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

Responsible Party Name:____

Responsible Party Address:____

Responsible Party Phone: ____________________________ Date of Birth: _______________________

Employer's Name:____

Employer's Address:____

Spouse's Name:____Spouse's Birthdate:____________

Spouse's Employer:____

Next of Kin (not living with you):____

Home Phone:_____________________________ Work 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):____________________________________

Chart________

RIO FAMILY MEDICINE

POLICIES

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees and policies with you. Your clear understanding of our financial and office policies is important to our professional relationship. If you have any billing questions that we cannot answer directly, please call (434) 982-7794.

Insurance

Rio Family Medicine participates with and accepts assignment of insurance benefits of most insurance organizations and we will file claims as a courtesy to you. If your insurance company denies payment, you will be billed for those services and payment in full is due upon request. If a patient does not provide an insurance card at the time of service, they will be considered "selfpay" until a card is provided.

If you have no insurance, you will be responsible for payment in full at the time of service unless prior arrangements have been made.

Co-payments

Co-payments are due at the time of check-in. Rio Family Medicine will accept cash, check, money -order, Visa or MasterCard. Of course, you are still responsible for the timely payment of deductibles, co-insurance, and/or non-covered services.

Referral Policy

We require at least **2 business days** for completion of referrals.

Minors

Payment at the time of service for minor children is the responsibility of the person bringing the child to the visit, and parent/guardian. Please make arrangements to bring payment with you at the time of the appointment.

Worker's Compensation

We will attempt to collect payment for your care from your employer. In order to file your claims to your employer please provide to us, an address to send your claims, a contact name, and a case number if one has been issued for you. If payment has not been received from your employer within 60 days, and a settlement has not been awarded from the state, you will be responsible for payment.

Prescription Refills

We require **2 business days** for prescription refills. When requesting refills, please have the following ready:
Name and Strength of medication
Quantity of medication (30 days or 90 days)
Directions (how you take the prescription)
Pharmacy Name

Extra Charges

$15 service charge to bill for co-pay (as these are due at time of visit)
$25 form fee
$25 returned check fee
$.10/page ($1 minimum) copying fee
$30 "no show" or less than 24 hr notice of cancellation fee

Chart ________

Billing Cycle

Patients who do not pay at the time of service will receive two (2) billing statements and one (1) phone call from the Central Billing Office (CBO). Should the balance remain unpaid, the CBO will start their internal collection process.

Collections

If payment is not received, your account may be referred to an outside collection agency. If your account is referred to collections, you will be responsible for all agency and attorney fees associated with collection. The patient will then be seen on a **"Cash Only"** basis. The patient will be required to pay a discretionary fee established by Rio Family Medicine **prior** to being seen for each appointment. The patient may also be given a 30-day notice of discharge from the practice.

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 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:

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Acknowledgement & Consent

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

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PRINT NAME

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Signature – Patient / Legal Guardian / Representative Date