

**REGISTRATION FORM**

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Social Security#: \_\_\_\_\_  
First Middle Last

Address: \_\_\_\_\_ Suite/Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

May leave message at:  Home  Work  Cell Web Enable:  YES (Fill in email address below)  NO

Email address: \_\_\_\_\_

Gender:  F  M DOB: \_\_\_/\_\_\_/\_\_\_ Marital Status: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Race/Ethnicity:  American Indian  Black/African American  Hispanic/Latino

Native Hawaiian  White  Asian  Other \_\_\_\_\_

Pharmacy Name and Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION (PLEASE COMPLETE IF OTHER THAN SELF)**

Relationship to Guarantor:  Self  Spouse  Child  Other \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Name: \_\_\_\_\_ Social Security#: \_\_\_\_\_  
First Middle Last

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ / \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

**EMERGENCY CONTACT**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
First Middle Last

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ / \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

**E-PRESCRIBING MEDICATION HISTORY CONSENT**

I understand that Virginia Physicians, Inc. has implemented e-prescribing for its patients. I also understand that e-prescribing involves the ability for the practice to send prescriptions electronically to pharmacies, eliminating the need for a more time-consuming, and sometimes more costly, approach to prescribing through paper, phone and fax. E-Prescriptions are fast, convenient, legible, secure, cost-effective and safe. The e-prescribing process also allows the health care provider to access critically important information about their patient's current and past medications from pharmacy benefit managers and community pharmacies. This information helps alert the provider to other potential medication issues with their patients and can improve safety and quality.

*I have been given an opportunity to ask questions about the e-prescribing process and have had those questions answered to my satisfaction. I hereby consent to the practice requesting and using my medication history from other health care providers or third party pharmacy benefit payors for treatment purposes in connection with the e-prescribing process.*

\_\_\_\_\_  
*Patient Signature (or Authorized Patient Representative)*

\_\_\_\_\_  
*Date*

## NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

Our Notice of Privacy Practices (available upon arrival to our office) provides information about how we may use and disclose protected health information (PHI) about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

***I have received\* a copy of Virginia Physicians, Inc.'s Notice of Privacy Practices. I understand that I may ask questions to the Medical Practice if I do not understand any information contained in the Notice of Privacy Practices.***

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***Patient Signature (or Authorized Patient Representative)***

***Date***

*\*If you are completing this form prior to your scheduled appointment please note that the Notice of Privacy Practices will be made available to you upon arrival to our office.*

## FINANCIAL POLICY

***General Information:*** Payment in full is due at the time of service. We accept cash, check, American Express, Discover, MasterCard and Visa.

***Regarding Insurance:*** We accept most major insurance plans, but you are responsible for checking with your carrier to see if services at our office will be covered. We *do not* participate with any Medicaid plans. We may accept assignment of insurance benefits; however we do require that all co-payments be made at the time of service. The balance is your responsibility whether your insurance company pays or not. It is your responsibility to notify us of any changes in your policy information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered and not considered reasonable and necessary under the Medicare Program and/or other medical plans. You will be responsible for these balances. Additionally, it is your responsibility to obtain and track referrals for your visits.

***Returned Checks:*** There will be a \$25 returned check fee on all returned checks. In the event that a check is returned for insufficient funds, we reserve the right to call your bank to verify funds for any future checks that are presented for payment.

***Collection Fees:*** In the event that your account is turned over to a collection agency, you will be responsible for all collection costs including reasonable attorney's fees.

***Missed Appointments:*** Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the minimum rate of \$60 per missed appointment. Please help us serve you better by keeping your scheduled appointments.

***Fees for Letters and Forms:*** Your physician will be happy to fill out any necessary form that you may need. Please be advised that due to the time required to dictate and complete letters and forms there will be a fee for this service. These costs are considered non-covered by insurance companies and will be your personal responsibility.

***I have read, understand and agree to this Financial Policy:***

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***Patient Signature (or Authorized Patient Representative)***

***Date***