VITALCARE
Family Practice

Patient Registration Information

Today's Date: _____

How did you hear about us: _____

Name: _____

Date of Birth: _____ Maiden Name: _____

Address:

_____

_____

Phone Numbers:

Home: _____ Work: _____ Cell: _____

Email Address: _____

Gender: ❑ Male ❑ Female Race: _____ Ethnicity: _____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Separated

Employer: _____

Emergency Contact: _____

Relationship: _____ Phone #: _____

Preferred Pharmacy Name: _____

Location: _____

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

Patient/Responsible Party Signature: _____ **Relationship:** _____

Conditions to Registration and Acceptance as a Patient of VitalCare Family Practice, LLC

Patient Name _____ **Date:**_____

Consent to Medical Care: the undersigned requests and authorized the physicians and other health care providers of VitalCare Family Practice, LLC and their professional staff to perform any medical diagnostic procedures and medical surgical care which in their professional judgment is deemed necessary to diagnosis and/or treat the condition(s) that have brought about my seeking medical services at the offices of VitalCare Family Practice, LLC. 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 VitalCare Family Practice, LLC 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 my 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 any and all insurance benefits due for the medical services rendered to the registered patient, be paid directly to VitalCare Family Practice, LLC. 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 VitalCare Family Practice, LLC 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 such test results as provided by law.

Consent to Obtain External Prescription History: I authorize VitalCare Family Practice, LLC 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 VitalCare FP to use the email address I provided to contact me in regard to my healthcare. I consent that protected health information may be transmitted to me via this email address.

Privacy Practices: I have received a copy of the Notice of Privacy Practices for VitalCare Family Practice, LLC.

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: _____ **Relationship:** _____ **Phone:**_ _____

Name: _____ **Relationship:** _____ **Phone:**_ _____

Name: _____ **Relationship:** _____ **Phone:**_ _____

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

Financial Policy

Patient Name _____ **Date:**_____

Thank you for choosing Vital Care Family Practice as your primary care provider. We are committed to providing you with quality and affordable health care. Please read this payment policy, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance**. We participate with most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. **Please contact your insurance company with any questions you may have regarding your coverage. Please note: VitalCare does not backdate insurance referrals. Referrals must be obtained and valid at the time of service.**
2. **Co-Payments and deductibles**. All co-payments and deductibles must be paid at the time of service. If you have a policy that includes a deductible that has not been met, we will collect an upfront amount of $80 towards your deductible. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered insurance fraud. Please help us uphold the law by paying your co-payments each visit.
3. **Non-covered services**. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. **Proof of insurance**. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.
5. **Claims submission**. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company. We are not part of that contract.
6. **Coverage changes**. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **Nonpayment.** If your account is over 60 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our providers will only be able to treat you on an emergency basis.
8. **Collection**s. 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 and collection agencies not to exceed 33.33%. There is a $25 fee for any returned checks.
9. **Missed Appointments**. Our policy is to charge for appointments that are missed or canceled with less than 24 hours' advance notice. These charges are the patient's responsibility and will be billed directly to the patient. Please note that we do not provide a grace period for appointments. Patients are expected to arrive on time and be present at their scheduled appointment time. Timely arrival helps us maintain our schedule and provide the best possible care to all patients. We appreciate your cooperation in keeping your scheduled appointments and arriving on time.

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 your understanding of our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

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