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: _____

Social Security Number:_____-_____-_____ Date of Birth:_____/_____/_____ Age:_____

Phone: (_____)_____ Cell: (_____)_____

Employer/School:_____ Work Phone: (_____)_____

Emergency Contact:_____ Phone: (_____)_____

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 Holder's Address:_____

City:_____ State:_____ Zip:_____ Phone: (_____)_____

Policy Holders Date of Birth:_____/_____/_____ Policy Holder's SSN:_____-_____-_____

Section IV **Billing Information**

Most services rendered during your visit will be submitted to your insurance company, employer, or third party payer. There is no guarantee of payment until they receive and process the claim. Any co-pay, coinsurance, or deductible that is over charged shall be reimbursed to the patient within 60 days from the time your insurance carrier notifies us. Any amount that was not collected at the time of service, that your insurance carrier deems your responsibility, will be sent to you as a bill. Any account balance not paid within 90 days will be referred to our collection agency.

Continue ⟶

EmergiCare of Harrisonburg, Inc.
CONSENT FOR HEALTH CARE SERVICES

Patient name: _____ **Date of Birth:** _____/_____/_____

1. **Consent for Medical Treatment.** I consent to and authorize medical treatment by Emergicare to evaluate or treat my medical condition. I understand that such treatment may include diagnostic procedures such as laboratory, x-ray, electrocardiogram monitoring, and other treatment(s) under general or specific instructions of the physician or other licensed independent practitioners supervising or providing my care at Emergicare. I acknowledge that I may be required to sign additional "informed" consent forms for specific medical treatments or procedures. I understand the practice of medicine is not an exact science and I acknowledge that Emergicare has made no guarantee or assurance to me as to the effect, result, or outcome of any examination or treatment I may receive.

2. **Release of Information.** I authorize Emergicare to release medical or other information about me to: (1) physicians, other health care practitioners, and health care institutions that are involved in my continued care and treatment, including referrals; and (2) my insurance company, HMO, or other third-party payor(s), as necessary for Emergicare to bill and receive payment for my care. I recognize that the information released may include sensitive information such as alcohol/drug abuse treatment, mental health, and HIV/AIDS information, and I authorize the release of all such information as necessary.

3. **To assist us in providing the best possible uninterrupted service to you, please answer the following questions:**

   May we contact you: At home? ☐ Yes ☐ No At work? ☐ Yes ☐ No

   What is the best way to contact you? ☐ Phone: H_____ Cell_____ W _____

   ☐ Mail: _____

   ☐ Fax#: H_____ W_____

   May we leave a message if you are not home? (Information will be limited ONLY to the name of the individual calling).
   ☐ Yes ☐ No

   May we discuss your health information and billing information with a family member, spouse, or other person involved in your care or payment for your treatment or services rendered (other than the third-party payor)?
   ☐ Yes ☐ No

   If Yes, name of individual(s)

   _____

   _____

4. **Notice of Privacy Practices Acknowledgement.** I acknowledge that I have been given the opportunity to receive a copy of the Notice of Privacy Practices. This notice describes how medical information about me may be used and disclosed and how I can get access to this information. I understand I have the right to receive a paper copy of this Notice at any time.

5. **Assignment of Benefits and Financial Responsibility.** I authorize payment directly to Emergicare or any insurance or third party benefits (otherwise payable to me) to which I am entitled for my treatment at Emergicare. I understand that I am responsible for providing Emergicare with information necessary to bill my insurance. I understand that I am financially responsible for payment of any charges not paid by insurance or other third-party, including if I have no insurance or if coverage is denied. If my account is referred to a collection agency or attorney, I agree to pay reasonable attorney's fees and collection expenses.

I have read the information on this form (or had it read to me). I have had the opportunity to ask questions and have had them answered to my satisfaction. I understand and agree to all of the terms above unless otherwise noted. I certify that I am the patient or the patient's legal representative with authority to sign this document on the patient's behalf.

_____ _____

Please circle one: Signature of Patient / Legal Guardian/ Agent under Durable Power of Attorney for Health Care — Date

Patient is unable to sign because: ☐ Minor ☐ Temporarily incapacitated ☐ Permanently incapacitated