Virginia Center for Medicine

43490 Yukon Drive, Suite 210, Ashburn, VA 20147
Phone: 703-726-2566 Fax: 703-726-1066

Patient Registration Form

Patient Information :

Patient's Name Last _____First_____MI_____

Address_____

Sex(M/F):_____ S.S.#:_____ Date of Birth: _____

Home Phone #:_____Cell Phone#: _____Work Phone#: _____

Email:_____ Referring Physician_____

Patient Employer _____

EMERGENCY CONTACT_____ Relation_____ Phone _____

How did you hear about us?

Responsible Party:

Policy Holder's Name_____

Address_____

Patient Relation to Guarantor_____ Guarantor Employer_____

Home Phone #:_____Cell Phone #:_____Employer's Phone #:_____

Employer's Address_____

Policy Holder's S.S.#:_____Birthdate_____ Sex(M/F)_____

Primary Insurance :

Name of Insurance Company_____ Policy Holder_____

Pt. Relation to Policy Holder_____ Policy #: _____Group #: _____

Insurance Co. Address_____ _____

Insurance Co. Phone #: _____Policy Holder's DOB_____ Sex(M/F)_____

Secondary Insurance :

Name of Insurance Company_____ Policy Holder_____

Pt. Relation to Policy Holder_____ Policy #: _____Group #: _____

Insurance Co. Address_____ _____

Insurance Co. Phone #: _____Policy Holder's DOB_____ Sex(M/F)_____

I, the undersigned, hereby consent to and authorize the administration and performance of all treatments, the administration of any needed anesthetics, the performance of such procedures as may be deemed advisable in the treatment of this patient, the use of prescribed medication: the performance of diagnostic procedures: the taking and utilization of cultures and performance of other medically accepted laboratory test, all of which the judgment of the attending physician or their designees, may be considered medically necessary or advisable. I fully understand that this consent is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in force until revoked in writing.

_____
Initials

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I hereby authorize VIRGINIA CENTER FOR MEDICINE INC. to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to VIRGINIA CENTER FOR MEDICINE INC. of benefits otherwise payable by me. I hereby, authorize to release my medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided. I understand that I am financially responsible for charges not covered by this authorization. If my insurance requires a selection of a Primary Care Physician (PCP) and I have not selected VIRGINIA CENTER FOR MEDICINE INC. or one of its physicians, or have not obtained the proper referral, I agree that I am financially responsible for those fees. A photocopy of this authorization shall be considered as valid as the original. I further acknowledge that I am indebted for past due charges and I understand that I am financially responsible for those charges also.

Notice of Privacy Practices: (Medical Information Disclosure and Patient Access Information)
VIRGINIA CENTER FOR MEDICINE INC. will use your health information for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of the healthcare that we provide to you. Continuity of care is part of treatment and your records will be shared with other providers and facilities to which you are referred by paper mail, electronic mail, fax, or other methods.

VIRGINIA CENTER FOR MEDICINE INC. may use or disclose identifiable health information about you without your authorization for the following reasons: Public Health Requirements, auditing purposes, research studies, quality assurance, and emergencies may result in the release or sharing of your medical information. We also provide information when required by law, such as for law enforcement. In any other situation, we will ask for your written authorization before disclosing any specific health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future disclosures.

VIRGINIA CENTER FOR MEDICINE INC. may change its policies at any time. But before we make a significant change in our policies, we will notify our patient. PLEASE SEE COMPLETE PATIENTS RIGHT AND HIPPA NOTICE.

Results Policy:
It is our policy to discuss your lab and radiology results at your follow up appointment or by phone. If you have not had y our follow up appointment or received a phone call please call us so that we may track down those results for you.

I have reviewed my patient's rights and responsibilities and privacy policies. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

PATIENT SIGNATURE (or responsible party) _____

Date _____