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_____

PrimeCare
FAMILY PRACTICE

Patient Financial Policy

Prime Care Family Practice is committed to providing high-quality, comprehensive family health care and personal service to our patients. For every commitment, there is an obligation. It is the patients' responsibility to meet their financial obligations. As we see patients from many different insurance plans, it is impossible for us to be certain of all the covered benefits, copays, and deductibles for each individual plan. While it is our intention to assist you, it is still your responsibility to ensure that all services rendered or referred by Prime Care Family Practice on your behalf are paid in full. To clarify Prime Care's Financial Policy, we have listed below our financial requirements:

Insurance Billing

Charges incurred for services rendered are the patient's responsibility regardless of insurance coverage. As a courtesy, Prime Care will submit claims to your primary and secondary insurance carrier for the medical services that we provide to you or your dependents. Please realize that having secondary insurance does not necessarily mean that your services will be 100% covered. Secondary insurances typically pay according to a coordination of benefits with the primary insurance.

To properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Remember, it is your responsibility to provide us with accurate insurance information and to inform us of any changes in your coverage as they occur. We accept many insurance plans but cannot guarantee their coverage of services or payment.

Copays, Coinsurance and Deductibles

Copays, coinsurance, deductibles, and non-covered services are due at the time of service and will be collected upon check in by the registration staff. We accept cash, debit card, check (except starter checks), Visa, MasterCard, Discover and American Express. If we make an exception due to an emergent circumstance and allow you to be seen without paying your co-pay at the time of service, there will be a billing fee of $15.00 added to your account. We ask that you pay your co-payment and the billing fee within fifteen (15) days. This exception is only made for patients whose accounts are in good standing.

Uninsured or Self-Pay Patients

Payment is required at the time of service. Uninsured patients will receive a "same-day discount" which is a 20% discount on their charge. Without knowing the exact care that will be provided prior to the actual visit, self-pay patients will be required to pay $85 towards the visit and will be asked to make payment arrangements for the balance. New patients and patients that are scheduled for a physical or procedure must pay $120 towards the visit and will be asked to make payment arrangements for the balance. Extended payment arrangements are available if needed. Please ask to speak with a billing coordinator to discuss a payment plan. The billing department can be contacted by calling 804-526-1111, option 3, Monday – Friday from 8am until 5pm. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

Balance Owed or Past Due Accounts

Unless an acceptable payment plan has been made with our billing department, account balances are to be paid in full by your statement due date. If you fail to keep the terms of your payment plan without contacting us further, we will be forced to turn your account balance over to an outside collection agency. If your account is turned over to a collection agency, you will be responsible for all collection

costs including reasonable attorney's fees. Please be advised that there is a finance charge of 1.75% per month on all past due balances.

Patient Payment Responsibilities

It is the patient's responsibility to understand his/her benefits and to keep us informed of any changes. Ask your insurer about any policy exclusions, including pre-existing conditions and verify deductible amounts. You should also verify your plan coverage for physicals, immunizations, and preventative services. This helps us better accommodate the patient at time of service and helps the patient to better anticipate any out-of-pocket expenses.

Please note, even if they cover an annual physical, your insurance company may not pay for additional problems that are addressed during the well exam. For physical exams or annual wellness visits that require additional services beyond the scheduled physical, an additional charge will be incurred, and you will be responsible for payment of the resulting copay, coinsurance, or deductible amount.

The patient or his/her legal representative is ultimately responsible for all charges for services rendered. Please call your insurance company directly if you are unsure whether a service is covered by your plan.

NSF/Returned Checks

There is a $30 fee for any check returned by the bank. If a check is returned on your account, we will no longer be able to accept checks and your account will be made cash/credit only.

Missed Appointments, Cancellations and Late Arrivals

There will be a missed appointment charge of $25 if you fail to cancel your appointment within 24 business hours prior to the scheduled appointment. After the third occurrence, any patient who fails to cancel an appointment may be discharged from the practice.

Patients who arrive more than 15 minutes after their scheduled appointment time will be asked to reschedule. New patients are asked to arrive 30 minutes prior to their scheduled appointment time and will be rescheduled if they fail to arrive on time.

Refund

In the event an overpayment was made, the refund will be issued to the appropriate party. Patient refunds will not be processed until all active or past due balances are paid in full. Refunds are processed at the end of each month. Please call our billing office if you have any questions regarding this policy.
I understand and agree to the Financial Policy of Prime Care Family Practice.

Print Name_____ Date_____

Signature_____

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

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FAMILY PRACTICE

In Office Visit During COVID

During the COVID-19 pandemic, there is some increased risk for patients who visit a healthcare provider. Health problems can happen from being exposed to:

- Other patients,
- Healthcare staff, or
- Healthcare facilities.

Some patients have a higher risk of complications from COVID-19, including those with:

- Asthma,
- Chronic Lung Disease
- Serious heart disease or problems,
- Chronic kidney disease,
- Extreme obesity,
- A compromised or suppressed immune system,
- Liver disease,
- Pregnant,
- Age 65 or older, or
- Nursing home or long-term care facility resident.

If these high risk-patients get COVID-19, they may have a greater chance for having more health problems. These may be serious. Patient may need to be in the hospital. They could even die.

There may be other ways to meet with your provider and be treated. You could have:

- A phone evaluation or
- A telehealth evaluation

These other options may or may not be right for you. This depends on your health problems and overall health. If remote assessment and treatment are not appropriate, your provider will explain why you need an in-person visit.

Medical and office staff may help your provider when you arrive and while you are evaluated and treated. They will follow state laws and recommendations from local, state, and national health officials related to caring for patients during the COVID-19 pandemic. However, they cannot eliminate risks, especially for high-risk patients.

_____ The first page of this consent form told you about COVID-related risks. If, after reviewing this form, you **do not believe that you really understand the risks and choices, do not sign this form until all questions have been answered.**

_____ I understand the facts provided to me on the first page of this consent form. I give my consent for in-office evaluation and treatment. By signing below, I agree that staff/doctor has discussed the facts in this form with me, that no one has given me any guarantee, that I have had a chance to ask questions, and that all my questions have been answered.

_____ _____

Signature of Patient or Responsible Party Date and Time

_____

Relationship to Patient (if Responsible party is not a Patient)

_____ _____

Witness Date and Time

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)

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FAMILY PRACTICE

It is the policy of Prime Care Family Practice that patients under the age of eighteen (18) must be accompanied by a parent or legal guardian. We do realize that sometimes, it may be necessary for someone else to bring your child to our office. We ask that you provide written permission for that to occur by completing the information below.

I _____ give my permission for the following person(s) to bring my child for health care services.

Name of minor child: _____

(Designee must be over 18 years of age):

_____ _____
Name Relationship to child

_____ _____
Name Relationship to child

_____ _____
Name Relationship to child

My child _____ is over the age of **sixteen (16)** and has my permission to seek medical care at Prime Care Family Practice.

Signature of Parent/Legal Guardian: _____ Date: _____

Witness: _____ Date: _____

This permission may be withdrawn at any time with a written request by parent/legal guardian.

PrimeCare
FAMILY PRACTICE

Conditions to Registration and Acceptance as a Patient of Prime Care Family Practice

Patient Name: _____

Consent to Medical Care: the undersigned requests and authorized the physicians and other health care providers of Prime Care Family Practice and their professional staff to perform any medical diagnostic procedures and medical surgical care which in their professional judgement is deemed necessary to diagnosis and/or treat the condition(s) that have brought about my seeking medical services at the offices of Prime Care Family Practice. 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 treatments I receive by the providers and professional staff.

Release of Medical Records: The undersigned hereby authorizes Prime Care Family Practice to disclose all or any part of the contents of the medical record of the patient named 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 otherwise may not serve the interest of the registered patient.

Assignment of Benefits: I hereby request and authorize that all insurance benefits due for the medical services rendered to the registered patient be paid directly to Prime Care Family Practice. The undersigned, whether signing as the patient or as representative for 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.

Deemed Consent: The undersigned acknowledges that the requested patient is informed of 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 bloody/body fluids of a health care provider/patient under the control or direction of Prime Care Family Practice 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, and to the release of suck test results as provided by law.

Consent to Obtain External Prescription History: I authorize Prime Care Family Practice and its providers to view my external prescription history via Surescripts (or any other) 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 at it may include prescriptions history 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.

Consent to Contact Via Email: To the extent that our medical records 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 to contact me regarding my healthcare. I consent that protected health information may be transmitted to me via this email address.

Consent to Communicate Protected Health Information: I consent to have my medical information shared with a national database so that my other healthcare providers may access it: **_____ Consent** **_____ Do Not Consent**

I consent to allow the providers and staff to leave messages regarding my protected health information. Please check the numbers where we can leave a detailed message: **___ home number** **____ cell number** **____ work number**

Please provide the names of people whom we are allowed to discuss your protected health information (appointment reminders, medical bills, and medical information) with:

Name and Relationship: _____

Name and Relationship: _____

Patient or Responsible Party's Signature: _____ **Date: _____**

PrimeCare
FAMILY PRACTICE

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 used and disclose protected health information (PHI) for treatment, payment and healthcare operations. Example 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 included, 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 requirement, 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 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, if 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 your 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 withdraws 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: 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.

PrimeCare
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 Prime Care Family 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: _____

PrimeCare
FAMILY PRACTICE

Welcome to PrimeCare! We appreciate the opportunity to be a part of your healthcare team.
To make the most of our visit, please provide the following background information:

NAME _____ **TODAY'S DATE** _____

DATE OF BIRTH _____

CURRENT MEDICATIONS

Prescription and over-the-counter medications you take on a regular basis

Medication	Dose	Frequency	Medication	Dose	Frequency

MEDICAL HISTORY

List current or past medical conditions, illnesses or injuries

ALLERGIES

SURGICAL HISTORY

List of inpatient or outpatient surgical procedures

FAMILY HISTORY *Medical conditions or illnesses in your family*

		Living? (Y/N)
Father		
Mother		
Siblings		

HEALTHCARE TEAM *Include other providers you currently see*

Name	What you see them for (your condition or diagnosis)

SCREENINGS

	I have had at least one	Date of most recent	N/A
Pap Test			
Mammogram			
Colonoscopy			
Bone Density			

VACCINES

	I have had at least one	Date of most recent
Flu		
Tetanus		
COVID		
Pneumococcal		
Shingles		

TOBACCO *Include any current or previous tobacco usage*

What kind	How much / how often	How long?	N/A

OTHER *Use this space to share any other information you'd like us to know about you, including any changes or improvements you'd like to experience when it comes to your health.*
