Embracing Health

Integrative primary care for the whole family

Patient Registration Form

Patient Information:

Patient Name: ____________________ Date of Birth: ____/____/____

Social Security Number: ____________________ Preferred Pharmacy: ____________________

Mailing Address: ____________________ City: __________ State: ________ Zip: ______

Home Phone: ____________________ Cell Phone: ____________________

Employer: ____________________ Work Phone: ____________________

Email Address: ____________________ Preferred Language____________________

Race (optional): ____________________ Ethnicity (optional): ☐ Hispanic, ☐ non-Hispanic

Emergency Contact Information:

Name:____________________ Relationship:____________________

Phone Number:____________________ or ____________________

Responsible Party Information: (Required if Patient is under 18 years of age)

Name:____________________ Relationship:____________________

Phone Number:____________________ or ____________________

Insurance Information:

Primary Insurance: ____________________ Policy Holder: ____________________

Policy Holder DOB: ____/____/____ Relationship to Patient: ____________________

Policy Number: ____________________ Group Number: ____________________

Secondary Insurance: ____________________ Policy Holder: ____________________

Policy Holder DOB: ____/____/____ Relationship to Patient: ____________________

Policy Number: ____________________ Group Number: ____________________

Important Payment Notice -- Signature Required:

Assignment of Insurance Benefits: I hereby authorize payment to this practice for any benefits payable to me for the healthcare services provided to the client/patient at this practice, to be paid directly to the practice. I understand that if the health insurance information is provided, this in no way relieves me of my financial responsibility for services rendered now or in the future at this practice.

Guarantee of Payment: I understand that I am ultimately financially responsible for all amounts payable with regards to fees for healthcare services rendered now and in the future by this practice. I am responsible for paying the difference between the invoiced amount and the amount my insurance provider chooses to pay. In the event of non-payment by me of any amount due to the practice after 90 days, I agree to pay the original amount due, any collection fees of 33 and 1/3% of the amount due, court costs and reasonable attorney's fees incurred by this practice in the process of collecting my debt owed.

Cancellation fee: I agree to pay a $30 cancelation fee if I fail to communicate my intent to cancel an appointment to an employee of Embracing Health less than 24 hours in advance of my appointment. If my appointment is scheduled on a Sunday or Monday, I must provide notification no later than noon the Thursday before my appointment. Cancelations must be communicated directly to an employee. Cancelations communicated by email or voicemail will still be subject to the cancelation fee.

Signature of responsible party: ____________________ **Date:**__________

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385 Garrisonville Road, Suite 121
Stafford, Virginia 22554
Phone: 540-318-8602 Fax: 540-657-1220

Authorization to Use or Disclose Protected Health Information

Patient Name: ___________________________________ *Date of Birth:* _____/_____/_____*Home#:*________________________

I, ______________________________, understand Embracing Health, Inc. is authorized by me to use or disclose my Protected Health Information for a purpose other than treatment, payment, or health care operations as designated below. I have read this authorization and understand the designated information will be disclosed only to the recipient(s) outlined below by any current employee or owner of Embracing Health, Inc. I understand that when the information is used to disclose pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization in writing at a later date.

My medical information may be discussed with the following person(s)

Name	Relationship	Phone

Signature: ____ ***Date:***____________________________________

TREATMENT AND PAYMENT POLICY IN VIRGINIA

The terms "you" and "your" as used in Embracing Health Treatment and Payment Policy in Virginia, mean the Patient and the Patient's Guarantor, if applicable. A Guarantor is the individual who accepts financial responsibility for services rendered to a minor, incapacitated or otherwise legally dependent Patient. The Guarantor may be a family member or non-family member with legal authority to act on the Patient's behalf, including the authority to consent to medical services. By signing this form the Guarantor is informing Embracing Health that he/she has such authority.

____

Printed Name of Patient or Guarantor **Signature of Patient or Guarantor** **Date**

____

Minor Patient's Name, (Relationship to Guarantor) **Witness Signature** **Date**

HIPAA- Please initial the following:

______________ I (Patient/Guarantor) hereby acknowledge that I have been provided with a copy of the **Privacy Practices of Embracing Health, Inc. and HIPAA Notice.**

FOR OFFICE USE ONLY:
A copy of the Privacy Practices of Embracing Health, Inc. and HIPAA Notice, was made available to the Patient/Guarantor, and the Patient/Guarantor refused to initial the acknowledgement. _______Initial Witness

PATIENT ENCOUNTER FORM

Date:_____/_____/_____ Patient Name:_____________________________________ DOB:____/____/____

Copay received: $______________ Pharmacy:____

Reason for visit and Date symptoms began: ____
____
____

Past Medical History: Please circle Y or N for any new or previous health conditions that apply to you and please be specific:

Disorders of the skin	Y	N	______________________________
Headaches	Y	N	______________________________
Disorders of the eye	Y	N	______________________________
Disorders of the ears	Y	N	______________________________
Nose	Y	N	______________________________
Throat	Y	N	______________________________
Respiratory disorders	Y	N	______________________________
Cardiovascular	Y	N	______________________________
Gastrointestinal	Y	N	______________________________
Genitourinary disorders	Y	N	______________________________
Male specific disorders	Y	N	______________________________
Female specific disorders	Y	N	______________________________
Endocrine	Y	N	______________________________
Musculoskeletal disorders	Y	N	______________________________
Immunologic disorders	Y	N	______________________________
Neurological disorders	Y	N	______________________________
Psychiatric disorders	Y	N	______________________________
Cancer	Y	N	______________________________
Last Pap/Mammogram	Y	N	______________________________

Known Exposure to TB, HIV, Viral Hepatitis: Y N

Medication allergies: ____

List prescription and over the counter medications, vitamins and dosage:

____
____
____

Past Surgical History: ____
____
____

Significant Family History:
Mother: ____
Father: ____
Siblings: ____
Marital status: ________________________________Occupation:____

Tobacco Use: Y N PPD______ **Alcohol Use: Y N** **Recreational drug use: Y N**

HT______________WT______________BP_______________HR______________RR_______________T_____________02________