



VILLAGE

FAMILY PRACTICE

TODAY'S DATE _____

PLEASE PRINT

PATIENT INFORMATION

COMPLETE PARENT /LEGAL GUARDIAN FORM IF PATIENT IS A MINOR.

LAST NAME _____ DATE OF BIRTH ____ / ____ / ____
 FIRST NAME _____ MI _____ SEX M F
 ADDRESS _____ SOCIAL SECURITY ____ / ____ / ____
 _____ EMPLOYER NAME _____
 CITY _____ EMP STATUS FULL PART RETIRED SELF
 STATE _____ ZIP _____ STUDENT STATUS FULL PART
 HM PHONE _____ CELL _____ MARITAL STATUS S M D W
 WK PHONE _____ EXT. _____ SPOUSE NAME _____
 EMAIL _____
 EMERGENCY CONTACT _____ RELATIONSHIP _____
 HM PHONE _____ WK PHONE _____ EXISTING PATIENT Y N

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE CO. NAME _____ INSURANCE PHONE _____
 POLICY HOLDER/SUBSCRIBER OF INSURANCE (RELATION TO PATIENT): SELF SPOUSE PARENT /GUARDIAN OTHER
 MEMBER I.D. # _____ GROUP# _____
 IF SPOUSE OR PARENT /LEGAL GUARDIAN PLEASE COMPLETE:
 NAME POLICY/SUBSCRIBER: _____
 (LAST) (FIRST) (MI)
 SS# ____ / ____ / ____ D.O.B. ____ / ____ / ____ EMPLOYER _____

SECONDARY INSURANCE

INSURANCE CO. NAME _____ INSURANCE PHONE _____
 POLICY HOLDER/SUBSCRIBER OF INSURANCE (RELATION TO PATIENT): SELF SPOUSE PARENT/GUARDIAN
 MEMBER I.D. # _____ GROUP# _____
 IF SPOUSE OR PARENT /GUARDIAN PLEASE COMPLETE:
 NAME POLICY SUBSCRIBER: _____ RELATION TO PATIENT _____
 (LAST) (FIRST) (MI)
 SS# ____ / ____ / ____ D.O.B. ____ / ____ / ____ EMPLOYER _____

I have read, understand, and agree to abide by the policies stated on the reverse side of this form.

(Please Print) Patient's Name

Patient or Responsible Party Signature

Date

AUTHORIZATION AND CONSENT

I hereby authorize the physicians and staff of Village Family Practice to release any information acquired in the course of my treatment to my insurance company or third party payer as required for claims filed, quality assurance, health plan administration, or complaints/grievances. I understand that the specific information to be released may include HIV virus, Acquired Immune Deficiency Syndrome (AIDS), and mental health.

I authorize direct payment to be made to the physicians of Village Family Practice for any and all medical or surgical services rendered. I understand that if any services or charges are not covered, or if Village Family Practice is unable to verify eligibility that I am responsible for all charges incurred for services rendered.

(Please Print) Patient's Name

Patient or Responsible Party Signature

Date

Office, Financial and HIPAA Policies Acknowledgement

Welcome to Village Family Practice. Village Family Practice's main goal is to provide the best quality of care for their patients. The doctors or staff of Village Family Practice will not perform any services that they do not feel are reasonable or necessary for your well-being. We will strive to make your visits to our office as comfortable as possible. Please read and sign these policies prior to your treatment so that you will have a better understanding of our office policies.

Payment in Full is due at the time services are rendered. For your convenience we accept cash, check and credit cards (MasterCard, Visa, American Express and Discover). All non-cash transactions and/or services that are to be filed to insurance require a legal form of picture identification (driver's license, state identification card, passport) to be scanned into our computer system and your social security number. Village Family Practice will file your claim to those insurance companies with whom we have current contracts. We do not accept Discount Plans or Medicaid and all of our charges are reasonable and customary for this geographical area.

There is a **\$30.00 charge** on all **Returned Checks** and we do not accept post-dated checks. It is our policy to report past due balances over 120 days to the credit bureau unless special arrangements have been made through the billing office.

Insurance Contracts obligate your physician to collect any and all copay, deductible, or co-insurance amounts from you. As a courtesy, this office attempts to verify your insurance benefits prior to any services you may receive but the information we receive is not a guarantee of payment and you are ultimately responsible for knowing your plan benefits and requirements and therefore responsible for any and all copays, deductibles, co-insurance and non-covered services as identified on the explanation of benefits we receive from your insurance plan.

It is your responsibility to notify Village Family Practice of any change in insurance coverage. To facilitate this process it is required at every visit that patients **complete** and **sign** the sign-in form. This helps to ensure that our office updates your information at every visit. Failure to provide this office with current insurance information at the time of service may result in you being held responsible for the full amount of the charges due to the claims filing deadlines required by your insurance which are typically 90-days or less.

Many insurance plans require prior-authorizations for certain tests, referrals, ER visits, and/or treatment. These must be obtained prior to treatment. Without the proper authorization, your insurance may refuse to pay, and you will be responsible for all charges. It is the patient's responsibility to obtain **referrals** at office visits, and takes to the specialist's office. Our office is not responsible for faxing referrals to the specialist's office.

It is the patient's responsibility to notify Village Family Practice of any change in insurance coverage. To facilitate this process it is required at every visit that patients **complete** and **sign** the sign-in form. This helps to ensure that our office updates your information at every visit.

Minors (Children under the age of 18) must be accompanied by an adult. The accompanying parent or guardian must assume financial responsibility.

For your convenience and safety **Prescriptions** are issued during office hours only. Due to HIPAA guidelines and to protect your confidentiality, we no longer refill medications by phone or fax. If you take medication for a chronic condition you are required to see the physician on a regular basis. It is your responsibility to plan ahead so that you do not run out of your medications.

Please keep the receipt given to you at each visit for your records. If you need an **Itemized Statement** of your account there is a \$15.00 fee per statement.

You may be assessed a \$25.00 **no-show fee** for any appointment not cancelled at least 24 hours before appointment.

This office has established an **Email policy** to better serve our patients. If you provide us with your Email address, you are giving us permission to email your test results or other personal health information. Email sent from this office is a one-way communication and return emails will not be accepted. You will need to contact this office or schedule an appointment if you have questions about any information contained in the email. Although this office is dedicated to keeping your medical record information confidential, third parties may have access to email messages despite our best efforts. You should be aware that some companies consider email corporate property and your messages may be monitored if you communicate from work. This office is not responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control

If you have **Lab Tests or X-rays** the "Normal" results of these will be mailed to you within 10-12 business days. Please allow 15 days from the date your tests were performed to phone our office for results. Normally within this time frame we have notified you of the results. There are times when the mailed notice may ask you to make an appointment. Please do not be alarmed, this typically means that the provider wants to speak to you in person for clarification or educational reasons. Please be assured that if your results are of an urgent nature the physician or nurse will call you immediately to discuss or give you further directions.

As a professional courtesy we will fax or mail copies of medical records to other physicians with a signed authorization to release health information. Medical records are available to patient with a signed authorization to release health information and a charge of \$15.00. Medical records requested by insurance companies or attorneys must be requested by those entities.



VILLAGE

FAMILY PRACTICE

TODAY'S DATE _____

PLEASE PRINT

PARENT/LEGAL GUARDIAN INFORMATION SHEET

PATIENTS NAME _____
Last First

DOB _____

CURRENT LEGAL GUARDIAN INFORMATION

PARENT OR LEGAL GUARDIAN (Please Circle)

PARENTS MARITAL STATUS: M, S, D, SEP W (Please Circle)

MOTHER/LEGAL GUARDIAN

FATHER/LEGAL GUARDIAN

NAME: _____
Last First

NAME: _____
Last First

ADDRESS: _____

ADDRESS _____

CITY _____

CITY: _____

ST: _____ ZIP: _____

ST: _____ ZIP: _____

DOB: _____ SS: _____

DOB: _____ SS: _____

EMPLOYER: _____

EMPLOYER: _____

WK#: _____

WK:# _____

HM#: _____

HM#: _____

MOBILE: _____

MOBILE: _____

WHO IS LEGALLY RESPONSIBLE FOR THE CHILD: _____

SIGNATURE OF WHOM COMPLETED THIS FORM: _____

NAME: _____ DOB: _____ TODAY'S DATE: _____

INFORMATION FOR YOUR PHYSICIAN

PLEASE ANSWER THE FOLLOWING QUESTIONS PRIOR TO YOUR FIRST EXAMINATION.

IT WILL HELP YOUR PHYSICIAN TO KNOW NOT ONLY ABOUT YOUR HEALTH BUT ALSO ABOUT YOUR FAMILY AND RELATIVES.

EDUCATION: _____ OCCUPATION: _____

HAVE YOU TRAVELED OR LIVED OUTSIDE THE US AND CANADA? _____

PLEASE IDENTIFY ANY SIGNIFICANT MEDICAL HISTORY FOR THE FOLLOWING FAMILY MEMBERS.

ALIVE

DECEASED

PRESENT HEALTH OR CAUSE OF DEATH

FATHER

MOTHER

BROTHERS

SISTERS

CHILDREN

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES _____ DIABETES _____ CANCER _____ BLEEDING TENDENCY
_____ KIDNEY DISEASE _____ TB _____ HEART DISEASE _____ STROKE _____ HIGH BLOOD PRESSURE _____ DEPRESSION/ANXIETY _____ ALLERGY _____ OTHER

CHECK ANY ILLNESS OR CONDITIONS YOU HAVE HAD _____ DIABETES _____ GLAUCOMA _____ HEART DISEASE _____ SEXUALLY TRANSMITTED DISEASE
_____ VEIN TROUBLE _____ CANCER _____ ASTHMA _____ JAUNDICE _____ BLEEDING TENDENCIES _____ TB _____ PNEUMONIA _____ KIDNEY DS _____ RHEUMATIC FEVER
_____ DEPRESSION/ANXIETY _____ STOMACH ULCERS _____ HYPERTENSION

LIST OTHER ILLNESSES NOT REQUIRING OPERATION FOR WHICH YOU WERE HOSPITALIZED

HAVE YOU HAD ANY SERIOUS INJURIES. BROKEN BONES, ETC. _____ NO _____ YES LIST: _____

HAVE YOU HAD ALLERGY OR SENSITIVITY TO MEDICATION OR OTHER SUBSTANCES _____ NO _____ YES LIST: _____

DO YOU USE TOBACCO NOW? _____ NO _____ YES TYPE AND AMOUNT: _____ HOW LONG _____
EVER USED: _____ HOW LONG: _____

DO YOU USE ALCOHOLIC BEVERAGES NOW? _____ NO _____ YES TYPE AND DAILY AMOUNT: _____ HOW LONG: _____

DO YOU DRINK COFFEE: _____ NO _____ YES WEEKLY AMOUNT: _____ HOW LONG? _____

DATE OF LAST IMMUNIZATION: INFLUENZA _____ HEPATITIS A _____ HEPATITIS B _____
TETANUS _____ PNEUMONIA _____ OTHER _____

(FOR CHILDREN, PLEASE PRESENT IMMUNIZATION RECORDS)

PREVIOUS OPERATIONS (DATES, HOSPITALS AND NAME OF SURGEON): _____

DENTAL (LIST ANY PROBLEMS YOU HAVE NOW): _____

MEDICATIONS (NAME OR OTHERWISE IDENTIFY MEDICINES NOW OR RECENTLY USED): _____

LAST MENSTRUAL PERIOD _____ LAST MAMMOGRAM _____ MENES ARE? _____ REGULAR _____ IRREGULAR

LAST PAP _____

NUMBER OF PREGNANCIES? _____ NUMBER OF MISCARRIAGES? _____ NUMBER OF ABORTIONS? _____

ORAL CONTRACEPTIVES? _____ NO _____ YES OTHER FOR OF CONTRACEPTION? _____

HAVE YOU RECEIVED A BLOOD TRANSFUSION? _____ NO _____ YES DATE: _____

HEIGHT _____ WEIGHT _____ HOW LONG HAVE YOU BEEN AT THIS WEIGHT? _____

WHAT IS YOUR MAIN MEDICAL PROBLEM AND HOW LONG HAVE YOU HAD IT? _____

WHAT ARE YOUR MAIN SYMPTOMS? _____

PREVIEWED BY PHYSICIAN _____ DATE _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of Village
(Patients Name)
Family Practice's Notice of Privacy Practices.

Please Print Name

Signature

Date

FOR VILLAGE FAMILY PRACTICES ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

