

Michael P Gross, MD
1940 Opitz Blvd., Woodbridge, VA 22191
9001 Digges Rd., Manassas, VA 20110
Tele: 703-494-1163 Fax: 703-494-2181

PATIENT INFORMATION (PLEASE PRINT)

Patient Name:	_____	Guardian:	_____
Nickname:	_____	Home Phone:	_____
Date of Birth:	_____	Work Phone:	_____
Sex:	_____	Cell Phone:	_____
Soc. Sec. #	_____	License / ID#	_____
Address:	_____	Contact Email:	_____
City:	_____	Emergency Contact:	_____
State:	_____	Emergency Phone:	_____
Zip Code:	_____	Primary Care MD:	_____
Country:	_____	Referring Physician:	_____
2nd Address:	_____		_____
	_____	2nd Physician:	_____
	_____	Prior Auth.	_____
Marital Status:	_____	Authoriz. Dates:	_____
Provider:	_____	How did they hear	_____
Pharmacy:	_____	about us?	_____

HIPAA Choices:

Did you receive a copy of the HIPAA Notice? Yes ___ No ___ Allow Voice Msg? Yes ___ No ___
Allow Postal Mail? Yes ___ No ___ Who may we leave a message with? _____
Allow eMail? Yes ___ No ___ Allow SMS (text message?) Yes ___ No ___
Allow Calls to Cell? Yes ___ No ___

Occupation:	_____	Employer Address:	_____
Employer:	_____	City:	_____
(Leave blank if inapplicable)		State:	_____
		Zip Code:	_____

Language:	_____	Family Size:	_____
Race / Ethnicity:	_____	Interpreter:	_____
		Seasonal Resident:	_____

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PATIENT INFORMATION (PLEASE PRINT)

Primary Insurance Provider: (Please provide a copy of your card)

Insurer:	_____	Subscriber:	_____
Plan Name:	_____	(If self - do not complete the following lines)	
Effective Date:	_____	Relationship:	_____
Policy Number:	_____	Date of Birth:	_____
Group Number:	_____	Soc. Sec. #	_____
Co Pay:	_____	Sex:	_____
Subscriber		Subscriber Address:	_____
Employer:	_____	City:	_____
Address:	_____	State:	_____
City:	_____	Zip Code:	_____
State:	_____	Country:	_____
Zip Code:	_____	Subscriber Tele#	_____
Country:	_____		

Secondary Insurance Provider: (Please provide a copy of your card)

Insurer:	_____	Subscriber:	_____
Plan Name:	_____	(If self - do not complete the following lines)	
Effective Date:	_____	Relationship:	_____
Policy Number:	_____	Date of Birth:	_____
Group Number:	_____	Soc. Sec. #	_____
Co Pay:	_____	Sex:	_____
Subscriber		Subscriber Address:	_____
Employer:	_____	City:	_____
Address:	_____	State:	_____
City:	_____	Zip Code:	_____
State:	_____	Country:	_____
Zip Code:	_____	Subscriber Tele#	_____
Country:	_____		

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PATIENT INFORMATION (PLEASE PRINT)

Tertiary Insurance Provider: (Please provide a copy of your card)

Insurer:	_____	Subscriber:	_____
Plan Name:	_____	(If self - do not complete the following lines)	
Effective Date:	_____	Relationship:	_____
Policy Number:	_____	Date of Birth:	_____
Group Number:	_____	Soc. Sec. #	_____
Co Pay:	_____	Sex:	_____
Subscriber		Subscriber Address:	_____
Employer:	_____	City:	_____
Address:	_____	State:	_____
City:	_____	Zip Code:	_____
State:	_____	Country:	_____
Zip Code:	_____	Subscriber Tele#	_____
Country:	_____		

Medical Information Release and Assignment of Benefits:

Michael P Gross, MD is hereby authorized to furnish information to insurance carriers concerning my illness and treatments, and to collect all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered or paid by insurance. I am also responsible for any Deductible, Copay, and/or Coinsurance at the time services are rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. I have the right to revoke this authorization at any time in writing.

Patient Signature _____

Date _____

Parent or Guardian
Signature _____

Date _____

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PATIENT HISTORY

Patient Name: _____

Reason for Visit: _____

Date of Birth: _____

Height (In): _____

Weight (lb): _____

BMI: _____

Chief Complaint: _____

How Long: _____ Days _____ Weeks _____ Months _____ Years

Previous Treatments: _____

Social History:

Caffeine: _____ None _____ Some _____ Average _____ Excessive

Alcohol: _____ Never _____ Rare _____ Occasional / Social _____ Daily

Smoking: _____ Never _____ Quit >10 yrs ago _____ Quit 1-10 yrs ago
_____ Quit < 1 yr ago _____ Current Smoker

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PATIENT HISTORY (continued)

Review of Systems: Please check all that apply.

Skin:

- Itching
- Hives
- Bruising
- Bleeding

Eyes:

- Vision changes or loss
- Double Vision

Ears:

- Hearing aids
- Hearing loss
- Pain
- Discharge
- Ringing
- Infections

Nose:

- Nosebleeds
- Discharge
- Infections
- Pain

Mouth/Throat:

- Cavities
- Dentures
- Bleeding Gums
- Sores / Lesions
- Hoarseness

Respiratory:

- Cough
- Blood
- Shortness of breath
- Asthma
- Emphysema
- Tuberculosis
- Pneumonia
- Bronchitis

Cardiovascular:

- Chest Pain
- Palpitations
- Shortness of breath
- when sleeping
- when walking
- Legs swelling
- Cramps
- Varicose veins
- Color changes
- Legs/feet

Gastrointestinal:

- Vomiting
- Constipation
- Diarrhea
- Heartburn
- Blood in stool
- Changes in stool
- Difficulty / pain
- in swallowing
- Jaundice
- Liver Disease
- Gallbladder Disease

Genitourinary:

- Urine frequency
- Pain
- Bloody urine
- Incontinence

Hematology / Lymphatic:

- Anemia
- Sickle Cell
- Hemophilia
- Swollen Glands
- Night Sweats
- Itching

Neck:

- Goiter
- Pain
- Thyroid problems

Neurological:

- Headaches
- Dizziness
- Numbness
- Falls
- Tremors
- Stroke / TIA's
- Loss of memory
- Problems with gait

Psychiatric:

- Depression
- Anxiety
- Bipolar

Endocrine:

- Increased thirst
- Increased urine
- Intolerance to heat
- Intolerance to cold
- Diabetes
- Hot flashes

Allergy / Immune:

- AIDS
- Hepatitis B
- Hepatitis C

Musculoskeletal:

- Weakness
- Paralysis
- Stiffness
- Joint Pain
- Swelling
- Arthritis
- Gout

Cancer

- Skin
- Melanoma
- Breast
- Colon
- Lung
- Other: _____

Patient Signature: _____

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NOTICE OF PRIVACY PRACTICES

In accordance with the Health Insurance Portability and Accountability Act of 1996, as of April 14, 2003 all health care providers are required to provide their patients with a "Notice of Privacy Practice" statement.

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.

The health provider named above is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

1. We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.
2. On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with the healthcare provider named above.
3. It is our policy to provide a substitute health care provider, authorized by the healthcare provider named above to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation.

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to us for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received.

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings.

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons.

We may disclose your health information to coroners or medical examiners.

Organ Donation.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

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NOTICE OF PRIVACY PRACTICES

Marketing.

We may contact you for marketing purposes or fundraising purposes, as described below.

1. As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.
2. It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Health Care provider sponsored fund-raising events.

Change of Ownership.

In the event that the health care provider named above is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

1. You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that the healthcare provider named above is not required to agree to the restriction that you requested.
2. You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
3. You have the right to inspect and copy your health information.
4. You have a right to request that the healthcare provider named above amend your protected health information. Please be advised, however, that the healthcare provider named above is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
5. You have a right to receive an accounting of disclosures of your protected health information made by the healthcare provider named above.
6. You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

1. The healthcare provider named above reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, the healthcare provider named above is required by law to comply with this Notice.
2. The healthcare provider named above is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please call the office number listed at the top of this page.

Complaints

Complaints about your Privacy rights, or how the healthcare provider named above has handled your health information should be directed to Practice Privacy Officer by calling this office at the number noted at the top of this page. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights, 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide the healthcare provider named above with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient's Name (print) _____

Patient's Signature _____ Date _____

Authorized Facility Signature _____ Date _____

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Financial Policy

If you are covered by health insurance with which we participate, we will submit claim forms to your insurance. You will be expected to pay your co-insurance payment and deductible in full at the end of each visit. If your co-pay is not paid at the time of visit there will be a \$5 administration fee add. If we do not participate with your insurance, payment for the initial consultation is to be made at the times of the visit. Claims will be filed for non-cosmetic surgeries. Payment of any balance is expected within 30days of the first billing date. An account unpaid after 90 days may be turned over to an attorney or collection agency. Attorney's fees, court cost and all fees involved with the collection process are additional and the sole responsibility of the patient.

I have read and understand this policy.

Patient Signature (Parent if patient is minor)

Date