

PATIENT INFORMATION

Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid / LP	
Birth date: / /	Age:	Social Security no.:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F		Home phone no.: ()	
Physical address:			Email Address:			Cell Phone: ()	
P.O. box/Mailing (if different):		City:		State:		ZIP Code:	
Occupation:		Employer:				Work phone no.: ()	
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Other:	
PCP/Family Doctor:		Is this visit result of an injury? Y or N		Date/Time of injury _____			

INSURANCE/PAYMENT INFORMATION

Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Person responsible for bill: <input type="checkbox"/> Self	Birth date: / /	Address (if different):	
Home phone no.: ()	Work no.: ()	Cell No: ()	Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No
(Please give your insurance card to the receptionist.)			
Primary insurance:		Policy no.:	Group no.:
Subscriber's name: <input type="checkbox"/> Self	Subscriber's S.S. no.:	Birth date: / /	Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Secondary insurance:		Policy no.:	Group no.:
Subscriber's name: <input type="checkbox"/> Self	Subscriber's S.S. no.:	Birth date: / /	Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other

WORKCOMP Patients (You must have proper written authorization or you may be considered a selfpay patient.)

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone no.: ()	Work phone no.: ()
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Authorization for Treatment, Release of Information, Insurance Authorization and Assignment & Financial Agreement

I hereby authorize treatment. I authorize Charlottesville Orthopaedic Center to furnish to insurance carriers any medical information necessary to process my claims. I hereby assign to Charlottesville Orthopaedic Center all payments, for medical good/services rendered to myself or my dependents. I understand that I am responsible for payment of any amount not covered by insurance. **AFTER INSURANCE PAYMENT IS RECEIVED, I AUTHORIZE CHARLOTTESVILLE ORTHOPAEDIC CENTER TO BILL ANY REMAINING BALANCE TO THE CREDIT CARD I PRESENT TODAY AND TO MAIL ME A RECEIPT.** I understand that an additional amount of 1% interest will be added to patient balances 30 days or more past due. I agree to reimburse the fees of any collection agency, equaling 30% of the debt, and all costs and expenses, including reasonable attorney's fees, incurred in such collection efforts. I hereby acknowledge responsibility for obtaining any referrals needed.

Patient or Guardian signature

Date

Patient Questionnaire Initial Evaluation

INSTRUCTIONS: Please complete the following questionnaire before you see the doctor. **Mark the word or phrase that best describes your situation. You may select more than one answer per question.** Answer the question in as much detail as possible. Write additional information in the margins if needed. The information you provide will help your doctor to more accurately understand your problem(s) and develop an appropriate plan of treatment for your care. **THANK YOU.**

Patient name: _____ Date: _____

Family/primary doctor: _____ Phone: _____

Family/primary doctor's address: _____

How were you referred here? Family/primary doctor Other doctor, please name: _____

Family Friend Telephone book Internet Referral service Other: _____

Age: _____ Sex: Male Female Are you pregnant? Yes (_____ Weeks) No

Are you breastfeeding? Yes No

What are you seeing the doctor for? _____

Is this injury work related? Yes (date/time of injury) _____ No

When did the problem first start or when did the injury occur? _____

Explain in your own words how this problem occurred: _____

Have you seen a doctor for this problem or injury? Yes No If yes, who and when?

What treatments have you had (tests, medication, surgery, therapy, splinting, etc)? Please include everything from previous providers as well as anything you may have done on your own. None Yes, please explain: _____

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS? Please check all that apply:

- | | | |
|---|---|---|
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Dental problems | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Increased infections | <input type="checkbox"/> Bleeding tendency |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Disturbed sleep |
| <input type="checkbox"/> Fingers/toes turn colors in the cold | <input type="checkbox"/> Chest pain | |
| <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Heartburn | <input type="checkbox"/> I do not have any of these symptoms |

PLEASE TELL US ABOUT YOUR PAST ORTHOPAEDIC HISTORY (not including today):

- | | | | |
|--|------------|---|------------|
| <input type="checkbox"/> Shoulder fracture | Left/Right | <input type="checkbox"/> Hip fracture | Left/Right |
| <input type="checkbox"/> Shoulder injury | Left/Right | <input type="checkbox"/> Hip injury | Left/Right |
| <input type="checkbox"/> Shoulder dislocation | Left/Right | <input type="checkbox"/> Thigh fracture | Left/Right |
| <input type="checkbox"/> Rotator cuff strain/bursitis | Left/Right | <input type="checkbox"/> Thigh injury | Left/Right |
| <input type="checkbox"/> Rotator cuff tear | Left/Right | <input type="checkbox"/> Knee injury | Left/Right |
| <input type="checkbox"/> Adhesive capsulitis/frozen shoulder | Left/Right | <input type="checkbox"/> Meniscal tear | Left/Right |
| <input type="checkbox"/> Arm fracture | Left/Right | <input type="checkbox"/> ACL ligament injury | Left/Right |
| <input type="checkbox"/> Arm injury | Left/Right | <input type="checkbox"/> Leg fracture | Left/Right |
| <input type="checkbox"/> Elbow fracture | Left/Right | <input type="checkbox"/> Leg injury | Left/Right |
| <input type="checkbox"/> Elbow injury | Left/Right | <input type="checkbox"/> Ankle fracture | Left/Right |
| <input type="checkbox"/> Tennis elbow | Left/Right | <input type="checkbox"/> Ankle sprains | Left/Right |
| <input type="checkbox"/> Forearm fracture | Left/Right | <input type="checkbox"/> Foot fracture | Left/Right |
| <input type="checkbox"/> Forearm injury | Left/Right | <input type="checkbox"/> Foot injury | Left/Right |
| <input type="checkbox"/> Finger fracture | Left/Right | <input type="checkbox"/> Toe fracture | Left/Right |
| <input type="checkbox"/> Finger injury | Left/Right | <input type="checkbox"/> Toe injury | Left/Right |
| <input type="checkbox"/> Hand fracture | Left/Right | <input type="checkbox"/> Herniated disc | |
| <input type="checkbox"/> Hand injury | Left/Right | <input type="checkbox"/> Back fracture | |
| <input type="checkbox"/> Wrist fracture | Left/Right | <input type="checkbox"/> Low back pain | |
| <input type="checkbox"/> Wrist injury | Left/Right | <input type="checkbox"/> Neck fracture | |
| <input type="checkbox"/> Carpal tunnel syndrome | Left/Right | <input type="checkbox"/> Neck injury | |
| <input type="checkbox"/> Trigger finger | Left/Right | <input type="checkbox"/> Other, please specify: _____ | |
| <input type="checkbox"/> Ganglion cysts | Left/Right | | |
| <input type="checkbox"/> Tendon lacerations | Left/Right | | |
| <input type="checkbox"/> Nerve or artery injury | Left/Right | | |

NO PREVIOUS ORTHOPAEDIC PROBLEMS

PLEASE TELL US ABOUT YOUR PAST MEDICAL HISTORY:

- | | | |
|---|--|--|
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Stomach ulcer | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Reflux/GERD | <input type="checkbox"/> Paralysis/spinal cord injury |
| <input type="checkbox"/> Past heart attack | <input type="checkbox"/> Gastritis | <input type="checkbox"/> Immune disorder |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Arrhythmia/Irregular heart beat | <input type="checkbox"/> Colitis | <input type="checkbox"/> Glasses/contacts |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Chron's disease | <input type="checkbox"/> Blind |
| <input type="checkbox"/> Heart valve dysfunction | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Detached retina |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Deaf/Hard of hearing |
| <input type="checkbox"/> Hypertension/High blood pressure | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Hearing aid use |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Adult onset diabetes | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Seasonal allergies |
| <input type="checkbox"/> Childhood onset diabetes | <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> DVT/Blood clot | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Osteoarthritis (age related) |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Enlarged prostate | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Sickle cell disease | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Menopause | <input type="checkbox"/> Fibromyalgia/Chronic pain |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Gynecologic problems | <input type="checkbox"/> SLE/Lupus |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Bone infections |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Depression | <input type="checkbox"/> Chronic/Non-healing wounds |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Migraines | <input type="checkbox"/> Burn injury |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Other condition, please list: _____ |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Seizure disorder | |
| | <input type="checkbox"/> Multiple sclerosis | |
| <input type="checkbox"/> Growth problems | <input type="checkbox"/> Cancer, specify type: _____ | |
| <input type="checkbox"/> Developmental delay | | |
| <input type="checkbox"/> Congenital anomalies | | |

NO MEDICAL PROBLEMS

PLEASE TELL US ABOUT YOUR PAST SURGICAL HISTORY: Place a mark beside any surgery you have ever had.

General Surgery

- | | YEAR | | YEAR |
|--|-------------|---|-------------|
| <input type="checkbox"/> Appendectomy | _____ | <input type="checkbox"/> Hernia repair | _____ |
| <input type="checkbox"/> Cataract extraction | _____ | <input type="checkbox"/> Hysterectomy | _____ |
| <input type="checkbox"/> Caesarian section | _____ | <input type="checkbox"/> Mastectomy | _____ |
| <input type="checkbox"/> Angioplasty | _____ | <input type="checkbox"/> Tonsillectomy | _____ |
| <input type="checkbox"/> Bypass/open heart surgery | _____ | <input type="checkbox"/> Prostate surgery | _____ |
| <input type="checkbox"/> Peripheral vascular surgery | _____ | <input type="checkbox"/> Other, please specify: _____ | _____ |
| <input type="checkbox"/> Gall Bladder surgery | _____ | | |
- NO PREVIOUS GENERAL SURGERY**

Orthopaedic Surgery

- | | | YEAR | | | YEAR |
|--|------------|-------------|---|------------|-------------|
| <input type="checkbox"/> Shoulder: fracture repair | Left/Right | _____ | <input type="checkbox"/> Hip: fracture repair | Left/Right | _____ |
| <input type="checkbox"/> Shoulder: arthroscopy | Left/Right | _____ | <input type="checkbox"/> Hip: total hip replacement | Left/Right | _____ |
| <input type="checkbox"/> Shoulder: rotator cuff repair | Left/Right | _____ | <input type="checkbox"/> Thigh | Left/Right | _____ |
| <input type="checkbox"/> Clavicle | Left/Right | _____ | <input type="checkbox"/> Knee: fracture repair | Left/Right | _____ |
| <input type="checkbox"/> Arm | Left/Right | _____ | <input type="checkbox"/> Knee: arthroscopy | Left/Right | _____ |
| <input type="checkbox"/> Elbow | Left/Right | _____ | <input type="checkbox"/> Knee: ACL reconstruction | Left/Right | _____ |
| <input type="checkbox"/> Forearm | Left/Right | _____ | <input type="checkbox"/> Knee: total knee replacement | Left/Right | _____ |
| <input type="checkbox"/> Hand/Wrist: fracture repair | Left/Right | _____ | <input type="checkbox"/> Leg | Left/Right | _____ |
| <input type="checkbox"/> Hand/Wrist: carpal tunnel | Left/Right | _____ | <input type="checkbox"/> Ankle | Left/Right | _____ |
| <input type="checkbox"/> Hand/Wrist: nerve repair | Left/Right | _____ | <input type="checkbox"/> Foot | Left/Right | _____ |
| <input type="checkbox"/> Hand/Wrist: tendon repair | Left/Right | _____ | <input type="checkbox"/> Toes | Left/Right | _____ |
| <input type="checkbox"/> Finger | Left/Right | _____ | <input type="checkbox"/> Other, please specify: _____ | | _____ |
| <input type="checkbox"/> Low back | Left/Right | _____ | | | |
| <input type="checkbox"/> Neck | Left/Right | _____ | | | |
- NO PREVIOUS ORTHOPAEDIC SURGERY**

PLEASE TELL US ABOUT YOUR FAMILY HISTORY:

Has any blood relative had any of the following conditions? Place a mark beside any condition, and fill in type if known

- | | |
|--|---|
| <input type="checkbox"/> Dysplasia , type: _____ | <input type="checkbox"/> Congenital musculoskeletal , type: _____ |
| <input type="checkbox"/> Bone diseases , type: _____ | <input type="checkbox"/> Neurologic disorders , type: _____ |
| <input type="checkbox"/> Connective tissue disorders , type: _____ | <input type="checkbox"/> Bone cancer , type: _____ |
| <input type="checkbox"/> Mucopolysaccharidosis , type: _____ | <input type="checkbox"/> Other cancer , type: _____ |
| <input type="checkbox"/> Muscular dystrophies , type: _____ | <input type="checkbox"/> Other please list: _____ |
| <input type="checkbox"/> Blood disorders , type: _____ | |
- NEGATIVE FAMILY HISTORY**

PLEASE TELL US ABOUT YOURSELF:

Occupation: _____ Retired Employer _____

Disabled (cause: _____) Permanent Temporary

Hand dominance: Right Left Ambidextrous

Education completed:

- Elementary school
- High school
- GED
- Vocational school
- College
- Graduate school

Marital status:

- Single
- Married
- Divorced
- Separated
- Partner
- Widow

Children:

- None
- _____ # son(s)
- _____ # daughter(s)

Home arrangements:

- Home, alone
- Home with family
- Home with roommates
- Assisted living, name: _____
- Nursing home, name: _____

What best describes your activity level? (Check only one)

- 30 minutes of an exercise program less than 1 day a week
- 30 minutes of an exercise program 1-2 days a week
- 30 minutes of an exercise program 3 or more days a week
- Active but no exercise program
- Sedentary/sit most of the day
- Minimal activity outside of home
- Stay at home only
- Stay in bed only

What assistive devices do

you use? (Check all that apply)

- None
- Full walker
- Cane
- Rollator
- Crutches
- Wheelchair
- One-handed walker

Do you now, or have you ever used tobacco? Yes (years _____) No Quit (year _____)

Type:

- Chew
- Cigar
- Cigarette
- Dip
- Pipe

Amount: (pack/can/each)

- <1
- 1
- 2
- 3
- >3

Frequency:

- Daily
- Weekly
- Monthly
- Occasionally
- Socially

Do you now, or have you ever consumed alcohol? Yes No Quit (year _____)

Type:

- Beer
- Liquor
- Mixed drinks
- Wine
- Other: _____

Amount: (glasses/servings)

- <1
- 1
- 2
- 3
- >3

Frequency:

- Daily
- Weekly
- Monthly
- Occasionally
- Socially

Do you now, or have you ever used recreational drugs? Yes No Quit (year _____)

Type:

- Amphetamines
- Cocaine
- LSD
- Marijuana
- Other: _____

Amount:

- <1
- 1
- 2
- 3
- >3

Frequency:

- Daily
- Weekly
- Monthly
- Occasionally
- Socially

Charlottesville Orthopaedic Center, PLC

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests

- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- Effective Date of this Notice: May 1, 2017
- The Office Manager for Charlottesville Orthopaedic Center also serves as the Privacy Officer. Email address is info@cvilleortho.com. Phone number is 434-244-8412.
- We never market or sell personal information. We do not create or manage a hospital directory. We do not create or maintain psychotherapy notes at this practice.
- We will never share any substance abuse treatment records without your written permission.

