Duyên T. Faria, DO – Dermatology, Nutrition, & Allergy (DNA) Associates
46440 Benedict Drive, Suite 203, Sterling, VA 20164 P 703-828-1133; F 571-313-8122

Today's Date:	Primary Care Physician:

PATIENT INFORMATION

Patient's last name: First:	Middle:	Who referred you to Dr Faria?
Address:	Birth Date:	Age: / Sex: M F
City: State: Zip Code:		

Email address:	Cell Phone No.:
Home Phone No.: / Employer	Employer phone No.:
Pharmacy:	Phone No.:
Address:	Fax No.:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Is this patient covered by insurance? Yes No	
Address (if different):		Home/Cell Phone No.:	
Occupation:	Employer:	Employer address:	Employer phone No.:
Primary insurance:		Policy No.:	
Subscriber's name:	Birth date: / Group No.: / **Issue Date (M/D/Y):**	Subscriber S.S. No:	
Patient's relationship to subscriber:	Other:		
Name of secondary insurance (if applicable):	Subscriber's Name and relationship:	Group No.:	Policy no.:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to Patient:
Address:	Preferred Phone Contact: Circle One: Cell Home Work

Circle Preferred Method of **OFFICE** Contacting You:

Home Phone Cell Phone Email SMS/Text

Circle Approved **APPOINTMENT REMINDER** Method:	May we email Receipts, Physician Notes, and Lab Orders to you? YES NO
Email (coming soon) SMS/Text or Voice Mail	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance.

PATIENT SIGNATURE DATE

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PATIENT NAME: _____ **DATE: _____**

PLEASE LIST YOUR THREE PRIMARY HEALTH CONCERNS:

1. _____
2. _____
3. _____

ADDITIONAL HEALTH CONCERNS: (Please Circle All That Apply)

HEADACHE	NECK PAIN	LOWER BACK PAIN
MID-BACK PAIN	UPPER BACK PAIN	FAINTING
LOSS OF MEMORY	CONFUSION	BLURRED VISION
DIZZINESS	NERVOUSNESS	IRRITABILITY
EARS RINGING/BUZZING	CHEST PAIN	DOUBLE VISION
SHORTNESS OF BREATH	LOSS OF SMELL	DEPRESSION
PINS/NEEDLES HANDS	PINS/NEEDLES ARMS	PINS/NEEDLES LEGS
LEFT/RIGHT	LEFT/RIGHT	LEFT/RIGHT

ALLERGIES: NO KNOWN ALLERGIES

MEDICATION	TYPE OF REACTION

ATTACH LIST IF NEEDED

CURRENT MEDICATIONS:

NAME	DOSE	FREQUENCY	PRESCRIBER

LIST ANY AND ALL SURGERIES:_____

SIGNATURE: _____DATE: _____

PATIENT NAME: _____ DATE: _____

MEDICAL HISTORY: (Circle All That Apply)

HEART ATTACK/CAD/STROKE	CHF	PACEMAKER	A-FIB
HYPERTENSION	HIGH CHOLESTEROL	CHEST PAIN/ANGINA	SEIZURES
NEURO DISEASE	ANXIETY / DEPRESSION	PSYCHIATRIC DISEASE	ADD/ADHD
MEMORY LOSS	REDUCED COGNITION	HORMONE IMBALANCE	DIABETES
INSULIN RESISTANCE	ASTHMA/COPD/TB	HEARING LOSS/TINNITUS	VERTIGO/DIZZINESS
RECENT WEIGHT LOSS/GAIN	OBESITY	SLEEP APNEA	INSOMNIA
KIDNEY/LIVER DISEASE	MIGRAINE/HEADACHES	ANY SKIN ULCER	IBS/ACID REFLUX/ULCERS
RECURRING INFECTIONS/SEPSIS	IMMUNE DEFICIENCY	HIV/AIDS	MS/PARKINSONS
BLEEDING DISORDER/ SICKLE CELL	CLOTTING DISORDER	OSTEOPOROSIS/GOUT	ARTHRITIS/PSORIASIS
PERIPHERAL NEUROPATHY	THYROID DISEASE	AUTOIMMUNE DISEASE	

CANCER(S) _____

FAMILY MEDICAL HISOTRY: (Circle All That Apply)

HEART ATTACK/CAD/STROKE	CHF	PACEMAKER	A-FIB
HYPERTENSION	HIGH CHOLESTEROL	CHEST PAIN/ANGINA	SEIZURES
NEURO DISEASE	ANXIETY / DEPRESSION	PSYCHIATRIC DISEASE	ADD/ADHD
MEMORY LOSS	REDUCED COGNITION	HORMONE IMBALANCE	DIABETES
INSULIN RESISTANCE	ASTHMA/COPD/TB	HEARING LOSS/TINNITUS	VERTIGO/DIZZINESS
RECENT WEIGHT LOSS/GAIN	OBESITY	SLEEP APNEA	INSOMNIA
KIDNEY/LIVER DISEASE	MIGRAINE/HEADACHES	ANY SKIN ULCER	IBS/ACID REFLUX/ULCERS
RECURRING INFECTIONS/SEPSIS	IMMUNE DEFICIENCY	HIV/AIDS	MS/PARKINSONS
BLEEDING DISORDER/ SICKLE CELL	CLOTTING DISORDER	OSTEOPOROSIS/GOUT	ARTHRITIS/PSORIASIS
PERIPHERAL NEUROPATHY	THYROID DISEASE	AUTOIMMUNE DISEASE	

SIGNATURE: _____ DATE: _____

PATIENT NAME: _____

NOTE: OUR GOAL IS TO KEEP YOUR SAFETY IN MIND. CERTAIN VERY RARE CONDITIONS MAY EXCLUDE YOU FROM TREATMENT. THESE CONDITIONS ARE FURTHER DEFINED BELOW.

GLUCOSE-6-PHOSPHATE DEHYDROGENASE (G6PD) DEFICIENCY: This is an inherited condition usually occuring in males. it's more common in those of African and Mediterranean decent. Triggers include infections, stress, fava beans, aspirin, and other drugs. When symptoms are triggered, they include fever, dark urine, abdominal pain and back pain, fatigue, and pale skin.

Most recover in a few days without treatment. However, patients are at risk of recurrent episodes, so avoidance of triggers is critical.

LEBERS HEREDITARY OPTIC NEUROPATHY (LHON): This is an inherited form of vision loss. Although this condition usually begins in a person's teens or twenties, rare cases may appear in early childhood or later in adulthood. For unknown reasons, males are affected much more often than females.

THE MTHFR GENE: This provides instructions for making an enzyme call methylenetetrahydrofolate reductase. This enzyme plays a role in processing amino acids, the building blocks of proteins. Methylenetetrahydrofolate reductase is important for a chemical reaction involving forms of the vitamin folate (also called vitamin B9).

HAVE YOU OR ANYONE IN YOUR FAMILY BEEN DIAGNOSED WITH LEBERS: YES NO

IF YES, EXPLAIN: _____

HAVE YOU OR ANYONE IN YOUR FAMILY BEEN DIAGNOSED WITH MTHFR: YES NO

IF YES, EXPLAIN: _____

HAVE YOU OR ANYONE IN YOUR FAMILY BEEN DIAGNOSED WITHG6PD DEFICIENCY: YES NO

IF YES, EXPLAIN: _____

SOCIAL HISTORY:

SMOKER YES NO IF YOU QUIT, WHEN _____

PACKS PER DAY _____ NUMBER OF YEARS _____

HOW MANY CUPS OF CAFFEINE PER DAY_____

ALCOHOL USE YES NO HOW MANY GLASSES PER DAY _____ HISTORY OF STREET DRUGS YES NO

PROVIDER / STAFF NOTES:

_____

_____

_____

_____

_____

_____

SIGNATURE: _____ **DATE:** _____

First Visit Instructions

- ✓ **Bring in all completed paperwork that may have been sent to you.**
- ✓ **Bring all medications & supplements**
- ✓ **Also bring any shampoos, creams, foods, etc. that are a concern for assessment.**
- ✓ **Bring a snack with you if you tend to get hungry, weak, or frustrated without eating.**
- ✓ **Do NOT wear perfume or cologne. Many of our patients are dealing with detoxification issues, and many are chemically sensitive.**
- ✓ **Continue taking all prescription medications and supplements.**
- ✓ **Please arrive 15 minutes early to your appointment in order to allow for you initial paperwork to be processed.**
- ✓ **We apologize but we do NOT accept American Express.**
- ✓ **We are located at the corner of Route 7 and Potomac View Road.**
  - **Make an *immediate* right after leaving Route 7.**
  - **Our suite is on the second floor, at the very end of the hallway.**
- ✓ **There are several restaurants off of Epicerie Plaza, attached to the Harris Teeter parking lot.**

Thank you for trusting Dermatology, Nutrition, and Allergy Associates with your health needs!

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PATIENT FINANCIAL AGREEMENT

Thank you for choosing Dermatology, Nutrition & Allergy (DNA) Associates. We are committed to providing you with quality services. To help us better serve you, please read the following financial responsibility agreement.

- Payment in full is due at the time of service unless previous arrangement is made in advance. We accept personal checks after verification through our automated electronic check machine. This means that the payment will be deducted directly from your bank account. If that is not acceptable to you, we will gladly accept cash, Visa, Discover, American Express or MasterCard.
- We do not participate with your health plan, period payment in full is required at the time of service, as a courtesy, we will assist you in submission of your claim to the insurance. Your pathology, surgical, or dermatology specimen will be charged at the current Medicare allowable rates.
- Pathology and laboratory charges are billed separately per your insurance policy. Please check your insurance coverage for these services in advance of treatment. Blood or Specimens sent to your Pathology providers will be billed by the laboratory services. If specimens are sent to an outside laboratory, you will receive a separate bill for those services. Contact the laboratory or outside Pathology provider group with any billing concerns regarding Pathology and Laboratory charges.
- There is a $30 return check charge each time check is returned for any reason.
- Your appointment time is reserved exclusively for you. Reminders will be provided but are not guaranteed. We require 24 hours notice for all cancellations. There is a $50 charge for a missed appointment without the 24 hour notice unless there is urgent health related issues or unpredictable accidents. The broken appointment charge will be waived if you are rescheduled for an office visit at a later date.
- If you arrive more than 10 minutes late for your scheduled appointment, you may be asked to reschedule.
- For minor patients, the adult parent/legally authorized representative/guarantor who consents to care and treatment of the minor child is responsible for payment which will be collected at the time service.

Your signature indicates that you have read and understand DNA Associates' Financial Agreement and agree to abide by the terms set. Your signature indicates your acceptance of the aforementioned policies. You also understand that this agreement may be amended by the medical practice at any time.

Patient/Representative Name: _____

Signature: _____ Date: _____

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HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclose for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. DNA Associates provides this form to comply with the Health Insurance Portability and Accountability Act of 2013 (HIPAA).

The Patient understands the following:

- Protected health information may be disclosed or used for treatment or healthcare operations.
- DNA Associates has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- DNA Associates reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the use of the information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- DNA Associates may condition treatment upon the execution of this concern.

Printed Name of Patient/Representative: _____

Signature: _____ Date: _____