REGISTRATION

HARRISONBURG FAMILY PRACTICE

1831 Reservoir Street, Harrisonburg, VA
Phone: 540-433-9151 Fax: 540-433-0547
harrisonburgfamilypractice@gmail.com

NAME: _____ DATE OF BIRTH _____
(last first M.I.) WORK PHONE #:_____
CELL PHONE #: _____
ADDRESS: _____ HOME PHONE #: _____
CITY: _____ STATE: _____ ZIP: _____

SOC. SEC #: _____ Refused, *please initial*_____
SEX M F EMPLOYED YES NO RETIRED MARITAL STATUS: M S D W

RACE:_____ or (CIRCLE) White Native American Other Black Asian Unknown Pacific Islander

PREFERRED LANGUAGE:_____ ETHNICITY:_____ or (CIRCLE) Hispanic Non-Hispanic Unknown

---

EMPLOYER:_____ PHONE_____
STUDENT: SCHOOL: _____ PHONE_____
***PERSON RESPONSIBLE FOR BILL**: _____
ADDRESS: _____
DOB: _____ PHONE:_____
RELATIONSHIP TO PATIENT: Self Spouse Child Other
IS RESPONSIBLE PERSON/PATIENT HERE? YES/NO

PRIMARY PHARMACY:_____
CONSENT TO ACCESS PREVIOUS MEDICATIONS AND/OR *PBM (CIRCLE) Y N
***(PHARMACY BENEFIT MANAGEMENT) Helping negotiate affordable pharmacy options**

RELEASE OF INFORMATION

I authorize HARRISONBURG FAMILY PRACTICE to disclose my protected health information (PHI) to the party or parties listed below:

Party	Relationship
_____	_____
_____	_____
_____	_____

EMERGENCY CONTACT:_____
EMERGENCY CONTACT PHONE #:_____

I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to HARRISONBURG FAMILY PRACTICE for services rendered. I understand and agree that I am financially responsible for charges not paid for by my insurance company, interest on any outstanding balance not promptly paid, or any fees incurred by HARRISONBURG FAMILY PRACTICE to collect on such outstanding balances (i.e. collection agency fees, no show fee, medical records).

_____ **DATE:**_____

Signature of patient, insured, or beneficiary

READ AND SIGN BACK OF PAGE ↪

HARRISONBURG FAMILY PRACTICE

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, HARRISONBURG FAMILY PRACTICE may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to HARRISONBURG FAMILY PRACTICE's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **HARRISONBURG FAMILY PRACTICE reserves the right to revise its Notice of Privacy Practices at anytime.** A revised Notice of Privacy Practices may be obtained by forwarding a written request to HARRISONBURG FAMILY PRACTICE's Privacy Officer at 1831 Reservoir Street, Harrisonburg, VA 22801, Phone 540-433-9151.

With my consent, HARRISONBURG FAMILY PRACTICE may email, call my home and/or other designated location in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. HARRISONBURG FAMILY PRACTICE may mail or e-mail to my home and/or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and/or Confidential.

I give HARRISONBURG FAMILY PRACTICE permission to:

1. **leave message on voice mail, or leave message with family member** (circle one) **YES/NO**

By signing this form, I am consenting to HARRISONBURG FAMILY PRACTICE's use and disclosure of my PHI to carry out TPO. I am also acknowledging that I have access to the location of the current HARRISONBURG FAMILY PRACTICE's Notice of Privacy Practices and at anytime can request a copy. HARRISONBURG FAMILY PRACTICE is committed to prompt care. As such, in order to accommodate ill/urgent visits expeditiously, we have a low tolerance for no shows. If an appointment is not cancelled 24 hours in advance it is considered a no show and is grounds for dismissal from the practice, and/or subject to no show fees. If bankruptcy is filed for our balance it is grounds for dismissal along with prolonged unpaid balances with collections. When terminations occurs 30 days urgent care can be extended.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in attempts reliant upon my prior consent. If I do not sign this consent, HARRISONBURG FAMILY PRACTICE may decline to provide treatment to me.

Full payment in the form of cash, check or credit card is expected at the time of service unless arrangements are made prior to appointment. Insurance required copays due day of service. If not insured I realize I am responsible for all services. All returned checks are subject to return check fee.

_____

Signature of Patient or Legal Guardian

_____

Patient's Name (printed)

_____

Date

_____

Email for patient portal acceptance & communication

Revised January 2018