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13911 St Francis Blvd. /Suite 101/Midlothian, VA 23114

**Patient Registration**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_

Gender Identity: Male:\_\_\_ Female:\_\_\_ FTM Trans: \_\_\_ MTF Trans: \_\_\_ Genderqueer: \_\_\_ Choose not to disclose: \_\_\_\_

Ethnicity: \_\_\_\_Hispanic or Latino \_\_\_\_Non-Hispanic or Latino \_\_\_\_ Declined

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_

Home Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Please complete if person responsible for bill is other than above patient:**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_

Home Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COMMUNICATION PREFERENCES:**

 Please complete the following section indicating your preferences regarding communication from our office with you or your designated contact regarding your medical care.

Yes / No We may contact you through FPA's secure patient portal regarding your medical care, test results and refills at the following EMAIL address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We may leave a message regarding your medical care:

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

We may speak with or leave message with the following individual(s):

   Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_  Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_  Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In the event of a medical emergency we may contact the following Individual(s)**

 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_  Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_  Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION:** Do you request that we file your insurance and authorize your carrier to pay us benefits directly? \_\_\_\_ yes \_\_\_\_no

**Co-PAYMENTS** are due at the time services are rendered as defined in your contract. New patients may need to reschedule if for any reason you are not prepared to pay. There is a processing fee of $10.00 if we need to bill you.

**INSURANCE.** Your insurance is a contract between you and your carrier. We are NOT party to that contract. We cannot predetermine the benefits your specific plan will cover: furthermore it is your responsibility to know and to understand your policy. You shall pay any portion of the charges not covered by your insurance. If your insurance changes, you shall notify us **before** your appointment. You may be responsible for the entire visit if you have not provided us with any changes.

**Primary Insurance:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Carrier Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Subscriber/ Relationship to Patient Date of Birth

Policy ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_ Effective Date \_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Carrier Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Subscriber Relationship to Patient Date of Birth

Policy ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_ Effective Date \_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature (or authorized representative) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PERMISSION TO TREAT:**

I understand that I have the opportunity to discuss any plans for treatment the provider and clinical staff may advise for my care and treatment. I understand that I can decline for any reason.

In the event that a healthcare worker has come in contact with my blood or body fluid in a way that may transmit HIV, Hepatitis B virus or Hepatitis C Virus; I consent to the testing (at no cost to the patient)for these infections and that results will be discussed with appropriate safety management.

**Patient Signature (or authorized representative) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**E-PRESCRIBING MEDICATION CONSENT:**

E-prescribing involves the ability for Family Practice Associates to send prescriptions electronically to pharmacies, eliminating the need to prescribe by paper, fax or phone. 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.

**Patient Signature (or authorized representative) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ACKNOWLEDGEMENT OF PRIVACY PRACTICES NOTICE (Effective 09/23/2013):**

Our Notice of Privacy Practices (available on our website and 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 have changed our notice, you may obtain a revised copy.

I have received or had the opportunity to review a copy of Family Practice Associates of Chesterfield’s Notice of Privacy Practices. I understand that I may ask questions if I do not understand any information contained in the Notice of Privacy Practices.

**Patient Signature (or authorized representative) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FINANCIAL POLICY:**

**GENERAL INFORMATION:** Co-pays, unmet deductibles and prior balances are due at the time of service. We accept cash, check, credit and debit cards.

**MISSED APPOINTMENTS:** Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the minimum rate of $35 per missed appointment or $100 for extended visits such as physicals.

**REGARDING INSURANCE:** We accept most major insurance plans, It is your responsibility to confirm with your carrier that we are in-network ensuring services at our office will be covered. We may accept assignment of insurance benefits; however the balance is your responsibility whether your insurance company pays or not.

*Policy Changes:*  It is your responsibility to notify us of any changes in your policy information before your appointment. Failure to do so may result in your responsibility for the entire bill.

*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.*

**RETURNED CHECKS:** There will be a $40 returned check fee on all returned checks. In the event that a check is returned for insufficient funds, we reserve the right to cancel future appointments until paid.

**COLLECTION FEES:** In the event that your account is turned over to a collection agency, you will be responsible for the account balance plus all collection costs including reasonable court and attorney’s fees. In case of a suit, you agree the venue shall be in Chesterfield County, Virginia.

**FINANCE CHARGES** will be added to any account that is not paid within thirty (30) days of the time the service became the patient responsibility. The finance charge will be computed at the rate of one and one-half percent (1.5%) per month or an annual percentage rate of eighteen percent (18%). The minimum monthly finance charge is $0.75.

**DIVORCE.** The party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for the subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent’s responsibility to collect from the liable parent according to the terms of the decree.

**PERSONAL INJURY.**  Payment of the bill remains the responsibility of patient in the event medical services arise from an event for which a third party may be responsible. At your request, we shall bill your personal insurance and reimburse them when the case is settled and we have been compensated.

**WORKERS COMPENSATION.** Written authorization/approval by your employer and/or workers compensation carrier shall be required prior to your initial visit. If your claim is denied, you will be responsible for any and all charges incurred.

**NOTIFICATION.** You authorize this office or its designated agents to contact you by mail, by telephone or through the patient portal to discuss this account.

**Patient Signature (or authorized representative) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Account No. \_\_\_\_\_\_\_\_\_

Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_