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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PATIENT ENCOUNTER FORM

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

Copay received: $_____ Pharmacy:_____

Reason for visit and Date symptoms began: _____

_____

_____

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

	Yes	**No**	
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_____

Embracing Health
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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

Embracing Health, Inc
385 Garrisonville Road, Suite 121
Stafford, Virginia 22554
540-318-8602 phone
540-657-1220 fax

Embracing Health Prescription Refill Request Policy - (Effective 24 March, 2020)

Refill request must be made during an appointment

Embracing Health will gladly address request for refills during any appointment with a provider or during a nursing visit. If you forget to ask about your refills during a provider appointment, you can call and schedule a one-time nursing visit for no more than a 30-day supply -- providing your refill does not require a lab draw and is not for: emergency inhaler, antibiotics, antiviral, or controlled substances. Please note that a copay is required for the nursing visit.

We highly encourage patients prepare for medication refills at each and every visit with our office.

- Before arriving, please look over your medications, diabetes supplies, inhalers etc. to determine if you will need refills.
- We require periodic office visits for all of our patients taking prescription medication. The interval of the visits depend on the type of medication prescribed. Please be sure you have enough medication to last until your next scheduled visit.
- Some conditions (list examples here) require a lab draw prior to the refill.

Please understand, it is your responsibility to schedule an appointment before you run out of medication. We encourage you to schedule your next visit before you leave our office as a matter of routine. To avoid having an additional nurse visit and copay, make sure your request refills during your appointment.

I, _____ acknowledge that I have received a copy of the
Printed Name

March 24th, 2020 prescription refill policy from Embracing Health.

_____ _____
Patient / Guarantor's Signature Date