Mary Washington Healthcare
Physicians

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name:	**Date of Birth:**	**Age:**	
Address :	**Social Security #:**		
City:	**Sex:**	**Marital Status:**	
State: **Zip:**	**Language:**		☐ **Pt Declines**
Home Phone#:	**Race:**		☐ **Pt Declines**
Work Phone#:	**Ethnicity/Nationality:**		☐ **Unknown**
Cell Phone#:	**Employer:**		
Email Address:	**Emergency Contact:**		
Primary Doctor:	**Emergency Phone#:**		
Referring Doctor/Phone Number:	**Emergency Relationship:**		
Preferred Retail Pharmacy:	**Preferred Mail Order Pharmacy:**		

GUARANTOR INFORMATION

Name:	**Date of Birth:**
Address:	**Social Security#:**
City:	**Employer:**
State: **Zip:**	**Employer Address:**
Home Phone#:	**Employer City:**
Work Phone#:	**Employer State:** **Zip:**
Cell Phone#:	

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Certificate#:	**Certificate#:**
Group Number:	**Group Number:**
Group Name:	**Group Name:**
Copay:	**Copay:**
Subscriber Name:	**Subscriber Name:**
Subscriber Date of Birth:	**Subscriber Date of Birth:**

Patient Name: **DOB:**

Patient Signature: _____ **Date:** _____

Patient Representative: _____ **Relationship to Patient:** _____

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CONSENT TO OBTAIN ELECTRONIC MEDICATION HISTORY

Our medical practice has adopted an electronic medical record system which will further enhance the quality of our services. This system allows us to collect and review your "medication history." A medication history is a list of prescription medicines that we or other doctors have prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer.

An accurate medication history is very important to helping us treat you properly and avoid potentially dangerous drug interactions. By signing this consent form you give us permission to collect your medication history without limitation or exclusion as is required and/or reasonably necessary for your care and treatment. Please understand that your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking and for you to point out to us any errors in your medication history.

Patient Name: **DOB:**

Patient Signature: _____ **Date: _____**

Patient Representative: _____ **Relationship to Patient: _____**

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POLICIES AND PROCEDURES AGREEMENT

In the effort to serve all of our patients equally, fairly and to the best of our ability, we ask that you review and understand our Patient Policies and Procedures.

Late Policy: Every effort is made to keep our physicians' schedules on time; therefore if you are more than **15** minutes late we can not guarantee that you will be seen immediately, but we will do our best to work you in to the schedule as time permits. If all the physicians' schedules are full you will be asked to reschedule your appointment to a later date.

Missed/Cancelled Appointments, Procedures or Surgeries: Every effort is made to accommodate our patients' requests for appointment, procedure or surgery dates/times; therefore, it is important that you make every effort to keep your scheduled appointments. No shows and appointments cancelled within 24 hours will be subject to a fee of **$40.00**. Cancellation of a surgery or scheduled procedure, for any non-medical reason, within 5 business days of the procedure date will be subject to a **$150** cancellation fee. **Please be advised that multiple missed appointments may result in dismissal from our practice.**

Fee for Completion of Forms, Reports, and Letters: This is a non-insurance covered service which requires time from administrative and nursing staff as well as the doctors. A fee of **$30** will be charged for the completion of all forms.

Transferring of Records: All patients must sign a records release form to have their records copied, electronically downloaded, or sent to another provider or organization. There is no fee to transfer records directly to another provider or healthcare organization. For patients with very large charts who request a paper copy, we agree to release the medication list, problem list, up to the last 3 progress notes, most recent labs and radiology reports at a cost of **$0.50** per page. This will enable the patient to obtain the most critical documents for follow up at a nominal cost. If you chose to obtain a paper copy of your complete medical record the fee will be **$0.50** per page up to 50 pages and **$0.25** per page thereafter. An electronic copy of records can be provided to the patient for a **$5.00** fee. This will cover the cost of the CD and other administrative costs.

Payment for Services for Patients with Insurance: According to your health insurance plan you are responsible for paying your co-payment /coinsurance at the time of service.

Payment for Services for Patients without Insurance: You will be responsible for payment by cash, check or credit card on the day of service. On bills with extensive procedures and with approval of our billing department and office manager, you may set up a payment plan with our office. If your household income falls below 400% of the federal government's current poverty guidelines you may be eligible for discounted services. If you believe you may qualify, please request a copy of the current poverty guidelines and an application for financial assistance from this office today. Patients requesting consideration for discounted or charity care must submit an application for financial assistance and provide all requested documentation to this office. Patients who do not meet the criteria for charity care and/or patients who do not provide all information necessary to determine eligibility will be required to pay in full at the time of service unless a payment plan has been established and compliance with this plan has been demonstrated.

Returned Checks: There is a **$50.00** fee for any check returned by your bank.

Patient Name: **DOB:**

Patient Signature: _____ **Date: _____**

Patient Representative: _____ **Relationship to Patient: _____**

Mary Washington Healthcare
Physicians

AUTHORIZATION TO RELEASE INFORMATION

I authorize Mary Washington Healthcare Physicians to leave messages regarding my treatment; including lab results, x-rays, names(s) of medication(s), information pertaining to my treatment and/or office updates by the following method (please circle Yes or No):

Yes **No** Home answering machine: **Yes** **No** Cell Phone/Voicemail:

I authorize Mary Washington Healthcare Physicians to release any information regarding my treatment; including lab results, x-rays, names(s) of medication(s), information pertaining to my treatment and/or office updates. This includes leaving message(s) on the designated contact(s) phone number. Mary Washington Healthcare Physicians may not release information to the named individuals and or entities unless you identify them below.

Name _____ Relationship to Patient _____ Contact Info _____
Name _____ Relationship to Patient _____ Contact Info _____
Name _____ Relationship to Patient _____ Contact Info _____
Name _____ Relationship to Patient _____ Contact Info _____

Mary Washington Healthcare Physicians will use my home phone number and primary address supplied during registration to contact me regarding my treatment; including lab results, x-rays, names(s) of medication(s), and information pertaining to my treatment and/or office updates..I will ensure this information is up to date at every visit.

AUTHORIZATION TO TREAT AND BILL

I consent to be treated by Mary Washington Healthcare Physicians. If I am not the patient being treated today, I am authorized to consent to treatment and billing for the patient identified below. I authorize Mary Washington Healthcare Physicians to bill my medical insurance for the care I received today and to release any information the insurance carrier requires to process this bill. I authorize payment of medical benefits to Mary Washington Healthcare Physicians, or to outside labs as described below, for all services performed and billed by Mary Washington Healthcare Physicians. I understand that I am responsible for all charges for the treatment I receive today.

As a courtesy, Mary Washington Healthcare Physicians will bill my medical insurance. If I do not provide complete and accurate insurance information to Mary Washington Healthcare Physicians, I understand Mary Washington Healthcare Physicians may not receive payment for my carrier and I will be entirely responsible for my bill. Even after my medical insurance company pays Mary Washington Healthcare Physicians, I may owe Mary Washington Healthcare Physicians payment for services not covered by my insurance and I agree to pay these charges promptly to Mary Washington Healthcare Physicians. I authorize any lab performing services for me to bill my medical insurance for their services. I understand that my medical insurance may not pay for all services provided by the lab and I agree to pay any remaining balance promptly to any outside lab providing services to me. I understand that Mary Washington Healthcare Physicians is not responsible for payment to outside labs for tests provided to me.

To protect my privacy and prevent fraud, I understand that if I cannot provide acceptable photo identification at the time of service, Mary Washington Healthcare Physicians may choose not to bill my insurance and may decline credit/debit cards and checks as form of payment. I understand that if I fail to pay Mary Washington Healthcare Physicians for services provided to me, the balance owed will be sent to collections and I may incur collections fees in addition to the amount owed for services/treatment rendered. I understand that I may contact Mary Washington Healthcare Physicians to set a payment arrangement that may prevent this additional cost.

Patient Name: **DOB:** **Patient Account#:**

Patient Signature: _____ **Date: _____**

Patient Representative: _____ **Relationship to Patient: _____**

Mary Washington Healthcare
Physicians

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY

I, «PName», understand that Mary Washington Healthcare (MWHC), of which this Mary Washington Healthcare Physician Practice (The Practice) is a wholly-owned subsidiary, may use and disclose my protected health information for purposes of treatment, payment and health care operations. I also acknowledge that I have received, have been offered, or have received in the past a copy of the Notice of Privacy Practices for MWHC, which provides information about how the physicians, facilities and individuals involved in my care may use and disclose my protected health information. As provided in the Notice, the terms of the notice may change. To obtain a copy of any current Notice, I may contact the Privacy Officer at 1-800-442-8762.

I understand that I have the right to request that The Practice restrict how my protected health information is used or disclosed for treatment, payment or health care operations, but I also understand that The Practice is not required to agree to a requested restriction.

Patient Name: **DOB:**

Patient Signature: _____ **Date: _____**

Patient Representative: _____ **Relationship to Patient: _____**

Patient Medical History Record

In an effort to better serve you, we ask that you complete this survey as accurately as possible. **Please answer all questions**. Thank you.

Today's Date: ____ /____ / _____

Name: _____ **Date of Birth:** ____ /____ / _____

Occupation: _____ **Medical Doctor:** _____

Pharmacy: _____

Allergies: **List all known allergies**. No Known Drug Allergies _____

_____

CURRENT Medications: Please list below (or provide a list of) all medications, **including eye drops & non-prescription drugs.**

_____

_____

Review of Systems:

Do you <u>currently</u> have any of the following problems?	**Yes**	**No**	**If YES, please explain:**
Heart Problems (chest pain, irregular heart beat)	O	O	_____
Respiratory Problems (shortness of breath, wheezing, cough)	O	O	_____
Gastrointestinal Problems (heartburn, abdominal pain, diarrhea)	O	O	_____
Urinary Problems (pain or discomfort, blood in urine)	O	O	_____
Skin Problems (rashes, excessive dryness, rosacea)	O	O	_____
Musculoskeletal Problems (muscle aches, joint pain, swollen joints)	O	O	_____
Neurologic Problems (numbness, weakness, headaches, paralysis)	O	O	_____
Psychiatric Problems (depression, anxiety)	O	O	_____
Chronic fever, unexpected weight loss/gain, fatigue	O	O	_____
Ear/nose/throat Problems (hearing loss, sinus problems, sore throat)	O	O	_____
Endocrine Problems (diabetes, thyroid problems)	O	O	_____

Any eye injury? previously __ currently __ explain: _____

Any heart surgeries? (Stents, Angioplasty, Bypass) explain: _____

Have you or immediate family member (parent, grandparent, sibling) ever had any of the following conditions?

	Self	Family		Self	Family		Self	Family		Self	Family
Cataract	O	O	High Blood Pressure	O	O	Diabetes	O	O	Migraines	O	O
Glaucoma	O	O	Heart Disease	O	O	Asthma	O	O	Seizures/Epilepsy	O	O
Crossed/Lazy Eye	O	O	Stroke	O	O	Chronic Bronchitis	O	O	Arthritis	O	O
Retinal Detachment	O	O	Heart Arrhythmia	O	O	Sinus Problems	O	O	Thyroid Disease	O	O
Dry Eye Syndrome	O	O	Anemia	O	O	Tuberculosis	O	O	Cancer	O	O
Macular Degeneration	O	O	Bleeding Problems	O	O	HIV/AIDS	O	O	Liver Disease	O	O
Blindness	O	O	Cholesterol	O	O						

Surgeries: List any previous surgeries, **including eye surgeries and laser procedures:**

_____

Glasses/Contact lenses:

Do you wear glasses? Yes __ No __ Contact lenses? Yes __ No __ Type? _____

If you wear Contact Lenses, do you like what you are wearing? _____

Do you smoke? Yes __ No __ If yes, how much? _____

Do you drink alcohol? Yes __ No __ If yes, how much? _____

Are you using or have you ever used recreational (including IV) drugs? Yes __ No __

Hobbies: _____

Computer use: Do you use a computer? Yes__ No ___ How long per day? _____

Reviewed by: _____OD/MD Date: _____

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