# Virginia Surgical Institute
# Patient Demographic Profile

## PATIENT INFORMATION

Name: _____

Address: _____

City, State: _____ ZIP: _____

Phone: _____ [ ] Home [ ] Work [ ] Cell

Phone: _____ [ ] Home [ ] Work [ ] Cell

Email Address: _____

Ethnicity: _____ Preferred Language: _____

Living Will [ ] Yes [ ] No On file with VCI? [ ] Yes [ ] No

DNR [ ] Yes [ ] No On file with VCI? [ ] Yes [ ] No

Durable Medical Power of Attorney [ ] Yes [ ] No

On file with VCI? [ ] Yes [ ] No

Patient ID # _____ Sex: [ ] M [ ] F

Date of Birth: _____

Social Security #: _____

Referring Physician: _____

Primary Physician: _____

Race [ ] White/Caucasian [ ] African American [ ] American Indian
[ ] Hispanic [ ] Asian [ ] Other

Marital Status: [ ] Married [ ] Single [ ] Divorced
Gender Identity [ ] Identifies as Male [ ] Identifies as Female [ ] Male to Female
[ ] Female to Male [ ] Genderqueer neither exclusively male nor femal
[ ] Choose not to disclose

Sexual Orientation [ ] Lesbian, gay or homosexual [ ] Straight or Heterosexual
[ ] Bisexual [ ] Don't know [ ] Choose not to disclose

## RESPONSIBLE PARTY

[ ] Same as Patient

Name: _____

Address: _____

_____

City, State: _____

## EMPLOYMENT

Employer: _____

Phone: _____

Phone: _____

Social Security #: _____

Date of Birth: _____

## PRIMARY INSURANCE

[ ] Same as Patient [ ] Same as Guarantor [ ] Other

Insured Party: _____

Insured Phone: _____

Insurance Company: _____

Date of Birth: _____

Relationship to Patient: _____

Social Security#: _____

Insured ID: _____

Policy Group: _____

I authorize Virginia Surgical Institute to provide medical treatment to me. I understand that I am financially responsible for charges incurred by me and that in the event my account is turned over to an attorney for collection, I shall be responsible for attorney fees and court costs. I further authorize Virginia Surgical Institute to release medical information neccesary to process my claims. In the event any employee is exposed to my blood and/or body fluids, I consent to laboratory testing for Hepatitis B, Hepatitis C and HIV antibodies and that the results of those tests be shared with the exposed party. A photocopy of this information shall be considered as valid as the original.

Signature of Patient/Responsible Party: _____ Date: _____

**VIRGINIA SURGICAL INSTITUTE**

**Consent To Release of Confidential Health Information**

We frequently receive phone calls from family members inquiring about the health status or treatment of a patient. To protect confidentiality, we ask that you notify us of any family members or others to whom you may wish to have your medical information disclosed. If a family member is not listed below, they will NOT be given information regarding your medical care and treatment.

PATIENT NAME: _____ PHYSICIAN: _____

RELEASE INFORMATION TO:

NAME: _____ RELATION: _____

ADDRESS: _____ PHONE: _____

NAME: _____ RELATION: _____

ADDRESS: _____ PHONE: _____

NAME: _____ RELATION: _____

ADDRESS: _____ PHONE: _____

NAME: _____ RELATION: _____

ADDRESS: _____ PHONE: _____

By signing this consent, I am giving permission to Virginia Surgical Institute, Inc. (VSI) to release my confidential medical information to the individual(s) named above. I understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to VSI. A copy of this consent shall be included with my original records. I further acknowledge that a separate consent or authorization will be required for the production of copies of medical records.

I authorize VSI to disclose all information regarding my medical treatment to the individuals named above unless such release is otherwise limited as follows:

_____

VSI [is ___/is not ___] authorized to leave a voicemail using the phone number designated as primary on my account regarding appointment reminders and requests to contact VSI's office.

This consent shall not expire unless I notify VSI. that this release is revoked.

Signature: _____ Date: _____

VIRGINIA
SURGICAL
INSTITUTE

# PATIENT RESPONSIBILITY FOR PAYMENT

You are responsible for any services rendered by the physicians or staff of Virginia Surgical Institute, Inc. (VSI). VSI will bill your health insurance if it is supplied to VSI before or at the time of your service. However, VSI is not responsible for ensuring that its services are covered under your specific insurance policy. You are responsible for being aware of any deductibles, copayments, and non-covered services. You will be expected to pay these amounts at the time of service, unless other arrangements have been made in advance. Some insurance companies require a referral or pre-authorization before you can be treated by a specialist. It is your responsibility to bring this information with you at the time of your visit. We reserve the right not to see you if the referral is not here at the time of your visit.

YOU ARE RESPONSIBLE FOR ANY SERVICES RENDERED BY VSI THAT ARE NOT PAID BY YOUR INSURANCE CARRIER AND ARE NOT OTHERWISE PRECLUDED BY LAW. YOU ARE RESPONSIBLE FOR ANY COLLECTION AGENCY COSTS, COURT COSTS, OR ATTORNEY'S FEES INCURRED BY VSI IN COLLECTING ANY OUTSTANDING BALANCE FOR SERVICES RENDERED TO YOU.

## AUTHORIZATION STATEMENTS:

1. **Medicare Patients Lifetime Agreement:** I authorize any holder of medical or other information about me to release such information necessary for the processing of Medicare claims to the Social Security Administration and the Centers for Medicare and Medicaid Services or its intermediaries, carriers, billing agents or successors. I further permit a copy of this authorization to be used in place of the original and I request payment under Medicare to be made to VSI for the services and/or supplies furnished during my treatment.

2. I authorize VSI to release or obtain any information necessary in the course of my treatment for billing or clinical requirements.

3. I authorize my health insurance carrier(s) to pay VSI directly for all medical, laboratory, surgical, and other services and procedures rendered to me under the benefits provided by, and within the terms of, my policy.

I understand that I am directly responsible for all services rendered.

I have read and understand all of the above and agree with the terms of this document.

Signature: _____ Date: _____

VIRGINIA
SURGICAL
INSTITUTE

# Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name & Address: _____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

Signature: _____ Date: _____

**FOR OFFICE USE ONLY**

**We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:**

[ ] An emergency existed and a signature was not possible at the time.

[ ] The individual refused to sign.

[ ] A copy was mailed with a request for a signature by return mail. Unable to communicate with the patient for the following reason:

_____

_____

[ ] Other: _____

_____

Prepared By: _____

Signature: _____ Date: _____

# VIRGINIA SURGICAL INSTITUTE
# NOTICE OF PRIVACY PRACTICES

**This Notice of Privacy Practices ("Notice") explains how your medical information may be used and disclosed, and how you can access this information. Please review it carefully.**

If you have questions about this Notice, please contact our Privacy Officer at 804-673-0134.

We are dedicated to protecting the privacy of your Protected Health Information (PHI). This Notice outlines how your PHI may be used within our practice or network, and how it may be disclosed (shared outside our practice or network) for treatment, payment, or healthcare operations. We may also share your information for other purposes permitted or required by law. Additionally, this Notice describes your rights to access and manage your PHI.

We are legally required to maintain the confidentiality of your PHI and will comply with the terms described in this Notice.

We reserve the right to update this Notice at any time. Any changes will apply to all PHI we maintain. Upon request, we will provide you with the revised Notice by posting it in our office, making copies available upon request or by mail, and posting the updated version on our website (https://www.vasurg.com/).

**Uses and Disclosures of Protected Health Information (PHI)**

We may use or disclose your PHI for your health care treatment. Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office involved in your care to provide health care services.

> **Example:** If you are referred to another physician for evaluation, your PHI may be provided to ensure the physician has necessary information for diagnosis or treatment. Similarly, we may share your PHI with specialists or laboratories involved in your care.

Your PHI may be used or disclosed for payment purposes, including billing or collecting payments. PHI may be shared with billing companies, insurance companies, health plans, government agencies, and collection agencies.

> **Example:** If you undergo a procedure at our facility, we must share service details (such as x-rays) with your insurance provider for billing. Occasionally, prior authorization is needed before performing certain procedures, requiring us to share your PHI.

We may use or disclose your PHI as needed to support the business activities of our practice, known as healthcare operations.

> **Examples:**
> - Training healthcare personnel, students, or ancillary staff such as billing personnel.
> - Performing quality improvement initiatives.
> - Resolving internal issues or complaints.

We may use or disclose your PHI in connection with contracted services provided by entities known as "business associates." Only the minimum necessary PHI will be shared, and these associates are required to safeguard your information.

**Uses and Disclosures Without Your Authorization**

We may use or disclose your PHI without your permission in the following situations:

- **Required by Law:** Adhering to requirements to report gunshot wounds, suspected abuse, or neglect.
- **Public Health Activities:** Controlling disease, injury, or disability, as required by public health authorities.
- **Health Oversight Activities:** Compliance audits, investigations, and inspections by authorized agencies.
- **Legal Proceedings:** Assisting in legal matters as required by judicial order or lawful process.
- **Law Enforcement:** As authorized by law.
- **Coroners, Medical Examiners, and Funeral Directors:** For identification or determination of cause of death.
- **Research:** With appropriate Institutional Review Board approval.
- **Government Functions:** For national security, military, or correctional institution requirements.
- **Workers' Compensation:** In accordance with applicable laws.

**Uses and Disclosures That May Involve Your Input**

Unless you object, we may share your PHI with family members, friends, or persons identified by you, to the extent they are involved in your care or payment. When you are unable to agree or object, the healthcare provider will use professional judgment to determine whether sharing the information is in your best interest. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.

We may use or disclose your PHI to notify or assist in notifying a family member or other responsible person, about your location, condition, or death. Further we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts.

**Uses and Disclosures Requiring Written Authorization**
The following uses and disclosures require your explicit written consent:

- Marketing communications
- Sale of your information
- Release of psychotherapy notes

Written authorization specifies how you wish your information to be used or disclosed. You may revoke your authorization at any time in writing, except where information has already been acted upon based on prior authorization.

**Your Privacy Rights**
You have specific rights concerning your PHI. All requests to exercise these rights must be made in writing.

**Right to Access:** You may inspect and obtain copies of your PHI maintained in our records. Electronic copies are available upon request. Certain exceptions may apply, and reasonable fees may be charged. There are some exceptions to records which may be copied, and the request may be denied. You may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

**Right to Request Restrictions:** You may ask us not to use or disclose any part of your PHI for treatment, payment, or healthcare operations. While we are not obligated to agree, we will honor agreed-upon restrictions unless the information is needed for emergency treatment. We must accept restriction requests limiting disclosure to a health plan when you pay out of pocket in full.

**Right to Confidential Communications:** You may request communication through alternative means or locations. We will accommodate reasonable requests and will not require explanations.

**Right to Amend:** If you believe your PHI is incorrect or incomplete, you may request an amendment, providing a reason. If denied, you will be given the opportunity to submit a disagreement.

**Right to an Accounting of Disclosures:** You may obtain a list of disclosures of your PHI for purposes other than treatment, billing and payment, or healthcare operations made after April 14, 2003, up to six years back. Additional requests within a 12-month period may incur fees.

**Breach Notification:** In the event of a breach of privacy or security of your health information, we will provide you with written notification of the incident and provide you with applicable steps to reduce the impact of the breach.

**Copy of Notice:** You have the right to obtain a paper copy of this Notice. If you would like a paper copy of this Notice, please request one from our Privacy Officer or request one when you are in our offices.

**Complaints:** If you believe your rights have been violated or have concerns about our privacy practices, contact our Privacy Officer at 804-673-0134. You may also file a complaint with the United States Secretary of Health and Human Services. We will not retaliate against anyone filing a complaint.

**Additional Notices**
**Substance Use Disorder (SUD) Treatment Privacy:** If we receive or maintain treatment records about you from a SUD program, subject to 42 CFR part 2, or testimony about records, we will not use or disclose it in any civil, criminal, administrative, or legislative proceedings against you unless you provide written consent, or we receive a court order, after notice and an opportunity to be heard is provided to you or the record holder. Additionally, any court order for use or disclosure must come with a subpoena or identify applicable legal authority.

**Redisclosure:** PHI disclosed for any reason may be redisclosed by the recipient and is no longer protected by HIPAA or state law.

This Notice was published and is effective as of March 1, 2026.

VIRGINIA
SURGICAL
INSTITUTE

# No Show/Cancellation Policy and Fee

Your care team at Virginia Surgical Institute strives to provide comprehensive, compassionate, and timely care to every patient. To enable a timely clinic flow for all patients, we ask that you notify us at least 24 hours in advance if you need to reschedule or cancel your clinic appointment. **If you are unable to provide a 24-hour cancellation notice, you may be charged a $50 No Show fee.**

We understand that there are times when you may encounter an emergency and miss a scheduled appointment. We do ask that - as much as possible - VSI is notified of any potential conflicts or changes in your schedule. It is important to us that we balance our clinical teams to support all the patients within the office.

At Virginia Surgical Institute, we do have a patient appointment No-Show/Cancellation policy. Key guidelines of this policy include:

- Patients are expected to provide 24-hour notice of any appointment that needs to be rescheduled or cancelled.
- Patients who arrive more than 15 minutes after his or her scheduled appointment may be rescheduled to another day.
- Patients can be dismissed from Virginia Surgical Institute for regularly -
    - Arriving late to a scheduled appointment.
    - Failing to show up for a scheduled appointment.
    - Providing less than 24 hours of notice to reschedule or cancel an appointment.

We are committed to supporting all our patients with their care needs. And we appreciate your support in recognizing our patient appointment No-Show/Cancellation policy.

Printed Name: _____

Signature: _____

Date: _____

VIRGINIA
SURGICAL
INSTITUTE

## Notice for Self-Pay and High Deductible Patients

It is the policy of Virginia Surgical Institute to require a $200 pre-payment for all patients registered as self-pay or patients with high-deductible insurance plans. This will be collected during the registration process at your first office visit.

Please be prepared to make this payment by cash, check, or debit/credit card when you arrive.

You will be responsible for the full payment of charges less the prepayment once you receive your bill from Virginia Surgical Institute.

If you have any questions, please contact our office at 804-348-2814.

_____

**Signature** **Date**

# Virginia Surgical Institute

## HEALTH HISTORY

Acct# _____ Date: _____

Name: _____

Gender: M or F Race: _____

Reason for visit today: _____

**REVIEW OF SYSTEMS** *(circle any symptoms you have now or have had within the past month)*

**GENERAL:** Chills, Fatigue, Fever, Night Sweats, Weight loss
**SKIN:** Bruising, Hives, Rash
**HEENT:** Blurred vision, Double vision, Visual loss, Hoarseness, Sore throat
**RESPIRATORY:** Bloody sputum *(cough)*, Cough, Difficulty breathing *(shortness of breath)*, Wheezing, Waking up from sleeping wheezing or short of breath *(sleep apnea)*
**CARDIOVASCULAR:** Chest pain, Leg cramps, Leg pain &/or swelling *(or foot pain at rest)*, Palpitations, Swelling of extremities *(ankle/foot)*
**GASTROINTESTINAL:** Abdominal pain, Bloody stool, Change in bowel habits *(change in stool caliber or color)*, Constipation, Diarrhea, Food intolerance *(no appetite)*, Nausea, Vomiting, Vomiting blood
**FEMALE GENITOURINARY:** Blood in urine, Difficulty emptying bladder, Excessive menstrual bleeding, Menstrual irregularities, Painful urination, Urinating at night, Vaginal bleeding
**MUSCULOSKELETAL:** Back pain, Joint pain *(aches)*, Muscle cramps, Muscle pain *(aches)*
**NEUROLOGICAL:** Difficulty speaking, Headaches, Numbness, Trouble walking *(or limited ability to walk)*, Weakness in extremities *(of arms or legs)*
**PSYCHIATRIC:** Anxiety, Depression *(sadness, hopelessness)*, Memory loss
**ENDOCRINE:** Cold intolerance, Excessive thirst, Excessive urination, Heat intolerance
**HEMATOLOGY:** Gland problems *(swollen lymph glands)*

**PAST MEDICAL HISTORY (*circle all that apply*)**

**Abdominal Problems**
Last Colonoscopy:
Date:___/___/___
Diverticulitis
Diverticulosis
Ulcer
Intestinal Cancer
Jaundice/Hepatitis
Esophageal Reflux

**Breast Diseases**
Last Mammogram:
Date:___/___/___
Cancer
Lumps
Fibrocystic
Nipple Discharge

**Endocrine**
Diabetes
Thyroid Problem

**Eye Problem**
Glaucoma

**Gynecologic Problems**
Infections
Cancer
Endometriosis
Bleeding
# of Pregnancies ____
# of Live Births ____
History of Breast Feeding
Last Menstrual Period:
Date:___/___/___
Last Pap Test: ___/___/___

**Heart Problems**
Angina
Heart Attack
Irregular Rhythm
High Blood Pressure
Heart Murmur
Enlarged Heart
Congestive Heart Failure

**Hematologic Problems**
Bleeding Disorder
Anemia

**Kidney/Urinary Problems**
Stones
Frequent Infections
Prostate

**Lung Problems**
Asthma
Shortness of Breath
Emphysema
Pulmonary Embolus
TB
Sleep apnea

**Neurologic Problems**
Stroke
Seizure

**Orthopedic Problems**
Fracture
Artificial Joint
Arthritis
Osteoporosis

**Psychiatric Problems**
Circle yes or no

**Skin Problems**
Skin Cancer

**Vascular Disease**
Phlebitis/ Blood clots
Carotid Disease
Varicose Veins

Immunizations
Influenza Vaccine Y/N
Date:___/___/___
Pneumonia Vaccine Y/N
Date:___/___/___

SOCIAL HISTORY
Have you ever smoked? Y/N
How many years?___
How many packs per day?___
When did you quit?___
Do you drink alcohol? Y/N
Marital Status ___
Occupation: _____
Are you HIV positive? Y/N
Have you had an HIV test? Y/N

FAMILY HISTORY
(circle all that apply)
Breast Cancer
Colon Cancer
Prostate Cancer
Ovarian Cancer
Diabetes
Heart Disease
Stroke
High Blood Pressure
Other Cancer _____

SURGICAL HISTORY
Previous Surgery: _____
and approximate year: _____
Previous Surgery: _____
and approximate year: _____
Previous Surgery: _____
and approximate year: _____

Medications:

_____ ____mg____per day
_____ ____mg____per day
_____ ____mg____per day
_____ ____mg____per day
_____ ____mg____per day

Vitamins/Herbs:

_____ ____mg____per day
_____ ____mg____per day
_____ ____mg____per day

INFORM NURSE IF YOU ARE TAKING ASPIRIN

Allergies: Yes or No
Environmental:_____
Food:_____
Medication:_____

## DEPRESSION SCREENING (PHQ-2)

Over the past 2 weeks, how often have you been bothered by the following problems?

**Little interest or pleasure in doing things:**

[ ] Not at all (0)
[ ] Several days (1)
[ ] More than half the days (2)
[ ] Nearly every day (3)

**Feeling down, depressed, or hopeless:**

[ ] Not at all (0)
[ ] Several days (1)
[ ] More than half the days (2)
[ ] Nearly every day (3)

**PHQ-2 Screening score:_____**
(3 or higher indicates a need to complete PHQ-9 Screening)