PATIENT REGISTRATION INFORMATION AND CONSENT

PLEASE PRINT CLEARLY ***Date*** _____

Patients Full Name _____ SS# _____
First Middle Last

Address _____
Number Street City and State Zip Code

Home Telephone Number _____ Work Telephone Number _____ Ext _____

Cell _____ Email Address _____ Maiden Name _____

Employer _____

Address _____

Sex ____ Marital Stat ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated Date of Birth _____

Emergency Contact _____ Relation _____ Telephone Number _____

INSURANCE INFORMATION: *(Please use your Insurance Identification Card)*

Primary Insurance Company Name

Policy Number _____ Group Number _____ Effective Date _____

Name of the Insured _____ Relationship to Patient _____

Birth Date of the Insured ____/____/____ Social Security Number of Insured ____-____-____

Name of Employer _____ Address _____

Secondary Insurance Company Name

Policy Number _____ Group Number _____ Effective Date _____

Name of the Insured _____ Relationship to Patient _____

Birth Date of the Insured ____/____/____ Social Security Number of Insured ____-____-____

Name of Employer _____ Address _____

Person with Financial Responsibility for Patient's Account The Account Guarantor

If financial responsible party is the same as the patient ☐ Check here If not, complete the following:

Name of Responsible Party _____ Relationship to Patient _____

Street Address _____ City State, Zip Code _____

Home Telephone Number _____ Birth Date _____ SS# _____

Place of Employment _____ Work Telephone Number _____

Employer's Address _____

This notice describes how information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

NOTICE OF PRIVACY PRACTICES

1. Prime Care Family Practice may use and disclose protected health information (PHI) for treatment, payment and healthcare operations. Examples of these include, but are not limited to, requested preschool, life insurance or sports physicals, referral to nursing homes, foster care homes, home health agencies and/or referral to other providers for treatment. Payment examples include, but are not limited to insurance companies for claims including coordination of benefits with other insurers; collection agencies. Healthcare operations include, but are not limited to, internal quality control and assurance including auditing of records.

2. Prime Care Family Practice is permitted or required to use or disclose PHI without the individual's written consent or authorization in certain circumstances. For example: for public health requirements, court orders, law enforcement investigations or when we are required to do so by federal, state or local law.

3. Prime Care Family Practice will not make any other use or disclosure of a patient's PHI without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.

4. Prime Care Family Practice may, at times, contact the patient to provide appointment reminders or information regarding treatment alternatives or other health-related benefits and services that may be of interest to the individual patient. We may contact you by mail or telephone. Our message will include the name of our practice and/or the name of our provider, as well as the date and time for your appointment or a reminder that an appointment needs to be scheduled.

5. Prime Care Family Practice will abide by the terms of this notice or the notice currently in effect at the time of the disclosure.

6. Prime Care Family Practice reserves the right to change the terms of its notice and to make new notice provisions effective for all PHI that it maintains.

7. Prime Care Family Practice will make available to each patient a copy of any revisions of its Notice of Privacy Practice at the time of their next visit. Copies may be requested at any time at our office.

8. You have the right to inspect and obtain a copy of your PHI that we maintain and have in our possession, including medical records and billing records, but not including psychotherapy notes. There will be a fee associated with your request. Any request must be made in writing. Under certain

circumstances, we may deny your request to inspect your medical information. If denied, you have a right to have that determination reviewed.

9. You have the right to ask us to amend your medical information, as long as we maintain this information. Any request must be made in writing. In certain circumstances, we may deny your request for an amendment. If we deny your request, you have the right to file a disagreement with us and we will respond in writing to you.

10. You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or healthcare operations as described in this notice. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care (like a family member or friend). Prime Care Family Practice is not required to agree to your request. You have the right to withdraw restrictions at any time. Any request for restrictions or withdrawals must be made in writing.

11. Any person/patient may file a complaint to the Practice and Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, please write to the Compliance Officer at the following address: Ms. Varratta Boose, 4700 Puddledock Road, Suite 300, Prince George, VA 23875. All complaints will be addressed and the results will be reported to the Prime Care Family Practice Corporate Compliance Committee.

12. It is the policy of Prime Care Family Practice that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

13. For further information, contact Deidra F. Mann, Office Administrator at 4700 Puddledock Road, Suite 300, Prince George, VA 23875.

14. The effective date of this document is April 11, 2003.

Authorization for Release of Information – Compound Release

Name of Patient_____ Date of Birth_____

Prime Care Family Practice is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information Check each person/entity that you approve to receive Information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
__ **Voice Mail**	__ **Financial** __ **Medical** __ **Other** _____
__**Spouse (provide name and phone number)** _____	__ **Financial** __ **Medical**
__ **Parent (provide name and phone number)** _____	__ **Financial** __ **Medical**
__ **Other (provide name and phone number)** _____	__ **Financial** __ **Medical**
__ **Receive detailed lab results via automated phone message. The number to contact is:** _____	

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

Name:
Chart:
Date:

CONDITIONS TO REGISTRATION AND ACCEPTANCE AS A PATIENT OF PRIME CARE FAMILY PRACTICE, PC

1. **CONSENT TO MEDICAL CARE:** The undersigned requests and authorized the physicians and other health care providers of Prime Care Family Practice, PC and their professional staff, to perform any medical diagnostic procedures and medical or surgical care which in their professional judgment is deemed necessary to diagnose and/or treat the condition(s) that have brought about by my seeking medical care services at the offices of Prime Care Family Practice, PC. I understand that the practice of medicine is not an exact science, that there are risks and benefits associated with receiving medical treatment, and I acknowledge that no guarantees are made to me concerning the results of the medical examinations and treatment I receive by the providers and professional staff of Prime Care Family Practice, PC.

2. **RELEASE OF MEDICAL RECORDS:** The undersigned hereby authorizes Prime Care Family Practice, PC to disclose all or any part of the contents of the medical record of the patient named in this Registration Record to such insurance companies, organizations or agencies that may be concerned with the payment of medical services provided to the patient. This authorization is given with the full knowledge that such disclosure may contain information which may result in a denial of insurance benefits or which otherwise may not serve the interest of the registered patient.

3. **ASSIGNMENT OF BENEFITS:** I hereby request and authorize that any and all insurance benefits due for the medical services rendered to the registered patient, be paid directly to Prime Care Family Practice, PC. The undersigned, whether signing as the patient or as representative of the patient, accepts responsibility for and agrees to pay for any health insurance co-payments, deductibles, and co-insurance required under the terms of the insurance policies.

4. **FINANCIAL AGREEMENT:** The undersigned agrees, whether signing as the patient or patient's representative, to accept payment responsibility for medical services not covered by insurance benefits and in the event of default, agrees to pay all costs associated with collection activities made to enforce payment, including attorney or collection agencies not to exceed 33 1/3%.

5. **DEEMED CONSENT:** The undersigned acknowledges that the requested patient is informed or the provisions of Section 32.1-45 of the Code of Virginia, 1950, that provide if any patient/health care provider is exposed to the blood/body fluids of a health care provider/patient under the control and direction of Prime Care Family Practice, PC in a manner which may transit Human Immunodeficiency Virus, Hepatitis B or C Viruses, then the patient/health care provider shall be deemed to have consented to testing for HIV, Hepatitis B or C Viruses, and to the release of such test results as provided by law.

6. The undersigned certifies that he/she has provided correct information in this Patient Registration Form and understands that false statements or concealment of material fact may be prosecuted under applicable federal or state laws. The undersigned further certifies that he/she has read the above information, is the patient or is the patient's legal representative, duly authorized to execute the above and to accept its terms.

Patient Signature _____ ***Date*** _____

Signature of Patient's Legal Representative _____ ***Date*** _____

Relationship to Patient _____

The individual signing this document has a right to receive a copy of this notice.

PRIME CARE FAMILY PRACTICE

Authorizations

Patient Name:_____

Patient Date of Birth:_____

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY:
I authorize Prime Care Family Practice and it's providers to view my external prescription history via Surescripts prescription service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years. I understand this will allow my providers to better coordinate my care and medication history to maximize the effectiveness and safety of my treatment plan.

- ☐ I certify that I read and understand the scope of my consent and that I authorize the access.

CONSENT TO CONTACT VIA EMAIL:
To the extent that our Medical Record software allows it, we may be able to contact you via email to remind you of appointments or to share other pertinent information about your healthcare.

- ☐ I authorize Prime Care Family Practice to use the email address I provided above to contact me in regard to my healthcare. I consent that protected healthcare information may be transmitted to me via this email address.

CONSENT TO COMMUNICATE PROTECTED HEALTH INFO
At my request, I also authorize Prime Care Family Practice to communicate my protected health information (including appointment reminders) to me via the following methods:

- ☐ Detailed message on my home answering machine
- ☐ Detailed message on my personally identifiable voice mail at work
- ☐ Detailed message on a personally identifiable cell phone voice mail
- ☐ Detailed message left by text at the cell number provided by me

MISSED APPOINTMENT POLICY
I understand that Prime Care Family Practice REQUIRES 24 hours advanced notice to cancel or re-schedule an appointment. I understand a fee may be charged to my account for missed appointments.

Patient or Responsible Party Signature_____

Today's Date:_____

Prime Care Family Practice

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed & a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason: _____
- ☐ Other: _____

_____

Prepared By _____

Signature _____

Date _____