Today's Date: / /

PATIENT REGISTRATION FORM

PATIENT INFORMATION

PATIENT NAME LAST FIRST MIDDLE	☐ MR ☐ MRS ☐ MISS ☐ MS	Marital Status (circle) Single / Married / Separated Divorced / Widow

Is this your legal name ☐ YES ☐ NO	If not, what is your legal name?	Birthdate	Age	Sex/Gender ☐M ☐F ☐T

Street or Mailing Address (circle one)	City	State	Zip Code	Home Phone Number

Cell Phone Number	Patient Portal Email Address	Social Security Number
	_____ I authorize **First Choice Family Care** to web-enable the patient portal. _____ I **DO NOT** authorize **First Choice Family Care** to web-enable the patient portal.	
Occupation	Employer	Employer Phone Number

Employment Status: ☐1 – Full-Time ☐2 – Part-Time ☐3 Not Employed ☐4 – Self-Employed ☐5 – Retired ☐6 – Active Military
Student Status: ☐F – Full-Time Student ☐P – Part-Time Student ☐N – Not a Student

Race: ☐American Indian/Alaska Native ☐Asian ☐Native Hawaiian/Pacific Islander ☐Black/African American ☐White ☐Hispanic ☐Other ☐Declined
Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined
Language: ☐English ☐Spanish ☐Indian ☐Japanese ☐Chinese ☐Korean ☐French ☐German ☐Russian ☐Other_____

Pharmacy:

Referred by: (Please check one box)
☐Dr. _____ ☐Insurance ☐Hospital ☐Family ☐Friend ☐Yellow Pages ☐Other_____

Other family members seen here

RESPONSIBLE PARTY INFORMATION

Responsible Party: ☐Another Patient ☐Guarantor ☐Self ☐Check if information is same as patient

Name	Home Phone Number
Address	

Birthdate	Email Address	Social Security Number
Occupation	Employer Employer's Address	Employer Phone Number

INSURANCE INFORMATION

Is this visit for one of the following? ☐Worker's compensation (WC) ☐Occupational Medicine (OM) ☐Motor Vehicle Accident (MVA) ☐Accident Date

Name of Insured:	Insured date of birth:	

EMERGENCY CONTACT

Name (Last, First)	Relationship to patient	Home Phone Number	Other Phone Number

I agree the information supplied on this form is accurate and up-to-date to the best of my knowledge.

_____ _____

Patient/Guardian Signature **DATE**

Wythe Physician Practices

360 Virginia Ave Wytheville, VA 24382

HIPAA ACKNOWLEDGEMENT, PATIENT CONSENT AND FINANCIAL POLICY

I. **CONSENT FOR TREATMENT:** I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s). I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any medical personnel or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

II. **NOTICE OF PRIVACY PRACTICES:** Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change; if we change our notice, you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office. The Clinic provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPAA).

_____

Patient Initials

The patient understands that:

- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the notice of privacy practices.

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the individuals listed below. Please note that this does not allow these individuals to obtain copies of my medical records without a complete and valid authorization from me.

NAME	RELATIONSHIP	CONTACT NUMBER

III. **ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION:** I authorize Clinic to provide a copy of the medical record of my treatment, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility(ies) to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence,, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this episode of care, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Clinic, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

IV. **PARTICIPATION IN HEALTH INFORMATION EXCHANGE(S):** Federal and state laws may permit this Clinic to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I hereby authorize Clinic to provide a copy of my medical record or portions thereof to any health information exchange or network with which Clinic participates and to any other participant in such health information exchange or network for purposes of treatment, payment, health care operations, and the purposes discussed above, and in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or networks with which Clinic participates may be found in the Notice of Privacy Practices, which is available on the Clinic website, and this list may be updated from time to time if and when Clinic participates with new health information exchanges or networks. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.

V. **EMAIL AND TEXT COMMUNICATIONS:** If at any time I provide an email or text address at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the Clinic to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer-assisted technology, or by electronic mail, text messaging, or by any other form of electronic communication from Clinic, its affiliates, contractors, servicers, Clinical providers, attorneys, or agents, including collection agencies. Practice may contact me via email and/or text messaging to remind me of an appointment, to obtain feedback on my experience with the Practice's healthcare team, and to provide general health reminders/information.

VI. **FINANCIAL POLICY:** The undersigned, in consideration of the services to be rendered to the patient, is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided.

- The Clinic will file your insurance as a courtesy to you; however, you are responsible for the entire bill. **All co-payments, unmet deductibles, and other patient-responsible services must be paid at the time of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**

- In the event your insurance company does not pay the claim within a reasonable amount of time (45-60 days), then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.

- If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.

- Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.

VII. PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUESTS: If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate State agency for payment of a Medicaid claim. I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I request that payment of assignment benefits be made on my behalf.

I acknowledge receipt of the HIPAA Acknowledgement and Consent Form. I further acknowledge that I have been given the opportunity to ask questions.

_____ _____

Printed Name of Patient or Representative | Signature of Patient or Representative

_____ _____

Date | Relationship to Patient (if other than patient)

CLINIC STAFF USE ONLY: ☐ Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known:

_____ _____ _____

Today's DATE | Witness (Staff) Signature | Witness (Staff) Printed Name

Wythe Physician Practices

First Choice Family Care
360 Virginia Ave Wytheville, VA 24382

NOTICE OF DEEMED CONSENT

TESTING FOR BLOOD BORNE INFECTIONS

Should an employee of Wythe Family Care Center be exposed to my blood or body fluid, in a way that might allow transmission of infection due to blood borne disease (i.e. HIV, Hepatitis B, Hepatitis C, etc.) or other communicable diseases, then I understand that according to Virginia state law, for the safety, health, and possible treatment of the employee, samples of my blood or body fluid may be tested for evidence of infectious diseases.

Likewise, I also understand that Wythe Family Care Center employees and physicians are obligated to submit to blood tests for certain infectious diseases if I am inadvertently exposed to their blood or body fluid during the course of my treatment.

Routine testing of blood for HIV and other blood borne infections is not performed. Testing for such will only be performed as outline above unless I am specifically informed and counseled otherwise.

Print Patient Name: _____ Date of Birth: _____

Signature of Responsible Party: _____ Date: _____

Signature of Employee: _____ Date: _____

Wythe Physician Practices

First Choice Family Care
360 Virginia Ave Wytheville, VA 24382

Name: **Today's Date:**

CURRENT MEDICATIONS - Including over the counter vitamins and supplements	

___Not currently taking any medications

ALLERGIES / INTOLERANCES	

☐ NO KNOWN ALLERGIES

HAVE YOU RECEIVED THE FOLLOWING-MARK ALL THAT APPLY	
☐ FLU VACCINE – DATE:	☐ LAST MENSTRUAL CYCLE – DATE:
☐ PNEUMONIA VACCINE – DATE:	☐ MAMMOGRAM – DATE:
☐ COLONOSCOPY – DATE:	☐ PAP SMEAR – DATE:

SURGICAL HISTORY			
DATE		**DATE**	

☐ NO PAST SURGICAL HISTORY

HOSPITALIZATIONS			
DATE	**REASON**	**DATE**	**REASON**

☐ NO PAST HOSPITALIZATIONS

Name: _____ **Today's Date:** _____

SMOKING	☐ Never ☐ ½ Pack Per Day ☐ 1 PPD ☐ 1 ½ PPD ☐ 2 PPD or more How many years have you smoked? _____ ☐ Quit _____ years ago Do you use any of the following: ☐ Cigar ☐ Pipe ☐ Chewing tobacco/Snuff ☐ Vape
ALCOHOL	Do you ever drink alcohol? ☐ Yes ☐ No If yes, how many drinks a week? _____
DRUGS	Do you or have you ever used marijuana or other illicit drugs? ☐ Yes ☐ No If yes, explain _____
CAFFEINE	Do you drink caffeine? ☐ Yes ☐ No If yes, how many caffeinated beverages per day? _____ ☐ What type of caffeinated beverage? _____
EXERCISE	☐ None ☐ Less than once a week ☐ 1-3 days a week ☐ 4-6 days a week ☐ Daily Type of exercise? _____
EMPLOYMENT	Occupation: _____ ☐ Retired ☐ Disabled
EDUCATION	Circle highest grade completed Elementary School 1 2 3 4 5 6 7 8 High School 9 10 11 12 College 1 2 3 4 5+

FAMILY MEDICAL HISTORY

MOTHER ☐ ALIVE ☐ DECEASED	Present age or age at death _____ Medical Problems (cause of death):
FATHER ☐ ALIVE ☐ DECEASED	Present age or age at death _____ Medical Problems (cause of death):

Please check the appropriate blocks if anyone in your family has any of the following:

	Father	Mother	Brother / Sister	Child	Grandparent	Other
NO known medical history	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Allergy	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐

DEPRESSION SCREENING-answer the following:

1. DO YOU HAVE LITTLE INTEREST IN DOING THINGS? ☐ YES ☐ NO
2. DO YOU FEEL DOWN, DEPRESSED, OR HOPELESS? ☐ YES ☐ NO

Wythe Physician Practices

First Choice Family Care

360 Virginia Ave Wytheville, VA 24382

Office: (276) 228-5069 Fax: (833) 941-5025

Authorization for the Release of Protected Health Information

Patient's Name: _____ **DOB:** _____

Address: _____

Social Security Number: _____ **Phone Number:** _____

I hereby authorize: _____
(Name of previous provider or facility)

To provide confidential information contained within my medical records to:

WPP First Choice Family Care

Information to be released should include:

- ☐ **COMPLETE HEALTH RECORD**
- ☐ History and Physical Exam
- ☐ Laboratory Test Results
- ☐ Immunization Record
- ☐ Office Notes
- ☐ Consultation Notes
- ☐ X-ray Reports
- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ X-ray Films/Images
- ☐ Itemized Bill
- ☐ Demographic/Insurance Info

The purpose of this request is:

- ☐ Treatment and/or Consultation
- ☐ At the request of the patient
- ☐ Other (specify) _____

The following dates of service should be included in this request:

- ☐ **ALL DATES OF SERVICE**
- ☐ FROM (date) _____ TO (date) _____

I, the undersigned, have read and authorize the staff of the disclosing facility named to disclose information as herein contained. I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1998. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under "Purpose of Request." I can inspect or copy the protected health information to be used or disclosed. Except to the extent that action has been taken in compliance with this request, this authorization may be revoked by me at any time, by submitting a notice in writing to the Privacy Office at **First Choice Family Care.** Unless revoked, this authorization will expire in six months unless otherwise specified, or in the event of:

_____.

_____ _____
Signature of Patient/Legal Guardian Date

Initial _____ I acknowledge and hereby consent to such, that the released information may contain alcohol abuse, psychiatric, sexually transmitted disease, Hepatitis B or C, HIV testing, HIV results or AIDS information.