# 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.

**APPOINTMENT VERIFICATIONS/OFFICE ANNOUNCEMENTS/PATIENT SURVEYS**
By supplying my home phone number, mobile phone number, email address and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointments(s), and other limited information , for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the numbers provided by me.

**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 the office and leave a message on our prescription refill line. Prescriptions for narcotics will not be ordered after hours or on weekends. Please remember to contact us in advance (at least 24 hours' notice) 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 _____