

**Reason for Today's Visit** \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

I give permission to leave a detailed message including results at the following numbers  Home  Cell  WorkE-mail \_\_\_\_\_ Are you interested in our Patient Portal?  Yes  No

Primary Care Physician \_\_\_\_\_ Preferred Pharmacy \_\_\_\_\_

How did you hear about PrimeCare? \_\_\_\_\_

**AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION (PHI)**List names of those authorized to receive your PHI and their relationship to you. We will **not** discuss your PHI with anyone who is **not** listed by name on this form. Please include spouse, parent/legal guardian names, as applicable.

1. I authorize you to speak to \_\_\_\_\_ Relationship \_\_\_\_\_

2. I authorize you to speak to \_\_\_\_\_ Relationship \_\_\_\_\_

3. I authorize you to speak to \_\_\_\_\_ Relationship \_\_\_\_\_

**GUARANTOR/RESPONSIBLE PARTY INFORMATION**

(Complete only if patient is not financially responsible, i.e. minor child)

Guarantor Name \_\_\_\_\_ Relationship to Patient  Parent  Legal Guardian

Guarantor Date of Birth \_\_\_\_\_ Guarantor SSN \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**INSURANCE INFORMATION****Primary Plan Name** \_\_\_\_\_

Policyholder Name \_\_\_\_\_ Policyholder Date of Birth \_\_\_\_\_

Policyholder SSN \_\_\_\_\_ Policyholder Relationship \_\_\_\_\_

**Secondary Plan Name** \_\_\_\_\_

Policyholder Name \_\_\_\_\_ Policyholder Date of Birth \_\_\_\_\_

Policyholder SSN \_\_\_\_\_ Policyholder Relationship \_\_\_\_\_

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_

## Treatment and Financial Policy Agreement

By signing below, you indicate you are the patient or have legal authority to consent to medical treatment on the patient's behalf. You consent to, understand and agree to the following treatment policies:

- The physician or provider will explain the risks and benefits of treatment and you will have the opportunity to ask questions and discuss your treatment plan
- Prime Care strives to provide quality care based on accepted standards of medical practice but cannot guarantee results of treatment
- Prime Care participates in the Virginia Prescription Monitoring Program which may be reviewed prior to prescribing any controlled substances
- Prime Care reserves the right to refuse non-emergency services for any threatening, intimidating, or abusive behavior of any kind

To provide the most cost-effective care, you consent to, understand and agree to the following financial policies:

- If Prime Care participates with your insurance, claims will be filed as a courtesy if we have complete and accurate information. This in no way relieves you of your financial responsibility for services rendered.
- If Prime Care does not participate with your insurance, you will be considered self-pay and required to pay at the time of service, and any remaining balance will be collected upon check out. If you are covered under workers' compensation and your claim is denied, a claim will be submitted to your private insurance on file. We do not file claims to automobile insurance carriers.
- You agree to pay at the time of service any required co-payments, co-insurance and deductible amounts, as well as non-covered services, outstanding balances, and delinquent accounts. We accept cash, checks and credit cards. If a check is returned for any reason, there is a \$50 fee.
- You are responsible for, and agree to pay, the cost of any services that your insurance plan determines are not covered, or services that are covered but applied to a deductible. It is your responsibility to determine whether services to be provided by Prime Care are covered by your insurer.
- If your insurance plan requires a referral from your primary care physician or insurance plan prior to a visit and you did not obtain the proper approval or referral, you agree to pay any costs determined not covered under your plan.
- You assign Prime Care all health care benefits to which you are entitled under any policy of insurance and authorize, to the extent permitted by law, payment of those benefits directly to Prime Care.
- The parent or guardian who brings the patient into our office will be held financially responsible, regardless of provisions in a divorce decree, custody agreement, or who is the policyholder.
- You are responsible for paying balances in full unless payment arrangements are approved by Prime Care. For payment arrangements, you must contact our office. For questions regarding insurance payment, you must contact your insurance company directly.
- All overdue accounts will be sent to a collection agency. You agree to be responsible for a \$40 collection fee, and all associated legal fees, such as interest and court costs, in addition to the amount owed.

**PLEASE NOTE: Prime Care reserves the right to deny non-emergency services for delinquent accounts.**

I certify that I received, read, understand, and agree to all the terms and conditions of the Treatment and Financial Policy Agreement as described above applicable to Prime Care Family Care, Inc. and Prime Care Urgent Care, Inc. I also acknowledge I received or was offered a copy of the HIPAA Notice of Privacy Practices.

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Signature of Patient/Responsible Party

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Date Signed

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Printed Name of Patient/Responsible Party

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Relationship to Patient