ATWOOD FAMILY MEDICAL CENTER
CHESAPEAKE EXECUTIVE FAMILY CARE

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PATIENT REGISTRATION FORM

PATIENT NAME: ______________________ MAIDEN/OTHER NAME: ______________________

ADDRESS: ______________________

CITY: ______________________ STATE: ______________ ZIP CODE: ______________

EMAIL ADDRESS: ______________________

HOME TELEPHONE: ______________________ CELL PHONE: ______________________

SOCIAL SECURITY NO.: ______________________ GENDER: MALE/FEMALE

DATE OF BIRTH: ____/____/______ AGE: ________ ETHNIC GROUP: ◻ HISPANIC/LATINO ◻ OTHER

RACE ◻ ASIAN ◻BLACK/AFRICAN AMERICAN ◻ NATIVE HAWAIIAN/PACIFIC ISLANDER ◻ WHITE ◻ OTHER

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED SEPARATED

EMPLOYER: ______________________ TELEPHONE NO.: ______________________

SPOUSE OR RESPONSIBLE PARTY: ______________________

ADDRESS: ______________________

CITY: ______________________ STATE: ______________ ZIP CODE: ______________

EMAIL ADDRESS: ______________________

HOME TELEPHONE: ______________________ CELL PHONE: ______________________

SOCIAL SECURITY NO.: ______________________ GENDER: MALE/FEMALE

DATE OF BIRTH: ____/____/______ AGE: ________

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED SEPARATED

EMPLOYER: ______________________ TELEPHONE NO.: ______________________

EMERGENCY CONTACT PERSON'S NAME: ______________________

RELATIONSHIP TO PATIENT: ______________________

HOME TELEPHONE: ______________________ CELL/WORK TELEPHONE: ______________________

INSURANCE INFORMATION (*PLEASE PRESENT ALL INSURANCE CARDS TO THE RECEPTIONIST*)

***PRIMARY* INSURANCE NAME**: ______________________

NAME OF POLICY HOLDER: ______________________ POLICY HOLDER DOB: ____/____/______

POLICY HOLDER SSN: ______________________ RELATIONSHIP TO PATIENT: ______________________

SUBSCRIBER/POLICY NO.: ______________________ GROUP NO.: ______________________

***SECONDARY* INSURANCE NAME**: ______________________

NAME OF POLICY HOLDER: ______________________ POLICY HOLDER DOB: ____/____/______

POLICY HOLDER SSN: ______________________ RELATIONSHIP TO PATIENT: ______________________

SUBSCRIBER/POLICY NO.: ______________________ GROUP NO.: ______________________

PATIENT SIGNATURES

PATIENT AUTHORIZATION

I authorize Ronald W. Atwood, M.D., P.C. dba Atwood Family Medical Center to release my Protected Health Information (PHI) in order to obtain payment, to obtain treatment and to conduct our health care operations. I consent to the release of this information in the original, copy, computer, and/or facsimile form at the discretion of the provider. I hereby release provider from any liability relating to the improper use of such information by the party to which such information has properly been release pursuant to this consent. I request that my health insurance or Worker's Compensation claims be paid directly to Ronald W. Atwood, M.D., P.C. I understand I am financially responsible for all non-covered services or services not considered reasonable and necessary. I understand co-payments, deductible and coinsurance is due at the time services are rendered.

In consideration of the services rendered, I/we agree and understand that each person(s) signing this document jointly and severable agrees to pay for all services rendered by Ronald W. Atwood, M.D., P.C. If this account is referred to an outside collection agency or attorney, the undersigned person(s) agree and promise to pay all collection costs including attorney fees of 27% of the principal amount due and owing when turned over for collection.

I authorize photocopies of this form to be valid as the original.

DEEMED CONSENT

I understand that, in accordance with Section 32.1-45.1 of the Code of Virginia, 1905, as amended, if a Ronald W. Atwood, M.D., P.C. dba Atwood Family Medical Center healthcare provider is exposed to my blood or other bodily fluids in a manner which may transit disease, I may be tested for infection with Human Immunodeficiency Virus (HIV), the virus which causes Acquired Immune Deficiency Syndrome (AIDS) or Hepatitis B or C viruses. I further understand that the results of any such test will be shared with me and the exposed healthcare provider; that the Virginia Department of Health will be notified; and that appropriate counseling shall be provided if the results are positive.

OFFICE POLICIES AND ADDITIONAL FEES

I have had the opportunity to read the Ronald W. Atwood, M.D., P.C. OFFICE POLICIES AND ADDITIONAL FEES, and I understand that I may ask questions regarding this policy.

PRESCRIPTION REFILL POLICY

There are several ways to request your prescription refills: contact your pharmacy and request a refill (even when there are no additional refills on your prescription the pharmacy will send us a new request); request a refill through our patient portal: or call us Monday through Friday, from 9:00a.m. to 4:00p.m. Please allow at least 24 hours for us to process your prescription refill request. Prescriptions for narcotics will not be ordered after hours or on weekends. Please remember to contact us in advance so you can receive your medications in a timely manner.

DISABILITY FORM INFORMATION

Ronald W. Atwood, M.D., P.C. will complete disability and/or FMLA forms that you require. Please allow at least two weeks for the completion of your forms. We require the fee for completing disability forms and copying necessary medical records paid prior to submission.

NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As provided in our Notice of Privacy Practices, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

Patient Signature: ______________________________ Date: ______________

Patient or Guardian's Signature ______________________________ Date: ______________

Relationship to Patient ____

ATWOOD FAMILY MEDICAL CENTER
PATIENT INFORMATION RELEASE

The Privacy Act of 1977 was designed to protect your privacy. It is to give you a feeling of security that when you visit our office your medical and financial information will not be discussed with anyone without your permission. This includes your spouse, family members, friends and employer. In order for us to speak with anyone regarding you, even in the event of an emergency, you must specify to whom we may speak. Under this same act, information can be released to your insurance company and other protected medical organizations.

If you wish for us to be able to release information regarding you, please indicate below. Our staff cannot give out this information without your permission.

I give permission for the staff of Atwood Family Medical Center to discuss information as indicated regarding myself.

Name	**Relationship to Patient**	**Type of Information to be Released (please circle)**
		MEDICAL/FINANCIAL
		MEDICAL/FINANCIAL
		MEDICAL/FINANCIAL
		MEDICAL/FINANCIAL
		MEDICAL/FINANCIAL

Patient's Name ____

Please PRINT Patient's Name

Date of Birth ______________________________

Patient must sign if 18 years of age or older

____

Patient/Parent/Legal Guardian Signature

____

Date