (PCP), we do recommend that you have a separate PCP. We are more than happy to discuss natural alternatives and even some medications for most problems, but these should always be discussed with your PCP as well. If you choose to not have a PCP in addition to this practice, it is imperative that you realize that natural alternatives are not a part of standard medical care and by accepting such recommendations you are accepting the potential risks and benefits that come with deviation from standard medical care.

_____ _____ _____/_____/_____

Patient/Authorized Party Relationship Date

OLD DOMINION
Osteopathic Medicine, LLC

A Hands-On Approach to Helping You Heal

Insurance Information

Primary Insurance: _____

Policy Number: _____ Group Number: _____

Policy Holder: Last Name _____ First Name _____

Policy Holder DOB: _____/_____/_____ Relationship to Patient: _____

Secondary Insurance: _____

Policy Number: _____ Group Number: _____

Policy Holder: Last Name _____ First Name _____

Policy Holder DOB: _____/_____/_____ Relationship to Patient: _____

Important Payment Notice -- Signature Required:

Assignment of Insurance Benefits: I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Old Dominion Osteopathic Medicine, PLLC for any medical services provided to me by that organization. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Center for Medicare and Medicaid Services, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original will be kept on file.

Guarantee of Payment: I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products received.

Cancellation Policy: In the event that you are unable to keep your scheduled appointment, please notify us within 24 hours of your appointment time. If you are unable to keep you appointment time and you do not call and give at least a 24-hour notice, our office has the following policy:

First Absence: You will be notified via phone of your missed appointment.

Second Absence: You will be notified by mail of your missed appointment.
You will also receive a $50.00 office charge.

Third Absence: You will be notified by mail of your missed appointment.
You will also receive a $50.00 office charge.

Fourth Absence: You will be notified by mail of your missed appointment.
You will also receive a $50.00 office charge.
You will be discharged from our practice.

Signature of responsible party: _____ **Date**: _____/_____/_____

Name of Policy Holder: _____ **Social Security #**:_____-____-_____

Name of Person Signing: _____ **Relationship**: _____

OLD DOMINION
Osteopathic Medicine, LLC

A Hands-On Approach to Helping You Heal

Consent for Treatment

General Consent for Treatment and Tests: I consent to treatment by Old Dominion Osteopathic Medicine, PLLC, physicians and staff for my illness and/or health evaluations, including but not limited to x-rays, blood tests, laboratory procedures, medications, and minor procedures. I acknowledge and agree that NO GUARANTEES have been made to me as to the results or outcomes of my medical care. I understand that State Law requires physicians to report certain communicable diseases to the Health Department.

Release from Liability for Leaving Against Medical Advice: I agree that if I leave a physician's office against the advice of my physician or Old Dominion Osteopathic Medicine, PLLC, then Old Dominion Osteopathic Medicine, PLLC, it's personnel, and my physician(s) are released from responsibility or liability for any injuries or damages which may result from my leaving against medical advice.

Phone Authorization: I authorize Old Dominion Osteopathic Medicine, PLLC to contact me by phone. I understand if I cannot be reached, a message may be left at my designated phone number.

Email: I understand that any email communications between myself and the staff of Old Dominion Osteopathic Medicine are unencrypted, and thus vulnerable to third party interception. Should I request medical information be sent to me via email, I hereby release Old Dominion Osteopathic Medicine and its staff from liability should it be intercepted by a third party.

Confidentiality Agreement: Old Dominion Osteopathic Medicine, PLLC, its physicians and staff may publicly call your (or your child's) name in the waiting room of Old Dominion Osteopathic Medicine, PLLC.

Notice of Privacy Practices: By signing this document, I also acknowledge that I have received the attached copy of the Privacy Practices of Old Dominion Osteopathic Medicine, PLLC and HIPAA Notice, as required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

I have read and understand this document, and agree to its terms.

_____ _____ _____/_____/_____

Patient/Authorized Party Relationship Date

Reason for your visit today:

_____

_____

Review of Systems: (check all that currently apply, please explain further in space below)

☐Unexplained Weight Changes
_____

☐Heat/Cold Intolerance
_____

☐Fatigue
_____

☐Trouble Sleeping
_____

☐Dizziness
_____

☐Fever
_____

☐Headaches/Migraines
_____

☐Sinus Problems
_____

☐Eye Problems
_____

☐Ear Problems
_____

☐Neck Pain
_____

☐Back Pain
_____

☐None of the above

☐Heart Problems
_____

☐Respiratory Problems
_____

☐Chest Pain
_____

☐Anxiety/Depression
_____

☐Pain in Extremities
_____

☐Muscle Problems
_____

☐Memory Problems
_____

☐Decreased Libido/Sexual Difficulties
_____

☐Abdominal/Gastrointestinal Problems
_____

☐Urinary Problems
_____

☐Swelling
_____

☐Other
_____

Prior Medical History: (check all that apply)

☐High Cholesterol ☐High Blood Pressure ☐Asthma ☐Diabetes

☐Other:_____

_____

Past Traumas: (Major Falls, Motor Vehicle Accidents, etc.)

Incident	Date

Surgical History: (Please list all surgeries)

Surgery	Date

Screenings:

	Date of Last Screening	Results
Pap Smear		
Mammogram		
Colonoscopy/Colon Cancer Screening		
Prostate Cancer Screening		
Bone Density (Dexa) Scan		

Please list any medical issues not previously addressed:

_____

_____

_____

Social History: (Please check all that apply)

Tobacco Use: ☐Never

☐Former: Packs/Day _____ Years Smoking: _____
Date Quit: _____/_____/_____

☐ Current Packs/Day: _____ Years Smoking: _____

☐Other Tobacco Use:_____

Alcohol Status: ☐Never ☐No Current Use ☐One or Less Per Day

☐ Two or Less Per Day ☐More than 2 Per Day

Recreational Drug Use: ☐No

☐Yes **If Yes**, Type/Frequency: _____

Employment: ☐Full-Time ☐Part-Time ☐Self-Employed ☐Unemployed

☐Disabled ☐Retired ☐Stay-At-Home Parent ☐Student

Marital Status: ☐Never Married ☐Currently Married ☐Divorced

☐Widowed ☐Separated ☐Committed Relationship

Family History:

Relation	Medical Conditions	Age Deceased
Mother		
Father		
Siblings		

Allergies to Medications:

Medication	Allergic Reaction

Medications & Supplements:

If possible, please bring in all prescription, over-the-counter, vitamins, and supplement bottles.

ALL Prescriptions, Over-The-Counter Medications, Vitamins, and Supplements	**Dosage** (mg, iu)	**Quantity & Frequency** (How many, How often)	**Prescribed By:**