REGISTRATION

HARRISONBURG FAMILY PRACTICE

1831 Reservoir Street, Harrisonburg, VA
Phone: 540-433-9151 Fax: 540-433-0547

PATIENT INFORMATION

NAME: _____ HOME PHONE #:_____
(last first M.I.) WORK PHONE #:_____
CELL PHONE #: _____
ADDRESS: _____ DATE OF BIRTH _____
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_____
EMPLOYER ADDRESS: _____
PERSON RESPONSIBLE FOR BILL: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
RELATIONSHIP TO PATIENT: _____
RESPONSIBLE PERSON'S DATE OF BIRTH:_____
RESPONSIBLE PERSON'S SOCIAL SECURITY #:_____
RESPONSIBLE PERSON'S PHONE #:_____

PRIMARY PHARMACY:_____
CONSENT TO ACCESS PREVIOUS MEDICATIONS AND/OR PBM (CIRCLE) Y N

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).

Signature of patient, insured, or beneficiary:_____DATE:_____

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 with Practice/Dr. name.** (circle one) **YES/NO**
2. **leave message with family member with Practice/Dr. name.** 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.

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

_____
Signature of Patient or Legal Guardian

_____
Patient's Name (printed)

_____ _____
Relationship to Patient Date

_____
Email for patient portal

Revised May 2015