Last Updated 7/2022

BATH COMMUNITY PHYSICIANS GROUP

PATIENT WELCOME

Welcome to Bath Community Physicians Group, and thank you for choosing our clinic as your provider for medical care. Our primary goal is to provide quality medical care which is easily accessible and responsive to you in your time of need. Our staff includes a comprehensive interdisciplinary team of professionals who consistently strive to exceed your expectations to ensure your experience with us is as comfortable and stress-free as possible.

We have four convenient locations: Hot Springs, Covington (Monroe St. and Riverside Ave.) and Millboro. Office hours can vary by location. To learn more about our hours of operation, please visit the following link which will redirect you to our website: https://bit.ly/3c8mptK

To provide access promptly, improve convenience, and become more efficient, we have centralized phone calls to Bath Community Physicians Group. We have three local phone numbers which will call into our switchboard to handle all your medical care needs. Our switchboard operators are able to send messages to your provider and nurse, answer questions, and schedule appointments.

Covington 540-962-1122

Hot Springs 540-839-7197

Millboro 540-997-1447

While we strive to schedule appointments appropriately, primary care emergencies occur. Our goal is to provide all patients the time they require and deserve. For this reason, we kindly request your patience and understanding should a delay or rescheduling become necessary on your appointment date.

CANCELLATION OF AN APPOINTMENT

To be respectful of the medical needs of our patients, please be courteous and call Bath Community Physicians Group promptly if you cannot attend an appointment. We will reallocate your time. This is how we can best serve our patients' needs. If it is necessary to cancel your scheduled appointment, we require that you call one (1) working day in advance. Appointments are in high demand, and your early cancellation will give another patient the ability to have access to timely medical care.

LATE FOR APPOINTMENT

We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 10 minutes late. We will strive to stay on time. From time to time a patient emergency arises and we may be running late for your visit. You will have the option to reschedule or stay to be seen and we will keep you informed of how long of a delay you may experience.

NO SHOW POLICY

A "no-show" is the term we use when a patient misses an appointment without canceling it within one (1) business day. Unfortunately, "no-shows" inconvenience those patients who need access to medical care in a timely manner. A failure to present at the time of a scheduled appointment will be recorded in your medical chart as a "no-show". A letter alerting you to the fact that you failed to show for a scheduled appointment and did not cancel the appointment within one (1) business day in advance will be mailed to you. A copy of the letter will be placed in your medical record. Three (3) "no-shows" within one (1) calendar year will result in a 30-day notice of dismissal from our practice.

OFFICE CLOSINGS DUE TO WEATHER OR OTHER CIRCUMSTANCES

If our office is closed due to weather conditions or other circumstances beyond our control, the following procedures are used to inform our patients:

- If you are scheduled for an appointment, you will receive a telephone call from our switchboard operators.
- Closings will be displayed at the clinic and on local radio stations.
- Closings will be displayed on our website and on Facebook.

INSURANCE

- Bath Community Physicians Group accepts most insurance plans. If you have specific questions regarding your insurance, please contact our billing department at 540-839-7175.
- It is patient responsibility to inform our office of any changes in insurance coverage. Failure to do so could cause delay or denial of insurance payment.
- All patients will be asked to present their current insurance card at each appointment. Failure to have your card could delay your appointment, and it will be the responsibility of the patient to provide proof of coverage**.**

PAYMENTS

- Patients are responsible for co-pays at time of service.
- If applicable, you will be billed for services not covered by your insurance (as stated in your insurance contract) by our billing department.
- Bath Community Physicians Group accepts cash, personal checks, MasterCard, Discover, Visa and American Express. Checks can be made out to Bath Community Physicians Group.
- It is the policy of Bath Community Physicians Group to make all reasonable attempts to collect outstanding balances should they accrue, including, convenient payment arrangements. Following these attempts, accounts in poor standing will be outsourced to a third party for the purpose of collection.

PRESCRIPTION REFILLS & PHARMACY INFORMATION

- Please inform Bath Community Physicians Group of which Pharmacy you use and update us if this should change. Please allow two to three business days for refill requests. We encourage our patients to review their medications prior to their office appointments and to request refills at that time, if needed.
- Please note that we do not fill Narcotic Medications or order Antibiotics over the phone, as you will need to see your provider for this care.
- Our Practice does not routinely order Narcotic Pain medicine; therefore, you may be required to obtain these medications through a Pain Management specialist.

OUR PATIENT PORTAL

As a means of ensuring timely communication with our patients, we strongly encourage you to sign up for the Patient Portal, which can provide a quick and easy method for scheduling appointments, entering and updating medications, etc. As a new patient, you will receive instructions on how to sign up for the Patient Portal. If you have questions or need assistance, please feel free to speak with a member of our reception team.

COMPLETION OF FORMS/LETTERS

We understand that at times, various forms or letters may be required to assist you with your healthcare needs. The staff at Bath Community Physicians Group will be happy to complete forms and write medical letters as necessary upon your request. However, because this can be time consuming, please allow 7-14 days for completion of requested forms/letters. The charges for completion of these forms is as follows:

If the form can be printed directly from the appointment summary checkout – no charge.

- Forms are 1 to 3 pages long - $10.
- Forms are more than 3 pages - $20.
- The payment is due at the time the forms are received / dropped off.

RECEIPT ACKNOWLEDGMENT FORM

By signing below, I acknowledge that I have received, reviewed, understand, and will comply with the policies and procedures explained in the Bath Community Physicians Group New patient packet.

_____

Printed Name

_____ _____

Signed Name Date

Thank you for choosing Bath Community Physicians Group.

BATH COMMUNITY PHYSICIANS GROUP

PATIENT REGISTRATION FORM -- CONFIDENTIAL

BATH COMMUNITY PHYSICIANS GROUP

PATIENT INFORMATION

Full Legal Name (Last, First, MI) _____ ☐Jr. ☐ Sr. ☐II ☐III ☐ Other _____

Preferred Name _____ SSN _____ Date of Birth _____

Legal Sex ☐Male ☐Female

Gender Identity ☐Male ☐Female ☐Transgender Male (Female-to-Male) ☐Transgender Female (Male-to-Female)
☐ Other _____ ☐Choose Not to Disclose

Sex Assigned at Birth ☐Male ☐Female ☐Unknown ☐Not Recorded on Birth Certificate ☐Choose Not to Disclose

Patient Pronouns ☐She/Her/Hers ☐He/Him/His ☐They/Them/Theirs ☐Patient's Name ☐Decline to Answer

Physical Address (Required)_____ City/State/Zip_____

Mailing Address (If Different) _____ City/State/Zip _____

Preferred Phone (___) _____ ☐Home ☐Cell ☐Work ☐Other_____

Secondary Phone (___) _____ ☐Home ☐Cell ☐Work ☐Other_____

Primary Care Provider _____ M.D. ☐ N.P. ☐ P.A. Phone_____

Primary Care Provider Location_____ Fax _____

Employer _____ ☐Full ☐P/T Email _____

Preferred Language _____ ☐Interpreter Needed Religion _____

Marital Status ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed ☐Partner

Race/Physical Feature(s) ☐American Indian ☐Asian ☐African American ☐Pacific Islander ☐White
☐ Other _____ ☐ Unknown ☐Choose Not to Disclose

Ethnicity/Culture ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Unknown ☐Choose Not to Disclose

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EMERGENCY CONTACTS

Primary Emergency Contact _____ Relationship to Patient _____

Primary Phone (____) _____ ☐Home ☐Cell ☐Work ☐Other_____

Secondary Phone (____) _____ ☐Home ☐Cell ☐Work ☐Other_____

Secondary Emergency Contact _____ Relationship to Patient _____

Primary Phone (____) _____ ☐Home ☐Cell ☐Work ☐Other_____

Secondary Phone (____) _____ ☐Home ☐Cell ☐Work ☐Other_____

RESPONSIBLE PARTY (GUARANTOR)

☐Full Legal Name (Last, First, MI) _____ ☐Jr. ☐ Sr. ☐II ☐III ☐ Other _____

PATIENT REGISTRATION FORM -- CONFIDENTIAL

Guarantor Relationship to Patient _____ SSN _____

Date of Birth _____ Legal Sex ☐Male ☐Female ☐Decline to Answer

RESPONSIBLE PARTY, CONTINUED

Physical Address (Required)_____ City/State/Zip_____

Mailing Address (If Different) _____ City/State/Zip_____

Preferred Phone (_) _____ ☐Home ☐Cell ☐Work ☐Other_____

Secondary Phone (____) _____ ☐Home ☐Cell ☐Work ☐Other_____

Employer _____ ☐Full ☐P/T Email _____

INSURANCE INFORMATION

Primary Insurance Company _____

Subscriber Name _____ SSN _____ Date of Birth _____

Address (if different from above) _____

City/State/Zip_____

Subscriber Number PCP _____ Effective Date _____ Group Number _____

Group/Employer Name _____

Physical Address_____ City/State/Zip_____

Secondary Insurance Company _____

Subscriber Name _____ SSN _____ Date of Birth _____

Address (if different from above) _____ City/State/Zip_____

Subscriber Number PCP _____ Effective Date _____ Group Number _____

Group/Employer Name _____

Physical Address_____ City/State/Zip_____

PHARMACY OF CHOICE

Pharmacy: _____ Location: _____ Phone: _____

COMMUNICATION PREFERENCE

Check All That Apply ☐MyChart ☐Text ☐Phone ☐Mail

☐ Check here if you'd like for Bath Community Hospital to provide information about our newest services, products and offerings. You may opt out at any time.

Thank you for choosing Bath Community Physicians Group.

PATIENT HEALTH HISTORY FORM -- CONFIDENTIAL

Patient Last Name: _____**First Name**:_____ **Middle In**._____

D.O.B._____/_____/_____ Preferred name:

Reason for your visit:

__

_____

Please check conditions which you have had.

GENERAL	**RESPIRATORY**	**GI/GU**	**NEUROLOGIC/PSYCHIATR**
__Serious Infection (e.g. pneumonia) _____	__Asthma	__Stomach Ulcers	__Chronic Vertigo (Meniere)
__Diabetes Mellitus	__Emphysema	__Ulcerative Colitis	__Peripheral Nerve Disease
__Rheumatic Fever	__Blood Clots in Lungs	__Crohn's Disease	__Migraine Headaches
__HIV Infection	__Sleep Apnea	__Bleeding from Intestines	__Stroke
__Cancer (where?) _____	**SKIN**	__Diverticulitis	__Multiple Sclerosis
CVS	__Acne	__Colon Polyps	__Depression
__High blood Pressure	__Eczema	__Irritable Bowel Disease	__Anxiety
__Congestive Heart Failure	__Psoriasis	__Hepatitis	**LYMPHATIC/HEMATOLOGIC**
__Heart Murmur	__Fibrocystic Breast Disease	__Cirrhosis of the Liver	__Thyroid Goiter
__Heart Valve Disease	**MUSCULOSKELETAL/ EXTREMITIES**	__Liver Failure	__Over Active Thyroid
__Angina	__Osteoporosis	__Pancreatitis	__Under Active Thyroid
__Heart Attack	__Rheumatoid Arthritis	__Gallstones	__Transfusions
__High Cholesterol	__Degenerative Joint Disease	__Kidney Stones	__Anemia
__Abnormal Heart Rhythm	__Fibromyalgia	__Kidney Failure	**HEENT**
__Blood Clots in Veins	__Neck Pain (herniated disc)	__Endometriosis	__Glaucoma
__Blocked Arteries in Neck	__Back Pain (herniated disc)	__Sex Transmitted Infection	__Allergies "hay fever"
__ Blocked Arteries in legs			__Frequent Ear Infections
			__Frequent Sinus Infections

Please list other conditions not listed above:

_____

Please check any surgeries

____Angioplasty	____Trauma Related Surgery	____Stomach Surgery	____Colonoscopy	____Tubal Ligation
____Carotid Artery Surgery	____Back or Neck Surgery	____Inguinal Hernia	____Gallbladder	____C-Section
____Other Vascular Surgery	____Hip Surgery	____Knee Surgery	____Appendectomy	____Hysterectomy
____Coronary Bypass Surgery	____Chest/Lung Surgery	____Carpal Tunnel Surgery	____Prostate Surgery	____Ovary Removed
____Neurosurgery	____Tonsillectomy	____Sinus Surgery	____Bladder Surgery	____Breast Surgery
		____Ear Surgery		____Thyroid Surgery

Please list other surgeries not listed above:

_____

Please indicate when you last had any of the following preventative test or services.

YEAR	**YEAR**	**YEAR**	**YEAR**
____Cardiac Angiogram	____Flu Vaccine	____Bone Density Test	____Pap Smear
____Stress Test	____Pneumonia Vaccine	____Prostate Cancer Blood Test	____Date of last Physical Exam
____Echocardiogram	____Tetanus Vaccine	____Rectal Exam	___ Colonoscopy
____Chest X-Ray	____ COVID Vaccine	____Colon Cancer Stool Test	____Other_____
____EKG	____ COVID Booster	____Flexible Sigmoidoscopy	_____
	____Hepatitis Vaccine	____Mammogram/Breast Exam	_____

Please list any ALLERGIES to drugs or substances below.

_____

_____

_____

_____

_____

Please list the medications currently taken, their dosage, and how many times per day you take them.

_____ _____
_ _
_____ _____
_ _
_____ _____
_ _
_____ _____
_ _
_____ _____
_ _
_____ _____
_ _
_____ _____
_ _
_____ _____

PATIENT HEALTH HISTORY FORM -- CONFIDENTIAL

FAMILY MEDICAL HISTORY

Please check or list any major illness in your family members.

Father	Mother	G.Father	G. Mother	Family		Father	Mother	G. Father	G. Mother	Family	
___	___	___	___	___	Heart Disease	___	___	___	___	___	Colon Cancer
___	___	___	___	___	High Blood Pressure	___	___	___	___	___	Epilepsy
___	___	___	___	___	Diabetes Mellitus	___	___	___	___	___	Anemia
___	___	___	___	___	Thyroid Disease	___	___	___	___	___	Hemophilia
___	___	___	___	___	Kidney Disease	___	___	___	___	___	Osteoporosis
___	___	___	___	___	Neurological Disorder	___	___	___	___	___	Tuberculosis
___	___	___	___	___	Liver Disease	___	___	___	___	___	Emphysema
___	___	___	___	___	Breast Cancer	___	___	___	___	___	_____
___	___	___	___	___	Ovarian Cancer	___	___	___	___	___	_____
___	___	___	___	___	Prostate Cancer	___	___	___	___	___	_____
											_____

Please list any other illnesses:

_____
_____
_____

PERSONAL INFORMATION

Please write in or circle the information that applies to you.

Occupation: _____ **Do you have child care concerns? Y/N:** _____

Education	Sexuality	Marital Status	Living Status	Diet	Exercise	Alternative Medicine
Primary	Heterosexual	Single	Alone	None	None	Holistic
Secondary	Homosexual	Married	With Spouse/Other	Low Fat	Walking	Chiropractic
College	Bisexual	Divorced	With Parents	Low Chol	Aerobics	Homeopathic
Post Grad	Transsexual	Widowed	Assisted Living	Low Carb	Weightlifting	Acupuncture
Doctorate		Separated	Nursing Home	Vegetarian	___days / wk	Herbal

Tobacco	Alcohol	Illicit Drugs	Caffeine	Sexually Active
Never/ Past/ Active	Never/ Past/ Active	Never/ Past/ Active	Never/ Past/ Active	[ ] Yes
Cigarette/ Cigar/Vape	Liquor/ Wine/ Beer How often/amt: __	Cocaine/ Marijuana	Coffee**/** Tea/ Soda	[ ] No
Snuff/ Dip/ Chewing	Day/ Week/ Month	Heroin/ Amphetamine	Cans/amt per day ____	
Start____ Stop_____ Packs/amt per day ___	AA/ Alcohol Rehab	Barbiturate/ LSD/ PCP IV Drug Abuse/ Drug Rehab		

PATIENT HEALTH HISTORY FORM -- CONFIDENTIAL

Any Other Information You Feel Would Be Beneficial To Your Health Care :

_____
_____
_____
_____

Do you feel safe at home Y/N
Have you had thoughts of harming yourself or others Y/N
Educational/ Learning needs we need to be aware of: _____
Any financial burden inhibiting medical health and wellness: _____

WOMEN'S HEALTH

Number of Pregnancies: ___ Full term pregnancies: ____ Miscarriages: __ Premature babies: _____ Abortions: ____
Recent Pregnancy: Maternal Depression: _____ Reaction of siblings to new child: _____
Child Care Plans: _____

Are you on birth control: _____
When was your last menstrual period: _____ How often do you have periods? _____
Are your periods (circle) light, heavy, or medium? How long do they last? _____
Do you do monthly self-breast exams? Y/N

Thank you for choosing Bath Community Physicians Group.

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