

CULPEPER MEDICAL ASSOCIATES, LLC
PATIENT REGISTRATION

DATE: _____		ALLERGIES: _____	
Patient: _____			
Last Name	First Name	Middle Name/Initial	
Mailing Address: _____			
City: _____		State: _____	Zip: _____
Patient Employer: _____			
Business Address: _____		Business Phone: _____	
Home Telephone: _____		SS# _____	
Sex: _____	M _____	F _____	Age: _____
DOB: _____	Marital Status: M S D W Other _____		

<u>Who is responsible for this account?</u>	<i>PAYMENT DUE AT THE TIME OF SERVICE!</i>
Name: _____	Relationship: _____
Who is legal Custodian/Guardian _____	
Responsible Party SSN _____	Employer: _____
Contact Phone Number _____	DOB: _____
<u>Do you have Medical Insurance:</u> _____ Yes _____ No If yes, please present your card EACH visit	
Name of Primary Insurance: _____	
ID# _____	Group# _____
SSN: _____	PolicyHolder: _____
DOB: _____	
Name of Secondary Insurance (if any) _____ ID# _____	
Group# _____	Policy Holder _____
SSN _____	DOB _____

ASSIGNMENT AND RELEASE/MEDICARE AUTHORIZATION: I, the undersigned will assign directly to Culpeper Medical Associates, LLC all benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I further understand that all COLLECTION AGENCY/ATTORNEY/COURT fees will be the responsibility of the patient/parent, if it becomes necessary to collect my debt. I authorize Culpeper Medical Associates, LLC to release all medical information necessary to secure payment for benefits. I authorize the use of this signature on all insurance submissions. I request that payment of authorized Medicare benefits to be made directly to Culpeper Medical Associates, LLC. All CMA offices accept Medicare as payment excluding patient responsibility of the deductible, co-payment and non-covered charges.
Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling 540/825-5595, going to www.culpepermedical.com or requesting one at any office of Culpeper Medical Associates, LLC office.

Signature: _____, Date: _____

As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.

Signature: _____ Date: _____

Relationship to Patient: _____

NOTICE OF DEEMED CONSENT TO HIV BLOOD TESTING

A law was enacted in Virginia in 1989 which authorizes health care providers to test their patients for HIV antibodies when the health care provider is exposed to the body fluids of a patient in a manner which may transmit human immunodeficiency virus (HIV). Pursuant to this law, in the event of such an exposure, you will be deemed to have consented to such testing, and to have consented to the release of the test results to the health care provider who may have been exposed. However, you would be informed before any of your blood would be tested for HIV antibodies pursuant to this provision.

I have read and understand the above "Notice of Deemed Consent of HIV Blood Testing".

Patient signature/Parent or Legal Guardian Signature: _____

Date: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO ANY INDIVIDUAL OTHER THAN YOURSELF

ALL MEDICAL INFORMATION, INCLUDING LABORATORY TEST RESULTS, MAY BE GIVEN ON MY BEHALF TO THE FOLLOWING INDIVIDUALS:

Name: _____ PHONE # _____

Name: _____ PHONE # _____

Name: _____ PHONE # _____

PATIENT/PARENT/LEGAL GUARDIAN SIGNATURE: _____

DATE: _____

Please let us know how to contact you with lab results or any other medical information:

ALTERNATIVE CONTACTS	YES	NO
Leave message w/ spouse		
Leave message w/ other family		
Leave message w/		
Leave message on answering		

Machine at home		
Leave message on answering machine at work		
Leave message on cell phone		
Other		

Signature: _____ Date: _____

If patient is a minor child, the following individual(s) are authorized to seek medical treatment for above named child:

Signature of parent/custodian/legal guardian: _____ Date: _____