EmergiCare of Harrisonburg, Inc.
REGISTRATION FORM

(For Office Use Only) Account #:_____ New or Existing Patient: _____ Entered by: _____

Section I: Patient Information

Name:_____ Suffix: _____ Gender:_____

Permanent Address:_____

City:_____ State:_____ Zip:_____

Phone (_____)_____ Cell (_____)_____ Date of Birth:_____/_____/_____ Age:_____

Social Security Number:_____-_____-_____ Employer/School:_____

Emergency Contact:_____ Phone (_____)_____

Email:_____ How did you hear about us?_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Section II Parent/Guardian Information

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone: (____)_____SSN#_____-_____-_____Date of Birth:_____/_____/_____

Employer_____Work Phone (____)_____

Section III Insurance Information

Policy Holders Name:_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Policy Holders Address:_____

City:_____State:_____Zip:_____Phone: (_____)_____

Policy Holders Date of Birth_____/_____/_____ Policy Holders SSN#_____-_____-_____

Section IV Consent/Assignment/Guarantee

I hereby consent to treatment of the above captioned patient by EmergiCare and its Physicians and further authorize the release of any medical information necessary to process claims arising from such treatment. I shall be personally liable for the fee(s) for services rendered (unless such fees are covered under a specific contractual agreement). I consent that interest charges may be added to balances remaining after sixty (60) days. I will be responsible for fees charged by collection agencies and attorney's if they are required for collection of this account.

_____ _____

Patient / Guardian Signature Date

Continue →

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Please indicate to whom you would like your patient records released (i.e. Mother, Father, Doctor's Office, etc.)

I, _____, request and authorize Emergicare of Harrisonburg, Inc to release protected healthcare information to:

Name:_____Relationship to Patient:_____Phone:_____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information ☐ Other_____ ☐ None

_____ _____

Patient Signature Date

Notice of Privacy Practices

Effective Date: 04-14-03

This notice explains how your health information will be used and disclosed by EmergiCare of Harrisonburg, Inc., and how you can gain access to this information.

The doctors and employees of EmergiCare of Harrisonburg, Inc. are required to abide by the terms of this privacy notice and to protect your health information. We will share your information with each other in the practice as necessary for your care.

We may use and disclose your health information without your authorization to other physicians, their staff, other health care entities, your insurance company and other business associates regarding your treatment, payment and/or health care operations. We may also disclose your information for emergencies, when required by law.

We may call you, leaving a message with the person that answers the phone or on an answering machine to check on your progress since your last visit.

At your visit, we may call you from the waiting room using your first and last names.

All other disclosures of your protected health information will be done only after we obtain your written authorization to do so. You may revoke any authorization after you have given it.

You have the following rights pertaining to your health information:

- The rights to request, read, or receive copies of your billing records.
- The right to request (in writing) to amend your records if you feel there is incorrect or missing information.
- The right to request (in writing) to see a list of disclosures made of your health information.
- The right to request (in writing) that we not disclose your information for treatment, payment, or health care operation without your authorization.

We are not required to comply with your request in some instances.

EmergiCare of Harrisonburg, Inc., reserves the right to change the terms of this Privacy Notice, and to make the new notice apply to the health information you already have in your record. We will provide you with revised copies to the Privacy Practice Notice during your first visit to our office after such revision.

If you are concerned that your privacy rights have been violated; would like to read, copy or amend your records; or have any other concerns or questions, contact Dee Anna Huffman: Compliance/Privacy Officer at (540)432-9996. You may also send written complaint to the US Department of Health and Human Services.

I acknowledge that I have been given a copy of the EmergiCare of Harrisonburg, Inc. Privacy Practice Notice. I understand the contents and have been given the opportunity to ask questions. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the office administrator. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ _____

Patient/Guardian Signature Date

Continue →