



Reynolds Primary Care

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.

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 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

Authorization for Release of Protected Health Information

Name of Patient: _____ Date of Birth: _____

The office of Virginia Physicians, Inc is authorized to release protected health information as described below for the identified patient.

Entity to Receive Information.

Check each person or class of persons 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 Messages on _____ number.

Appointment Reminders

Lab Results

Other

Spouse or Significant Other:

Phone Number: _____

Appointment Reminders

Lab Results

Treatment Notes and Record

Discuss Treatment

Other Person

Relationship: _____

Phone Number: _____

Appointment Reminders

Lab Results

Treatment Notes and Record

Discuss Treatment

Other Person:

Relationship: _____

Phone Number: _____

Appointment Reminders

Lab Results

Treatment Notes and Record

Discuss Treatment

Patient Rights:

1. I have the right to revoke this authorization at any time.
2. I may inspect or copy the protected health information to be disclosed as described in this document.
3. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
4. 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.
5. I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until I revoke it in writing.

_____ Date _____

Signature of Patient or Personal Representative

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

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:



**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
New Patient Paperwork**

Patient's Name _____

Date of Birth _____ SSN _____

Home _____ Work _____ Cell _____

Release records from:

Release records to:

Virginia Physicians, Inc.
6900 Forest Avenue, Suite 300
Richmond, VA 23230
804-346-1515 phone
804-273-6052 fax

Reason for request: _____

Information to be released:

_____ Completed health records
_____ Office notes - dates from _____ to _____
_____ Immunizations Labs only _____ X-Rays only _____

Other: _____

I Do _____ or I Do Not _____ authorize the release of information related to:

- AIDS (Acquired Immunodeficiency Syndrome)
- HIV (Human Immunodeficiency Virus) Infection
- Psychiatric care and/or Psychological assessment
- Treatment for alcohol and/or drug abuse

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by federal regulations. I need not sign this form in order to assure treatment.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present a written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Signature of Patient/Parent/Guardian/Representative _____ Date _____