



NAME: Last First DATE OF BIRTH:

PHONE: ADDRESS

Medical history: Have you ever been treated for any of the following medical conditions?

- Arthritis, Osteoporosis, Diabetes, Depression/anxiety, High blood pressure, Heart problem, Irritable bowel, Lung problem, Cancer, Thyroid problem

Please list any other medical conditions:

Have you ever been hospitalized overnight? yes no If yes, reason

Have you ever had surgery? yes no If yes, reason

Medications:

Supplements/vitamins:

Drug allergy: other healthcare allergy(latex,etc)

Last tetanus booster

Family history: Please list any known medical problems for the relatives listed below:

For example: diabetes, cancer, heart disease, high blood pressure, alcohol abuse, depression, osteoporosis

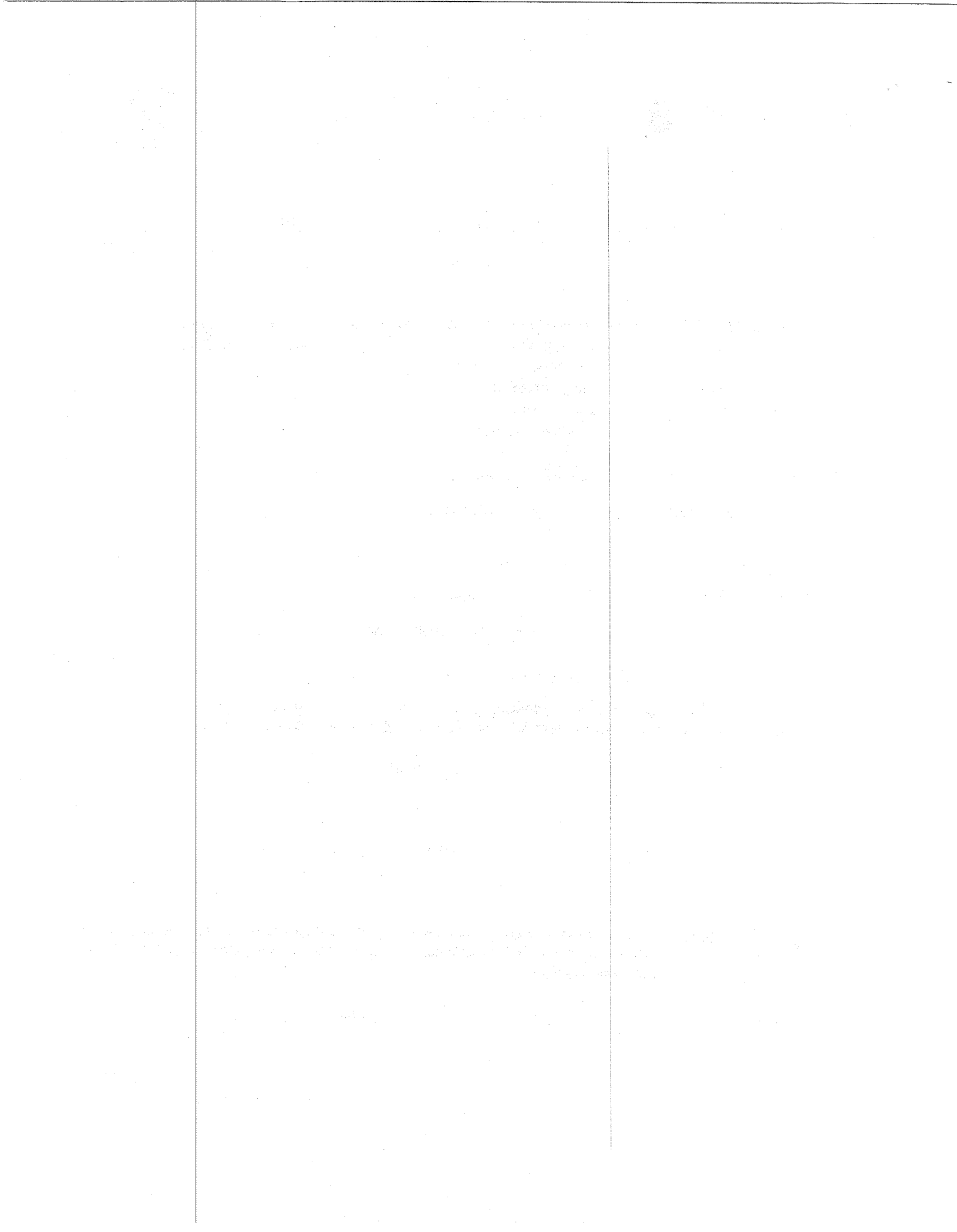
Mother: Father

Brothers/sisters:

Children: Other:

I hereby authorize the physician/ clinicians of Longwood University Student Health Center to examine, test, and treat me as they may deem advisable. There shall be no release of information to any person or agency without prior written agreement by me, unless required by law.

Patient Signature Date



LONGWOOD UNIVERSITY HEALTH CENTER
106 Midtown Ave, Farmville, VA. 23901
434-395-2102 Fax 434-395-2783

Notice of "Deemed Consent" for HIV, HBV and HCV Testing
and Lab work consent form

As a health care provider, we are required by 32.1-45.1 of the code of Virginia (1950) as amended, to give you the following notice.

1. If one of our health care professionals, workers, or employees should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with Human Immunodeficiency Virus ("HIV", the "AIDS" virus) and for the presence of the Hepatitis B and Hepatitis C Viruses. A physician or other health care provider will tell you and that person the result of the test and provide counseling, if necessary.
2. If you should be directly exposed to blood or body fluids of one of our health care professionals, workers, or employees in a way that may transmit disease, that person's blood will be tested for infection with Human Immunodeficiency Virus ("HIV", the "AIDS" virus) and for the presence of the Hepatitis B and Hepatitis C Viruses. A physician or other health care provider will tell you and that person the result of the test and provide counseling, if necessary.
3. I understand I have the opportunity to discuss my need for lab work and/or other procedures with a clinician and understand that I am responsible for any payment associated with lab work, x-rays or other procedures ordered today. I wish to bill lab work to:
 - Insurance company (I understand that I will be responsible for any copay or getting a referral if necessary)
 - My home address
 - My campus address (for students)

Signature

date

1948

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Patient Demographic Form Please PRINT

Patient Name: _____
 Nick Name: _____ Date of Birth: _____ Sex: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Home #: _____ Cell #: _____ Work #: _____
 Language (other than English): _____ Race: _____ Ethnicity: _____
 Email address: _____ Employer: _____
 Emergency Contact: _____ Phone #: _____
 Insurance? Yes _____ No _____ PCP _____

INSURANCE INFORMATION

Ins Co Name: _____ Policy/ Member ID #: _____
 Patient Relation to Insured: Self: _____ Spouse: _____ Child: _____ Other: _____
 Policy Holder: _____ Sex: _____
 Address: _____ City: _____ Zip Code: _____
 Home #: _____ Date of Birth: _____
 Employer: _____

SECONDARY INSURANCE

Ins Co Name: _____ Policy/ Member ID #: _____
 Patient Relation to Insured: Self: _____ Spouse: _____ Child: _____ Other: _____
 Policy Holder: _____ Sex: _____
 Address: _____ City: _____ Zip Code: _____
 Home #: _____ Date of Birth: _____
 Employer: _____

Diagnostic Testing: We recommend that you call your insurance company to be informed of your benefits for any diagnostic test that The University Health Center may order for you. You should inquire if pre-certification is needed. If so, you will need to contact our office one week prior to your scheduled procedure to avoid claim denial.

Financial Policy: To ensure accurate claim filing, please give your most current insurance card to our front office to be copied. Potomac Healthcare Solutions, LLC participates with most managed care plans. We will bill your insurance company in compliance with the guidelines of our contract. If you do not have health insurance, please indicate above. Random audits may be completed to ensure the accuracy of reported information.

I hereby authorize Potomac Healthcare Solutions, LLC to provide me with medical treatment. I understand and agree that I am responsible for all fees not covered by my insurance company. I hereby authorize the release of any medical information necessary to file a claim with my insurance company. I understand that any refusal or misrepresentation of my insurance coverage may result in a balance for services rendered.

Patient/Responsible party signature

Date



PRIVACY POLICY
LONGWOOD UNIVERSITY HEALTH SERVICES

Acknowledgement of receipt of the Notice of Privacy Practices

I understand and have been provided with the Notice of Privacy Practices that provides a detailed description of medical information uses and disclosures.

I understand that I have the right to review the notice prior to signing this acknowledgment form.

I understand that the organization reserves the right to change their notice and practices. The change will be posted in the Health Center and available to me on the Longwood web site.

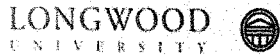
I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that Potomac Healthcare Solutions is not required to agree to the restrictions requested.

I understand that I may revoke this acknowledgment in writing, except to the extent that the organization has already taken action in the reliance thereon.

Signature of Patient or Legal Representative

Date

If representative, define the relationship to the patient. _____



LONGWOOD UNIVERSITY HEALTH CENTER
 106 Midtown Ave, Farmville, VA, 23901
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2 Hour Cancellation & "No Show" Policy

As a participant at Longwood University Health Center (LUHC), it is your responsibility to keep record of your scheduled appointment. If you are unable to make a scheduled appointment, we request that you cancel or reschedule at a minimum of 2 hours in advance. You can cancel or reschedule your appointment by (a) calling 434-395-2102 and speaking to a staff member or by leaving a message, (b) (students only) by canceling your appointment on the Student Health web portal, or (c) coming to LUHC at 106 Midtown in the Landings Complex.

A **No Show** is when a patient does not show for a scheduled appointment without cancelling or rescheduling the appointment.

If a patient establishes a pattern of cancellations or rescheduled appointment and/or no shows, they will receive a letter, email, secure message via the portal (students only) and/or a phone call from LUHC asking them to make an appointment with the Director before services can resume. If the pattern continues, then there will be a fee of \$25.00 charged to the patients account for each reoccurrence.

By signing below, you acknowledge that you have received this notice and understand this policy.

 Printed Name

 Date

 Signature



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Signature

date