Albemarle Center for Family Medicine

a division of Anchor Healthcare, PLC.

Patient Registration

PATIENT DEMOGRAPHICS:

Last Name: _____ First Name:_____ Middle Initial_____

Date of Birth: ___/____/____ Social Security Number:_____-_____-_____ Male / Female

Race:_____ Ethnicity (please circle) : Hispanic / Not Hispanic

Marital Status (please circle) : SINGLE MARRIED DIVORCED WIDOWED

Spouses Name: _____

If patient is a minor child, Parents Name: _____

_____

Are there other members of the family that are patients of the practice? **YES / NO (If yes, please list.)**

_____ _____

_____ _____

Physical Address: _____ Apt: _____

City:_____ State:_____ Zip: _____

Mailing Address (if different than physical address): _____

City:_____ State:_____ Zip: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Work Phone Number: _____ Email Address: _____

PHARMACY INFORMATION:

Preferred Local Pharmacy: _____ Location: _____

INSURANCE AND BILLING INFORMATION: (please provide your insurance card upon completion of this form).

Insurance Company Name: _____

PRIMARY POLICY HOLDER: ____Self _____Other **(If other, please complete information below.)**

Last Name: _____ First Name:_____ Middle Initial_____

Date of Birth: ___/____/____ Social Security Number:_____-_____-_____ Male / Female

Relationship to the patient: _____

Is this person financially responsible for the account? YES / NO

This information is confidential and will not be released without your prior written consent.

- I authorize the release of any medical information necessary to process an insurance claim for payment, and request that payment be made directly to Albemarle Center for Family Medicine, a division of Anchor Healthcare, PLC.
- I understand that I am fully responsible for the entire balance of my account not covered or paid by my insurance.
- I understand that if my insurance company does not pay a claim within 60 days, it will become necessary to contact my insurance company to discuss timely payments to my medical provider. In addition, it may become necessary to pay my account in full, only to be reimbursed should my insurance company make a payment to ACFM.
- I understand that it is my responsibility to make and keep appointments**. In the event that an appointment is missed, without the required 24 hours notice, my account may be assessed a fee of $75.00.** While ACFM makes every effort to place an appointment reminder call, it is ultimately my responsibility to come to my appointments as scheduled. This balance is my responsibility and will need to be paid, prior to scheduling another appointment.
- I understand that if I am unable to pay my copay at the time of service, I will be billed an additional fee of $25.00. This balance is my responsibility and will need to be paid, prior to scheduling another appointment.
- Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's responsible party, understands that the practice has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's responsible party, understands and agrees to pay all collection fees in the amount up to thirty-three and one-third percent (33-1/3%) of the total unpaid balance due, plus court costs and filing fees incurred by the practice. I understand and agree that should the practice be awarded judgment relating to this agreement or any debt incurred thereof, I will pay a service charge of one and one-half percent (1-1/2%) per month, eighteen percent (18%) per annum, beginning on the date of the judgment.
- I understand that any forms or letters that I request will be subject to a minimum charge of $30, payable upon completion of the above mentioned documents.
- I understand that there is a returned check fee of $30.00 in the event that my payment is returned as unpaid. This balance is my responsibility and will need to be paid, prior to scheduling another appointment.
- I understand and acknowledge that my physician is a member of the Virginia Prescription Monitoring Program and will use this program as needed when determining my medical care and treatment.
- I acknowledge that I have received and or been offered a copy of the HIPAA, Notice of Privacy Practices for this office.

Signature: _____ Date: _____

Printed Name: _____

Relationship to patient: _____