

ATWOOD FAMILY MEDICAL CENTER
CHESAPEAKE EXECUTIVE FAMILY CARE

Ronald W. Atwood, MD*
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Elizabeth Dove, MSN, RN, FNP-C
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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 _____

OFFICE POLICIES AND ADDITIONAL FEES

Thank you for choosing Atwood Family Medical Center. We are committed to the success of your medical treatment and care. Please understand that payment for services rendered is part of your treatment and care.

- Our goal is to manage your time with our practitioners in an efficient manner. Therefore, all appointments must be cancelled **24 hours prior to your visit** or you will be responsible for paying a missed appointment/late cancellation fee. No further office visits will be scheduled until all missed appointment fees are paid.

Missed appointment/late cancellation fees:	\$25.00 routine office visit
	\$35.00 extended office visit, well-woman, pre-operative exam
	\$45.00 complete physical, well-child

This fee will **NOT** be filed to your insurance company. *Please remember, although we attempt to contact patients in advance as a courtesy reminder, ultimately keeping appointments is the patient's responsibility.*

Please arrive at least 15 minutes prior to your scheduled appointment. Should you arrive late for your scheduled appointment, you may be asked to reschedule your office visit.

- There may be a charge for medical forms (employment, disability, life insurance, DMV, scooter, etc.) completed by the practitioners. There will be a charge for any medical letters you request as well as copies of your medical records **including copies of labs and x-ray reports**. Requested copies will not be mailed or sent by fax. You may pick up your requested copies during normal office hours.

Completion of Forms/Medical Letters	\$10.00 to \$35.00
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Medical Records Copies

We **MUST** have a HIPAA compliant Authorization to Release Information **BEFORE** your information can be released on your behalf. Please allow two weeks for your records to be released.

Charge for chart retrieval, copying, postage and labor:	\$10.00
Pages 1 thru 50	\$.50 per page
Pages 51 and over	\$.25 per page

- Payment is expected at the time of service unless arrangements have been made prior to your visit. There is a **\$5.00 billing fee** for all deductibles, co-payments and coinsurance not paid at the time services are rendered. If for any reason you must be mailed a statement, the balance is due in full upon receipt or you must contact the office to make payment arrangements. You will be charged a **\$5.00 processing fee** for each additional statement mailed.
- There is a fee of **\$30.00** for all returned checks. We will no longer accept payment by personal check after the receipt of a returned check. We will accept cash, VISA, MasterCard, or Discover.
- We do **NOT** accept walk-in appointments. If you or a family member has an acute problem (e.g. fever, severe pain, bleeding, shortness of breath, etc.) that requires prompt medical attention, please call our office as soon as possible so we can determine the appropriate place of treatment.

I have read the above stated policies and fees of Ronald W. Atwood, M.D., P.C.

Patient's Name - **PRINT NAME**

Patient's **SIGNATURE** (Guarantor's Signature if a minor)

Date