



# 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.

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)