PATIENT REGISTRATION
Cavery Health Clinic
14330 Gideon Drive, Suite B, Woodbridge, VA 22192

PATIENT INFORMATION: (Please use full legal name, no nicknames)

***Last Name:** _____ ***First Name:** _____ **Middle Initial:** _____

***Address:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone #: (_____) _____-_____ ***Social Security #:** _____

***Date of Birth:** _____ **Age:** _____ ***Sex:** _____ **Marital Status:** _____ **Drivers Lic#:** _____

***Employer Name and Address:** _____

_____ **Work Phone #:** (_____) _____-_____

E-mail Address: _____ **Cell Phone #:** (_____) _____-_____

Emergency Contact Name: _____ **Emerg Phone #:** (_____) _____-_____

Please tell us how you heard about us: _____ ***Referred by*** _____

GUARANTOR INFORMATION: (List person or insured name responsible for bill - use full legal name, no nicknames)

***Relationship of Guarantor to Patient:** **Self** _____ **Spouse** _____ **Parent** _____ **Other** _____

***Last Name:** _____ ***First Name:** _____ **Middle Initial:** _____

***Address:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone #: (_____) _____-_____ ***Social Security #:** _____

***Date of Birth:** _____ **Age:** _____ ***Sex:** **Female** _____ **Male** _____

***Employer Name and Address:** _____

_____ **Work Phone #:** (_____)_____-_____

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INSURANCE:

Plan Name : _____ ***Insured's Name:** _____

Insured's Social Security #: _____ ***Insured's Date of Birth:** _____

***Policy / ID #:** _____ ***Group #:** _____ **Eff Date:** _____

Claims Address & Phone: _____

SECONDARY INSURANCE:

Plan Name : _____ ***Insured's Name:** _____

***Insured's Social Security #:** _____ ***Insured's Date of Birth:** _____

***Policy / ID #:** _____ ***Group #:** _____ *** Eff Date:** _____

Claims Address & Phone: _____

***REQUIRED FIELDS-PLEASE COMPLETE FOR BILLING.** ***ATTACH COPY OF INSURANCE CARDS.**

PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

Patient Name: _____ **Date of Birth:** _____
First Name M.I. Last Name

Cavery Health Clinic is dedicated to providing the best possible care and want you to have a full understanding of policies.

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Cavery Health Clinic or the medical provider individually for services rendered to my dependents or me by the medical provider or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services that I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Cavery Health Clinic is unable to collect from my insurance carrier for whatever reason.
*Returned checks will incur a $50.00 service charge.
Medical Record/Billing Copies: $10 copying fee, $0.50 first 50 pages, $0.25 per page for additional pages.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Cavery Health Clinic or medical provider on my behalf.

AUTHORIZATION TO MAIL, CALL, SMS/TEXT OR EMAIL:

I certify that I understand the privacy risks of the mail, phone calls, SMS/text messaging, and email. I hereby authorize a Cavery Health Clinic representative or my medical provider to mail, call, SMS/text, or email me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Cavery Health Clinic to that effect in writing.

CONSENT FOR TELEMEDICINE:

I hereby consent for Cavery Health Clinic to perform reasonable and necessary medical examinations, testing and treatment via real time video conference or telephone. In very rare instances, security protocols could fail, causing a breach of privacy of personal and medical information. I understand that based on my symptoms and or diagnosis my provider has the right to decline a telehealth visit. I understand that I have the right to rescind this authorization at any time by notifying Cavery Health Clinic to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by my Cavery Health Clinic medical provider or his/her designee.

NO SHOW POLICY:

I understand that Cavery Health Clinic charges a $50.00 NO SHOW fee for cancellations without a 24-hour notice.

PRIVACY PRACTICES ACKNOWLEDGEMENT:

I understand that I have the right to privacy regarding my personal and Protected Health Information and may request a written copy of Cavery Health Clinic's Privacy Practices. PHI and EPHI is used to conduct normal healthcare operations, conduct, plan and direct your treatment among multiple healthcare providers who may be involved with my care directly or indirectly, and/or obtain payment from my insurance company. I understand that I may refuse to consent or place restrictions in writing to the use of this disclosure of personal and health information. However, under this law, I understand that treatment may be refused should I choose to not disclose my PHI. Furthermore, I may not revoke actions that have already been taken. I also understand that Cavery Health Clinic is not required to agree to my request, but if agrees is bound to abide by the restrictions.

*I have read and understand the office and financial policies of Cavery Health Clinic and agree to be bound by its terms.
I also understand and agree that such terms may be amened by the practice at any time.

PATIENT SIGNATURE: _____ **DATE**: _____

GUARANTOR SIGNATURE (if different than patient: _____

GUARANTOR PRINTED NAME: _____ **DATE**: _____