REYNOLDS PRIMARY CARE

Virginia Physicians, Inc.

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 Email address: _____

Gender: ☐ F ☐ M DOB: ___/___/_____ Marital Status: _____ Preferred Language: _____
(if other than English)

Race/Ethnicity: ☐ American Indian ☐ Black/African American ☐ Hispanic/Latino
☐ Native Hawaiian ☐ White ☐ Asian ☐ Other _____

Pharmacy Name and Address: _____ Phone #:_____

Insurance Company Name(s): _____

RESPONSIBLE PARTY *(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.

_____

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.*

DISCLOSURES TO FAMILY MEMBERS AND FRIENDS

Disclosures may be made to family and friends related to the patient's health or as needed for payment of health care services. We will only disclose information relevant to current treatment.

I authorize Virginia Physicians, Inc. to disclose my health care information to:

Name	Phone Number	Relationship
Name	Phone Number	Relationship
Name	Phone Number	Relationship

_____

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

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 cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the minimum rate of $25 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:

_____

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

Virginia Physicians, Inc.

Reynolds Primary Care
Health Questionnaire

Today's Date: _____

PATIENT INFORMATION:

Name: _____ Date of Birth: _____ Gender: M F

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail Address: _____

Spouse's Name: _____ Number of Children: _____

CURRENT MEDICATIONS LIST (Please include dose, frequency and quantity)

_____

_____

_____

Pharmacy Name and Phone Number: _____

Medication Allergy: _____

IMMUNIZATIONS:

Diphtheria/Tetanus within 10 years:	Date _____	Tuberculin PPD:	Date _____
Measles/Mumps/Rubella:	Date _____	Pneumonia:	Date _____
Hepatitis A & B:	Date _____	Other:	Date _____
T-DAP (Diphtheria/Pertussis/Tetanus):	Date _____	Zostavax	Date _____

PAST MEDICAL HISTORY (DATES):

Medical Illnesses: _____

_____

Surgeries: _____

_____

Blood Transfusion? (Circle) Yes No Date if Yes: _____

SOCIAL HISTORY:

Occupation: _____ Smoking (amount): _____

Alcohol (amount): _____ Exercise (amount): _____

Caffeine (amount): _____ (include all coffee, tea, soda)

FAMILY HISTORY:

Mother, living, age: _____ Current Medical Problems: _____

If deceased, age at death: _____ Cause of Death: _____

Father, living, age: _____ Current Medical Problems: _____

If deceased, age at death: _____ Cause of Death: _____

Brothers: age: _____ Medical Problems: _____

age: _____ Medical Problems: _____

Sisters: age: _____ Medical Problems: _____

age: _____ Medical Problems: _____

OTHER PATIENT RELATED MEDICAL INFORMATION:

_____

_____

_____