SOPHIA MEDICAL ASSOCIATES P.C.

PATIENT REGISTRATION FORM

PLEASE FILL OUT ALL APPLICABLE AREAS AND SIGN WHERE INDICATED

Patient Name: _____

Date of Birth: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Marital Status: Single Married Divorced Widowed Committed

Name of Employer: _____ Occupation: _____

Is the patient the Responsible party: Yes No If No, please provide name of responsible party: _____

INSURANCE INFORMATION

Please provide ID and copies of all insurance cards. Copay is due at time of service

Check here if you are **UNINSURED** ☐

Name of Insurance Holder: _____ DOB: _____

Primary Insurance: _____ Policy Number: _____

Group Number: _____ Claims Address: _____

Name of Insurance Holder: _____ DOB: _____

Secondary Insurance: _____ Policy Number: _____

Group Number: _____ Claims Address: _____

I UNDERSTAND THAT I AM COMPLETELY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT MY INSURANCE COMPANY PAYS THEIR PORTION. I HEREBY AUTHORIZE THE DOCTOR AND BILLING COMPANY TO RELEASE MEDICAL INFORMATION TO MY INSURANCE COMPANY TO SECURE PAYMENT. I ALSO AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS AND AS AUTHORIZATION FOR PAYMENT TO BE SENT TO SOPHIA MEDICAL ASSOCIATES.

I UNDERSTAND THAT SOPHIA MEDICAL ASSOCIATES MAY USE AND DISCLOSE MY PHI (PROTECTED HEALTH INFORMATION) FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS. I AKNOWLEDGE THAT I HAVE THE OPTION OF OBTAINING A COPY OF THE HIPAA PRIVACY PRACTICES AT ANY TIME, AND THIS DOCUMENT PROVIDES INFORMATION ABOUT HOW THE PRACTICE AND INDIVIDUALS INVOLVED IN MY CASE IN THE OFFICE MAY USE AND DISCLOSE MY PHI. AS PROVIDED IN THE NOTICE, THE TERMS OF THE NOTICE MAY CHANGE AND I CAN CONTACT THE PRIVACY OFFICER AT 540-368-9380 FOR UPDATES AND A COPY OF THE MOST CURRENT NOTICE. I UNDERSTAND THAT I HAVE THE RIGHT TO REQUEST THAT THE OFFICE RESTRICT HOW MY PHI IS USED OR DISCLOSED FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS, BUT I ALSO INDERSTAND THAT THE PRACTICE IS NOT REQUIRED TO AGREE TO A REQUESTED RESTRICTION. HOWEVER, IF THE PRACTICE DOES AGREE, IT IS BOUND BY THE AGREEMENT. I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AGREEMENT IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT THE PRACTICE OR INDIVIDUALS INVOLVED IN MY CARE IN THE PRACTICE HAVE ALREADY USED OR DISCLOSED PHI IN RELIANCE ON MY PRIOR CONSENT.

_____

PATIENT OR RESPONSIBLE PARTY SIGNATURE

_____

RELATIONSHIP TO PATIENT

_____

TODAY'S DATE

PROVIDE NAME OF ALTERNATE PERSON THAT MAY REQUEST YOUR PHI (INCLUDING PRESCRIPTIONS, RECORDS, LABS, PHONE CALLS, ETC.). THE OFFICE WILL NOT RELEASE THIS INFORMATION IF THE PERSON IS NOT NAMED IN THIS SECTION.

_____

JUST A FEW FRIENDLY REMIDERS…

OUR OFFICE IS DEDICATED TO PROVIDING THE BEST POSSIBLE CARE FOR YOU, AND WE WANT YOU TO UNDERSTAND SOME OF OUR POLICIES.

COPAYMENTS ARE DUE AT THE TIME OF SERVICE.

WE DO REQUIRE 24 HOURS NOTICE FOR CANCELLED OR RESCHEDULED APPOINTMENTS. OUR OFFICE WILL CHARGE $25 FOR APPOINTMENTS THAT ARE MISSED AND ALSO IF THEY ARE CANCELLED OR RESCHEDULED WITHOUT 24 HOURS NOTICE.

WE ARE HAPPY TO FILE CLAIMS TO YOUR INSURANCE COMPANY ON YOUR BEHALF AS A COURTESY TO YOU. IF THE INSURANCE COMPANY DOES NOT PAY THE CLAIM, WE WILL HAVE TO LOOK TO YOU FOR PAYMENT. NOT ALL PLANS COVER ALL SERVICES, SO PLEASE BE AWARE OF YOUR INSURANCE POLICY'S RULES AND RESTRICTIONS.

PLEASE CONSULT YOUR INSURANCE POLICY ON THE LAB THEY PREFER YOUR SPECIMENS TO BE SENT TO. OUR OFFICE WILL SEND SPECIMENS WHERE WE FEEL THEY NEED TO GO UNLESS STATED OTHERWISE.

IF YOUR INSURANCE COMPANY REQUIRES A REFERRAL, IT IS YOUR RESPONSIBILITY TO PROVIDE OUR OFFICE WITH A CURRENT UP TO DATE COPY. IF YOUR REFERRAL EXPIRES, IT IS YOUR RESPONSIBILITY TO OBTAIN A NEW ONE.

PLEASE ALLOW 24 TO 48 HOURS FOR PRESCRIPTION REFILLS. DO NOT WAIT UNTIL YOU ARE COMPLETELY OUT OF MEDICATION TO REQUEST A REFILL. OUR OFFICE WILL NOT REFILL PRESCRIPTIONS AFTER HOURS OR WHEN THE OFFICE IS CLOSED.

FROM TIME TO TIME IT WILL BE NECESSARY TO LEAVE A MESSAGE FOR OUR STAFF AS THEY ARE ASSISTING OTHER PATIENTS. WE WILL RETURN YOUR CALL IN A TIMELY FASHION.

ACUTE OR URGENT APPOINTMENTS ARE ON A FIRST COME, FIRST SERVED BASIS AND ARE NOT ALWAYS AVAILABLE. IF YOU HAVE AN URGENT MATTER THAT CANNOT WAIT UNTIL THE NEXT AVAILABLE APPOINTMENT, PLEASE FEEL FREE TO PROCEED TO URGENT CARE OR THE EMERGENCY ROOM.

HEALTH HISTORY QUESTIONNAIRE

PATIENT NAME: _____ DOB: _____

DO YOU HAVE A PERSONAL HISTORY OF:

HEART DISEASE: YES NO
KIDNEY DISEASE: YES NO
LUNG DISEASE: YES NO
ASTHMA: YES NO
BLEEDING DISORDER: YES NO
HIGH CHOLESTEROL: YES NO
HIGH BLOOD PRESSURE: YES NO
CANCER: YES NO TYPE: _____
PROSTATE TROUBLE: YES NO
THYROID PROBLEMS: YES NO TYPE: _____
SKIN DISORDERS: YES NO
NEUROLOGICAL/BRAIN/NERVE DISORDERS: YES NO
STOMACH/COLON DISORDERS: YES NO
DIABETES: YES NO TYPE: _____

ANYTHING NOT COVERED: _____

DO YOU HAVE A FAMILY HISTORY OF: (LIST FAMILY MEMBER IF YES)

HEART DISEASE: YES NO
COLON CANCER: YES NO
PROSTATE CANCER: YES NO
BREAST CANCER: YES NO
HIGH BLOOD PRESSURE: YES NO
DIABETES: YES NO
THYROID PROBLEMS: YES NO

PLEASE LIST ALL SURGICAL PROCEDURES AND DATES:

PLEASE LIST ALL CURRENT MEDICATIONS:

PLEASE LIST ANY ALLERGIES: _____

DO YOU USE TOBACCO: YES NO
DO YOU IMBIBE ALCOHOL: YES NO
DO YOU USE ILLEGAL DRUGS: YES NO

UPDATED 6/20/2013 NLD