CHICKAHOMINY FAMILY PRACTICE, INC.

New Market
2660 New Market Road
Richmond, VA 23231
804-795-1144
804-795-1052

Quinton
9010 Pocahontas Trail
Quinton, VA 23141
804-932-4388
804-932-9860

Providence Forge
1850 Pocahontas Trail
Providence Forge, VA 23140
804-932-4388
804-966-9712

Patient Information

Name: _____ Social Security #:_____
Last Name First Name Middle Initial

Birth Date: _____ Marital Status: _____ Sex**:** □ Male □ Female

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home phone No: ( )_____ Cell Phone No: ( )_____ Work Phone No: ( )_____

Email Address: _____

"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 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 I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.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 Back Of This 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.