NEW PATIENT REGISTRATION FORM (PLEASE PRINT)

PATIENTS NAME:_____

DATE OF BIRTH:_____ AGE:_____

MARITAL STATUS: SINGLE/MARRIED/DIVORCED/SEPARATED

EMAIL ADDRESS: _____

HOME PHONE: _____ CELL PHONE:
_____

STREET ADDRESS: _____

CITY:_____ STATE:
_____

ZIP CODE: _____

INSURANCE INFORMATION

Is this a work related injury? YES/NO
If yes will the employer be responsible for the bill? YES/NO

Employer Name:
_____
Employer Phone Number:
_____
Employer Contact Person:
_____

PRIMARY INSURANCE

CARRIER:_____ POLICY #_____

GROUP # _____ CO-PAY _____

Relationship to subscriber: Self/Spouse/Child/Other

HEALTH HISTORY

What is your reason for your visit today?_____
_____
__

Primary Care Doctor:

_____

PAST MEDICAL HISTORY

Please check if you have or had any of these:

___Vertigo ___Hemorrhoids ___Anxiety ___Lower back pain

___Arthritis ___Depression ___Anemia ___Alcohol Abuse

___High blood pressure ___Bronchitis ___Abdominal pain

___Weight loss/Gain ___Swollen Ankles ___Hepatitis/Jaundice

___Heart Attack ___Pheumonia ___Heart Burn ___TB

___Thyroid Disease ___Cough ___Headache ___Gout

___Blood in stools ___Ulcers ___Nausea ___Vomiting

___Palpitations ___Asthma ___Diarrhea ___Drug Abuse

LIST ANY OTHER MEDICAL PROBLEMS THAT YOU HAVE BEEN DIAGNOSED WITH:

_____
_____
_____
_____
_____
_____

IMMUNIZATIONS: ___Tetanus ___Flu ___COVID-19 ___Pheunmonia

SURGERIES:

_____
_____
_____
___

PREFERRED
PHARMACY:_____
_

LIST YOUR PRESCRIBED MEDICATION AND DOSAGE AND OVER THE COUNTER MEDICATIONS:

_____
_____
_____
_____
_____
_____

ALLERGIES TO MEDICATION:

NAME OF DRUG:_____
REACTION:_____

NAME OF DRUG:_____
REACTION:_____

NAME OF DRUG:_____
REACTION:_____

Do you drink alcohol? Y/N How often?
_____

Do you use tobacco? Y/N How often?
_____

Do you vape? Y/N How often?
_____

Do you use recreational drugs? Y/N Name of drug:_____

FAMILY HEALTH HISTORY

Mother	Father	Sister	Brother
Age:	Age:	Age:	Age:
Health Problems:	Health Problems:	Health Problems:	Health Problems:
Alive/Deceased	Alive/Deceased	Alive/Deceased	Alive/Deceased

BODEN HEALTH URGENT CARE FINANCIAL POLICY STATEMENT

Thank you for choosing our physicians for your health care needs. We are committed to providing the very best medical care and treatment. The following is a statement of our Financial Policy, which you ***must*** read, agree to and sign, prior to treatment.

Practice Payment Policy Guidelines:

- Patients/ (guardians) are financially responsible for all charges, regardless of third-party involvement.
- Full payment is due at the time of services, unless prior insurance billing arrangements have been made.
- Patients with insurance will be required to pay all "out-of-pocket" financial obligations at time of service.
- We accept: Cash, Check, and debit/credit cards: Visa/ MasterCard.

Patient Responsibilities and Financial Policies: Provide Accurate Information: You have a responsibility to provide accurate and complete information about your health history, mailing address, health insurance and other billing information. If any information changes – name, address, phone, insurance coverage, etc. – you must inform this practice immediately. Insurance denials or billing errors due to patient supplied information will result in the transfer of the account balance to the patient's immediate financial responsibility.

Know Your Insurance Coverage, Benefits and Referral Requirements: Your health insurance is a contract between you and your health insurance plan(s). Patients are responsible for understanding their health insurance coverage(s), benefits and referral requirements per-authorizations or pre-certifications from their primary care physicians. Patients are responsible for securing the necessary written referrals, receiving the necessary per-authorizations or per-certifications from your primary care physician or health plan prior-to service rendered. If you have not received the necessary authorizations prior to your appointment, the appointment will be rescheduled. Please present your Insurance ID card to our staff upon registration for ***each office visit***.

Self-Pay Patients: Patients without insurance coverage are expected to pay for service received in full at time of service. **Patient with Private Insurance / Medicare / Medicaid Coverage:** Our physicians participate with the Medicare and Medicaid Programs, and with most major insurance companies. We will file claim(s) to your insurance provided you authorize the "assignment of benefits" below for payment directly to our practice. For participating insurance plans, the practice will accept payment based on contractual agreements. For plans that we don't participate in (i.e., there is no contractual agreement), the practice will expect full payment from the patient at time of service. Any coverage or payment dispute is a matter between the insurance policyholder and the insurance company.

Patient Payment Agreement: I understand that I am financially responsible for all charges, regardless of third-party involvement. I agree to pay any deductible coinsurance, co-payment, or service deemed as "non-covered" by my insurance carrier at the time of service. If my insurance has not paid on my account in 60 days, the outstanding service will become my responsibility for immediate payment (unless Medicare and Medicaid). Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, non-payment at time of service and/or any other reason, I agree to pay all charges within 30 days of notice. I understand that if I fail to pay outstanding

balances or make payment arrangements within 75 days, the amount due will be considered delinquent and subject to legal action. I further understand that delinquent accounts will be assessed at a 1.5% interest charge per month (18% APR), and will be subject to the possible dismissal of the patient from our care. If my account is forced to collection, I agree to pay all collection costs, including, but not limited to, court costs, attorney's fees equal to 33.33% of the amount owed, and accrued interest charges to date. I agree to pay a $25.00 returned check fee. Copies of my medical records can be obtained with advance notice in accordance with §8.01-413 of the Code of Virginia, with charges not to exceed $0.50 per page for the first 50 pages and $0.25 per page thereafter, in addition to a $10.00 handling fee plus postage expense. The completion of special forms or reports has a minimum charge of$25.00 for each form.
Authorization & Assignment of Insurance Benefits: I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of specific medical or other protected health information, whether manual, electronic or telephonic. I authorize the Practice to apply for benefits for services rendered to myself or minor child under any health insurance policies providing benefits and do hereby also assign and authorize payment of benefits from my insurance company to the Practice (including benefits payable under Title XVIII of the Social Security Act and/or any other governmental agency.) I irrevocably authorize all such payments to the Practice. I authorize the Practice to contact the employer or insurance company regarding insurance information, existence of insurance and coverage of my benefits.

In consideration for medical service rendered, I acknowledge receiving notice of the financial policy and agree to pay for said medical services according to the above terms. My signature below indicates that I have read and agree to the above policy.

Patient/Responsible/ Party/Guardian

Signature:_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize BODEN HEALTH URGENT CARE or insurance company to release any information required to process my claims. Medicare Beneficiary Lifetime "Signature on File": I request that payment of authorized Medicare benefits will be made on my behalf to Boden Health for any services furnished to me by physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent's information to determine benefits payable for services rendered.

Patient/Guardian Signature:_____ Date:_____