CHICKAHOMINY FAMILY PHYSICIANS – Quinton & Providence Forge

1850 Pocahontas Trail – PO Box 7 Quinton, VA 23141
Phone: (804) 932-4388 Fax: (804 932-9860

Patient Information

Name: ____ Social Security #:____________________

Last Name First Name Middle Initial

Birth Date: _________________ Marital Status: ___________________ Sex: □ Male □ Female

Mailing Address: ________________________________ City: ___________________ State: __________ Zip: _________

Email Address: ____

Home phone No: ( )______________ Cell Phone No: ( )______________ Work Phone No: ( )________________

"Our practice is now collecting new demographic data to aid health agencies understand healthcare disparities, improve quality of care, and strengthen research and outreach. We appreciate your assistance in meeting these new national standards. Chickahominy Family Practice, Inc. is dedicated to being your partner in improving patient care."

Preferred Language: □ English □ Spanish □ Other

Race: □ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or Other Pacific Islander □ Caucasian/White □ Multiracial □ Refused/Declined

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Refused/Declined

Emergency Contact

Name: ____ Relationship: ____

Phone No.: ( )______________ Work No.: ( )______________ Ext. ______ Cell No.: ( )_____________

Address: _____________________________________City:___________________________State:______________Zip:_____

***Responsible Party** (Person Responsible for any unpaid balance)*

Last Name: __________________________ First Name: __________________________ Middle Initial: _____________

Address: _____________________________________ City: _________________ State: ____________ Zip:__________

Relationship: _____________________________ Social Security No.: _____________________

Employer: ___________________________________ Work No.: ____________________ Ext. __________

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO CHICKAHOMINY FAMILY PRACTICE, INC.

I hereby authorize the physicians designated to release information acquired in the course of my examination. This information will be used to help obtain insurance reimbursement or assist other physicians regarding my care. I hereby assign payment directly to the designated physicians for any medical/surgical procedures performed. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. I understand that any overpayment made by my insurance company will be credited to my account.

I certify that the information I have given is correct and true to the best of my knowledge. "The undersigned jointly and severally guarantees payment to *Chickahominy Family Practice, Inc.,* the payment of all charges incurred by the patient, including reasonable collection agency or attorney's fees, if applicable."

Signature of Patient or parent/guardian if a minor: ________________________________ **Date:** _____________________

(Medicare Patients Need To Sign The 2nd Page of this Demographic Information Form)

Authorization of Consent for Medical Treatment

Because my child, ________________________________, must at times be left in the care of unrelated persons, we the parents/legal guardians of __________________________, grant full and unconditional permission to any physicians associated with Chickahominy Family Practice, Inc. to perform and/or authorize any treatment he or she deems necessary for the care of ___________________________________.

This notice authorizes and covers any treatments, procedures and medicines prescribed by stated physicians until such time that a parent or legal guardian can arrive on the scene and be consulted by the physician.

____ ______________________

Signature of Parent/Legal Guardian **Date**

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MEDICARE AUTHORIZATION

_____________________________________ _________________________ ____________________

Patient's Signature **Medicare Number** **Date**

I request that payment of authorized Medicare benefits be made either to me or on behalf to Chickahominy Family Practice, Inc. for any services furnished me by my provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.