John Carpenter, M.D. and Ernest Pugh, M.D.
889B Rio East Court, Charlottesville, VA 22901
Telephone (434) 978-7100 Fax (434) 978-4100

PATIENT REGISTRATION

Patient Name: ________________________________Sex:____Age:________Birthdate:_______________

Address: _________________________________City:__________________State:________Zip:________

Home Phone: ______________ Cell: ______________________ Work Phone: ________________________

Social Security#:____________________________ Marital Status: S M W D Separated

Race__________ Ethnicity - Circle: Hispanic/Non-Hispanic/Declined Language ______________________

Employer's Name: ______________________________________ Phone: ____________________________

Employer's Address: ____

Guarantor's Name ***(if patient is under age 18):*** ____________________________Birthdate: _____________

Guarantor's SS# _______________________Relationship to child: __________________________________

Guarantor's Address (if different): ____

Spouse's Name: ____Spouse's Birthdate: _____________

Spouse's Employer: ____

Next of Kin (not living with you):___________________________Phone: ______________________________

In case of emergency, notify: ______________________________Phone: _____________________________

Name of Previous Doctor: ____

How did you hear about us? ____

INSURANCE INFORMATION

Please present your card(s) for copying.

Primary Insurance: ____

Subscriber Name: ________________________ID #_______________________Group #_______________

Relationship of subscriber to insured: ________________ Subscriber SSN: _________________________

Subscriber Date of Birth: ___________________________ Subscriber Phone: ______________________

Subscriber Address: ____

Secondary Insurance: ____

Subscriber Name: ________________________ID #_______________________Group #_______________

Relationship of subscriber to insured: ________________ Subscriber SSN: _________________________

Subscriber Date of Birth: ______________________________ Subscriber Phone: ____________________

Subscriber Address: ____

Does your insurance company require Precertification or Preadmission review? _______________________

If yes, Preadmission Review Phone Number (from your card):_____________________________________

OUR FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you. Your clear understanding of our financial policy is important to our professional relationship. If you have any billing questions that we cannot answer directly, please call IMBS at (434) 984-4627

Rio Family Medicine participates with and accepts assignment of insurance benefits of most insurance organizations. If your insurance company denies payment, you will be billed for those services and payment in full is due upon request. Of course, you are still responsible for the timely payment of deductibles, co-insurance, and/or co-payments. ***Co-payments are due at the time of your visit. There is a $15 service charge to bill a guarantor for a co-pay***. Rio Family Medicine will accept cash, check, money order, Visa or MasterCard. If your check is returned by the bank, there will be a ***$25 return check fee*** added to your account. Your account may be referred to an outside collection agency or other collection sources for non-payment of outstanding balances. If your account is referred to collections, you will be responsible for all agency and attorney fees associated with collection. We will then schedule your appointments on a "cash only" basis – payment will be collected prior to your office visit.

RELEASE & ASSIGNMENT

I hereby consent to any necessary medical diagnosis and treatment for myself, child, or above-named individual for whom I am legally responsible. The release of medical information to any insurance carrier and direct payment to the practice for any treatment or examination rendered is authorized. I hereby acknowledge and accept final responsibility for payment of charges for medical services rendered.

NOTICE OF PRIVACY PRACTICES

Rio Family Medicine has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning our acknowledgment and consent. Many times spouses, children, or others may call on your behalf. **If you would like us to share your protected health information, please indicate to whom we may disclose information:**

____________________________ ____________________________

Name Relationship

____________________________ ____________________________

Name Relationship

O _______Please check and initial if you do **not** wish us to disclose **protected health information**

ACKNOWLEDGEMENT & CONSENT

I have read and understood the above policies.
I have received the Notice of Privacy Practices for Rio Family Medicine

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Signature of Patient/Responsible Party Date