Greater Prince William Community Health Center

Your Home for a Healthy Family and a Healthy Community

PATIENT REGISTRATION FORM

PATIENT INFORMATION (PLEASE PRINT)				
Today's Date:			**Social Security Number:**	
Last Name:	**First:**	**Middle:**	**Home Phone Number:** ( )	
Street Address:			**Cellular Phone Number:** ( )	
City:	**State:**	**Zip Code:**	**Work Phone Number:** ( )	
E-Mail Address:			**Date of Birth:**	**Gender:** ☐ M ☐ F
If Under 18, Parent/Guardian's Name:			**Contact Number:** ( )	

EMERGENCY CONTACT [IN CASE OF EMERGENCY, PERSON WE MAY CONTACT]

FIRST AND LAST NAME:_____

PHONE NUMBER:_____

RELATIONSHIP TO PATIENT: ❑ Spouse ❑ Child ❑ Parent ❑ Other: _____

PATIENT DEMOGRAPHICS (PLEASE ANSWER ALL QUESTIONS)

Race: ❑ African American ❑ Caucasian(White) ❑ Asian ❑ Hawaiian ❑ American Indian/Alaska Native ❑Pacific Islander ❑ Other: _____

Native Language: ❑ English ❑ Spanish ❑ French ❑ Urdu ❑ Arabic ❑ Hindi ❑ Farsi ❑ Chinese ❑ Japanese ❑Slavic Languages ❑ Vietnamese ❑ Other African ❑ Italian ❑ Other: _____

Ethnicity: ❑ Hispanic/Latina(o) ❑ Non-Hispanic/Latina(o) ❑ Prefer to Report

Veteran? ❑ Yes ❑ No	**Seasonal Worker (In the Area Temporarily)?** ❑ Yes ❑ No	**Current Housing Status?** ❑ Own ❑ Rent ❑ Staying with Family ❑ Staying with Friends ❑Shelter ❑Transitional Housing ❑Living In Car ❑Living Outdoors ❑Other:_____

Marital Status? ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widow

Employed? ❑ **Yes** ❑ **No**	**Name of Employer:**

INSURANCE INFORMATION [IF NOT INSURED, SKIP THIS SECTION]

Insurance Name:	Insurance ID:	Policy Holder's Name:
_____	_____	_____
_____	Group#:	Date Of Birth:
_____	_____	_____

How Did You Hear About The Health Center?: ❑Family ❑Friend ❑Newspaper ❑Radio ❑Internet ❑ Center Staff ❑Novant Hospital ❑ Sentara Hospital ❑CSB ❑Head Start ❑ Schools ❑Local Organization ❑Other: _____

Revised: 02/07/2018

PATIENT REGISTRATION FORM

All patients are requested to read, initial, and comply with the Center's policies below.
If you have any questions about our policies, please ask to speak with our Office Manager.

Notice of Patient Privacy Practice

I understand that as a patient of the Center, all information collected will be kept confidential under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. I acknowledge that I have received the Notice of Privacy Practices from the Center.

Patients Initials Here: _____

Appointment Expectations:

Please arrive 15 minutes prior to your appointment to register. All payments are expected at time of service. Alert a staff member of any changes in your information to make sure we have the most updated information in your account. Make sure you provide proper identification, required documentations, and insurance cards (if any) at the time of the visit. Minors must be accompanied by an adult at all times.

Patients Initials Here: _____

Appointment Confirmation

If the Center is not able to confirm your scheduled appointment (either with a voicemail message left on your telephone or actual confirmation by the patient) **within 24 hours**, **your appointment will be cancelled**. We will make every effort to re-schedule the appointment for a later time on the same day or another day depending on provider availability.

Patients Initials Here: _____

Late Arrival

Patients that **arrive** at the front desk **more than 10 minutes after their scheduled appointment** will not be seen at the scheduled appointment time. We will make every effort to re-schedule the appointment **for a later time on the same day or another day depending on provider availability.**

Patients Initials Here: _____

Cancellation Policy

Patients that need to cancel or reschedule an appointment may do so by calling the Center at 703-680-7950. **Appointment cancellation requires 24-hour advanced notice.** Voicemail messages left 24 hours in advance will suffice as notification to the Center. Failure to cancel an appointment will result in a **"no-show"** entry in your record. **Once** (2) **two no-shows are recorded in your record, it will be required that all future appointments are by walk-in only.** Sick patients will be seen on a first come, first served walk-in basis daily from 8:00am-10:00am (Woodbridge and Manassas only).

Patients Initials Here: _____

Revised: 02/07/2018

PATIENT REGISTRATION FORM

PATIENT CONSENT FOR TREATMENT

By signing below, I, (or my authorized representative on my behalf) authorize the Center providers and their staff to conduct any diagnostic examinations, tests and procedures, as well as provide any medications, treatment or therapy necessary to effectively assess and maintain my health, to assess, diagnose and treat my illness or injuries. I understand that, excluding emergencies or extraordinary circumstances, it is the responsibility of my individual treating health care providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

Signature: _____
Patient/Parent/Legal Guardian Signature Date

HIV, Hepatitis B & C Testing
In the event that Center staff comes in contact with my or my children's body fluids, I consent to be tested for HIV, Hepatitis B and C.

Signature: _____
Patient/Parent/Legal Guardian Signature Date

PATIENT REGISTRATION FORM

CONSENT TO TREAT MINOR

I give consent for _____ to seek health care (medical, dental, behavioral health)
(please print name of person accompanying child)

as indicated below for my child _____ from one of the providers at the Center.
(please child print name)

This consent is valid for the following dates: _____ through _____

I understand that I may revoke this authorization at any time except to the extent that action has already been taken in reliance on it. I understand that this Consent To Treat authorizes this individual full access to my child's health records.

_____ Urgent Sick Care

_____ Emergency Care

_____ Immunizations

_____ Preventative Care

_____ Dental Exam, X-Ray and/or Cleaning

_____ Dental Extraction

_____ Behavioral Health Services

I understand that a parent/guardian is required to be present at the first appointment regardless of health care reason for the

If the provider determines the authorized person is unable to supply sufficient information during a visit, the provider reserves the right to discontinue the visit, and reschedule the appointment when a parent can be present.

CONTACT INFORMATION: in case the provider needs to speak directly with you

Mother daytime phone: _____ Father daytime phone: _____

Please provide the number, description and expiration date of the **PICTURE ID** that the individual mentioned above will be using as identification.

_____ _____ _____
(Number) (Description) (Expiration Date)

EXAMPLE:
12345 VA Drivers License 01-31-2017
(Number) (Description) (Expiration Date)

_____ _____ _____
(Parent or legal guardian PRINTED name) (Signature) (Date)

Revised: 02/07/2018

PATIENT REGISTRATION FORM

PERMISSION TO RELEASE & EXCHANGE INFORMATION

Name of Patient:_____ **Patient Date of Birth:**_____

The Center creates and receives confidential records regarding your health while under our care. The Center will not release your confidential records to any individual or organization (including family members), without your express, written permission. This policy includes written consent for us to refer you to a specialist outside of our Center.

❑ I consent to the release and exchange of confidential records to all persons and organizations requesting it.

❑ I consent for the provider to obtain my prescription history from external sources.

❑ I consent to the release of confidential records, medications and prescriptions to the named individuals and organizations listed as follows: _____

_____

Signature: _____

Patient/Parent/Legal Guardian Signature Date

Federal Law requires we obtain your permission to contact you by phone or to leave messages.

Please review the following statements and ***check the appropriate choices***. This form will remain in your file. If you wish to revoke this permission, we require the request to be in writing.

❑ I **may** ❑ I **may not** be called at home/ cell phone.
❑ I **may** ❑ I **may not** be called at work.
❑ I **may** ❑ I **may not** be emailed.
❑ I **may** ❑ I **may not** allow an employee to leave messages at home / cell phone.
❑ I **may** ❑ I **may not** allow an employee to leave messages at work.
❑ I **may** ❑ I **may not** allow an employee to discuss my billing account with my spouse, family member, or significant other. If allow, only those listed here: _____

_____

❑ I **may** ❑ I **may not** allow an employee to discuss my medical results with my spouse, family member, or significant other. If allow, only those listed here: _____

_____

Signature: _____

Patient/Parent/Legal Guardian Signature Date

Revised: 02/07/2018

PATIENT REGISTRATION FORM

PATIENT PORTAL CONSENT FORM

The Center requests that you read and sign this consent form to gain access to your personal health care information on our Patient Portal (website). The Center provides the Patient Portal, for the exclusive use of established patients, in order to enhance patient-physician communications. All users must be established by a previous office visit.

We strive to keep all of the information in your records correct and complete. If you identify a part of your record that is incorrect, you agree to notify us immediately. In addition, by use of this portal you agree not to provide false or misleading information. The information on this site is maintained by the Center at 4379 Ridgewood Center Drive, Suite 102, Woodbridge, Virginia 22192. For questions about this site, you may contact us at 703-680-7950. We provide limited internet-based health care information related to reviewing lab results, medications, requesting prescription refills, and sending messages to our staff. **The Center does not provide emergency services for users through the Patient Portal website. If you feel you are having an emergency or other urgent matter you should proceed to the local Emergency Room**. For established patients, we have doctors on call nights and weekends who may be contacted by calling our office after hours.

The Center hereby informs you that:

- All internet communication with our staff is recorded in your medical record.
- Staff members other than your physician will be involved in receiving your messages, and routing them to the doctor, nurse, or management as necessary.
- Our hours of operation are 8:00am–4:30pm on Monday - Friday, and Wednesday from 8:00am-7:00pm. We encourage you to use the website at any time, however messages are held for us until we return the next business day. Messages are typically handled within 1-2 business days. If you do not get a response within 2 business days, please call our office at the number above.
- The types of transactions available online are: messaging to medical office staff, reviews of existing appointments, medication lists, refills, laboratory results, patient statements, medical history and contact information updates.

I acknowledge that I have read and fully understand all disclosures in this form and the risks associated with online communications, between my physician and me, and consent to the conditions outlined herein. This form applies to all family members that are established patients at the Center. This consent remains in effect until rescinded by the patient.

Patient Signature [On Behalf Of Family]_____

Date: _____

PATIENT REGISTRATION FORM

FINANCIAL RESPONSIBILITY AGREEMENT

Payment is expected at time of service. Payment may be made by cash or major credit card. No checks are accepted. Any fees, deductibles, co-insurance, or co-payment is payable at time of service.

PAYMENT RESPONSIBILITY: The undersigned assumes responsibility for payment for services in accordance with the standard rates and terms of the Center, whether to sign as a patient or guarantor, **where insured or uninsured**. As the undersigned, I fully understand (a) my insurance, if any, is a contract between myself and the insurance company, except in certain cases where the Center has a specific contract with my PPO, HMO, or other third party payer; the Center does not explain nor determine if services are covered by my insurance, if any, so any inquiries to explain or determine insurance coverage for services are between myself and the insurance company; (b) any balance remaining after insurance, if any, approves or denies payment is my responsibility to pay; if my insurance company denies a claim for services for any reason, whether at the time or subsequent to receiving services, I assume full responsibility for payment in accordance with the standard rates and terms of the Center; (c) if I am not able to pay the standard rates for services received or to be rendered, whether insured or uninsured, I can apply for the Center's Sliding Fee Discount Program.

In the event all charges for services are not paid in full when due, whether insured or uninsured, and collection activity is instituted, whether by a collection agency or an attorney (or both), I agree to be responsible for balance of charges for services and treatment received and all costs reasonably associated with such collection activity including, but not limited to, reasonable collection fees, attorney's fees, and court costs.

I hereby authorize the Center to release all medical information to all my insurance carriers, other third party payers, including Medicare or its agents, or the Social Security Administration, as may be required or requested for the processing of claims for insurance, social security, disability, or Worker's Compensation or other insurance purposes.

AUTHORIZATION TO PAY INSURANCE BENEFITS

I hereby authorize the payment of any insurance or other medical benefits directly to Greater Prince William Community Health Center. The undersigned, having read and understood the agreement, accepts this financial responsibility agreement.

Signature: _____

Patient/Parent/Legal Guardian Signature Date

PATIENT REGISTRATION FORM

UNINSURED PATIENT NOT ELIGIBLE FOR DISCOUNT

The Center is required by the Federal government guidelines to request personal information and documentation to validate **current household size** and **household gross income** if the patient wants to apply for the Sliding Fee Discount Program (SFDP).

By signing below, you confirm and understand:

(a) You do not qualify for the SFDP based on the personal information and documentation provided
or
(b) You decline to apply for the SFDP

In either case, **the patient is responsible for 100% of the financial cost of the medical services received** including, but not limited to, office visit, medical procedures, medical tests and/or laboratory services.

To receive an office visit and meet with a health care provider today, **you agree to pay a deposit of $120.**

You understand that the **payment of $120 fee is only a deposit.**

The actual office visit charge cannot be determined until you meet with your health care provider. You accept responsibility for actual charges of the office visit.

If the health care provider determines procedures and/or labs are necessary, you will be responsible to pay additional amount for those procedures and/or labs.

If the total charges are more than the $120 deposit, the charges in excess of $120 will be billed directly to you, the patient and paid by you, the patient.

If the total charges are less than the $120 deposit, the difference will be reflected as a credit on your account.

You can change your mind at any time and apply for the SFDP, however should you choose to apply for the SFDP and qualify for a discount, the **discount is not retroactive**.

_____ _____

Print Name Today's Date

_____

Signature

Revised: 02/07/2018

PATIENT REGISTRATION FORM

MEDICAL HISTORY

Patient Name _____ Birth Date_____

MEDICATIONS

Please List all Medications you are currently taking:

Medication	Dosage	Route	Frequency

ALLERGIES

Please List all Allergies:

Allergies	Allergies	Allergies

PAST MEDICAL HISTORY

Do you now or have you ever had:

☐ Diabetes	☐ Heart Murmur	☐ Crohn's Disease
☐ High Blood Pressure	☐ Pneumonia	☐ Colitis
☐ High Cholesterol	☐ Pulmonary Embolism	☐ Anemia
☐ Hypothyroidism	☐ Asthma	☐ Jaundice
☐ Goiter	☐ Emphysema	☐ Hepatitis
☐ Cancer (type) _____	☐ Stroke	☐ Stomach or Peptic Ulcer
☐ Leukemia	☐ Epilepsy (seizures)	☐ Rheumatic Fever
☐ Psoriasis	☐ Cataracts	☐ Tuberculosis
☐ Angina	☐ Kidney Disease	☐ HIV/AIDS
☐ Heart Problems	☐ Kidney Stones	☐Yes ☐No

PATIENT REGISTRATION FORM

SURGICAL HISTORY

Please list any surgeries you have had including the year and month:

Surgeries	Month	Year	Frequency

FAMILY HISTORY

Please list your Family History

	If Living Age (s)	If Living Health & Psychiatric	If Deceased Age(s) at Death	If Deceased Cause
Father				
Mother				
Siblings				
Children				

SOCIAL HISTORY

Do you use:

Tobacco ☐ YES ☐ NO	**Alcohol ☐ YES ☐ NO**	**Recreational Drugs ☐ YES ☐ NO**
Marital Status:	**Occupation:**	

_____ _____

Print Name Today's Date

_____

Signature

Revised: 02/07/2018

PATIENT REGISTRATION FORM

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose
Greater Prince William Community Health Center ("GPWCHC"}, its professional staff, employees, volunteers, and Medical Staff follow the privacy practices described in this Notice. This Notice, which was developed to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), describes the general ways your protected health information ("PHI") may be used and disclosed in order for GPWCHC to provide you with medical treatment, to collect payment for the services rendered to you by GPWCHC, and to facilitate GPWCHC health care operations. PHI, as defined by HIPAA, means your personal health information which is found in your medical and billing records and which relates to your past, present, or future physical or mental health conditions or the provision of payment for services related to those health conditions. During the course of treatment, payment and health care operations activities, this may include information created or received by health care providers, insurance companies, and/or your employer.

Your Health Information Rights
You have the following rights regarding your PHI. To exercise any of the following rights, you must submit a written request. Forms are available on our website, http://www.gpwchc.org, or by contacting the GPWCHC Privacy Office at (703) 680-7950 ext. 3107.

- **A copy of this Notice.** You may obtain a paper copy of this Notice at any time, even if you have been provided with an electronic copy. You do not have to submit a written request to obtain the Notice. Paper copies of this Notice may be obtained from the registration desk. You may obtain an electronic copy of this Notice on our web site, http://www.gpwchc.org.
- **Inspect and copy.** You may inspect and/or receive a copy of your PHI maintained by GPWCHC. GPWCHC may charge you a reasonable fee for copying your information.
- **Request restriction.** You may request limitations on how GPWCHC uses and/or discloses your PHI. GPWCHC is not required to agree to your request. If GPWCHC agrees to your request, GPWCHC will comply with your request unless the use or disclosure is necessary in order to provide you with emergency treatment or is otherwise required by law.
- **Amend your PHI as provided by law.** To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request If it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and (b) complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.
- **Receive confidential communications.** You may request communications from GPWCHC regarding your PHI be provided to you in a certain way or at a certain location. For example, you may prefer to receive mail regarding your PHI at an address other than your usual mailing address. You must specify how or where you wish to be contacted.
- **Accounting of disclosures.** You may request a list of disclosures made by GPWCHC of your PHI to persons or entities other than for the purposes of treatment, payment or health care operations, or pursuant to your specific authorization. This list will contain each disclosure GPWCHC has made for the past six (6) years, but not prior to April 14, 2003. If you make more than one request in a 12-month period, GPWCHC may charge you a reasonable fee.

GPWCHC Responsibilities
GPWCHC is required by law to ensure your PHI is kept private in accordance with federal and state law and provide you with notice of GPWCHC's legal duties and privacy practices with respect to your PHI. GPWCHC is required to abide by the terms of this notice as long as it is in effect. If GPWCHC revises this Notice, GPWCHC will follow the terms of the revised Notice as long as it is in effect.

PATIENT REGISTRATION FORM

Use and Disclosure of Your Protected Health Information

The following is a list of ways GPWCHC may use and disclose your PHI. Not every possible use or disclosure in any given section is listed. However, all of the ways GPWCHC is permitted to use and disclose your PHI will fall within one of the bold-faced print sections below.

- **Treatment.** GPWCHC may use your PHI to provide you with medical treatment or services. GPWCHC may disclose your PHI to doctors, nurses, technicians, medical students or other members of your health care team at GPWCHC to keep them informed about your health status or condition as necessary. For example, a doctor treating you for diabetes may need to tell the dietitian that you have diabetes so appropriate meals can be arranged. GPWCHC also may disclose your PHI to people outside GPWCHC who may be involved in your medical care, such as health care providers who will provide specialty care, physical therapy, medical equipment suppliers, or laboratories.
- **Payment.** GPWCHC may use and disclose your PHI to obtain payment from your Insurance company or a third party. For example, GPWCHC may need to provide your health plan with information about treatment you received for an ear infection so that your health plan will pay us or reimburse you for the treatment. Also, GPWCHC may disclose your PHI to your other health care providers to assist those providers in obtaining payment from your insurance company or a third party.
- **Health Care Operations.** GPWCHC may use and disclose your PHI for routine health care operations. Health care operations at GPWCHC include, but are not limited to, training and education programs, reviewing the quality of care provided by health care professionals; obtaining health insurance or stop-gap insurance; conducting legal services and auditing services; conducting business planning and development activities; conducting risk management activities and investigations; and managing the business and general administrative activities of GPWCHC. GPWCHC may also disclose your PHI to your other health care providers to assist them in their health care operations.
- **Appointments and Alternatives.** GPWCHC may use and disclose your PHI to contact you to provide appointment reminders, prescription refill reminders, information about disease management or wellness programs, and other communications regarding your case management or health care coordination.
- **Business Associates.** GPWCHC may disclose your PHI to GPWCHC business associates in order to carry out treatment, payment, or health care operations.
- **Coroners, Medical Examiners and Funeral Directors.** GPWCHC may disclose PHI to a coroner or medical examiner to identify a deceased person or to determine the cause of death, or as otherwise permitted by law. GPWCHC may also disclose PHI about patients of GPWCHC to funeral directors as necessary to carry out their duties.
- **Correctional Institutions.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, GPWCHC may disclose your PHI to the correctional institution or law enforcement official to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution or law enforcement official.
- **Group Health Plans.** GPWCHC maintains a group health plan for its employees, and may disclose PHI of individuals covered under this plan to the sponsor of the group health plan, as permitted by law.
- **Health Oversight Activities.** GPWCHC may disclose your PHI to a health oversight agency or entity for activities authorized by law, such as audits, investigations, inspections, and licensure.
- **Health-Related Benefits and Services.** GPWCHC may use and disclose your PHI to inform you about health- related benefits or services that may be of interest to you or to provide you a promotional gift of nominal value.
- **Individuals Involved in Your Care or Payment for Your Care.** GPWCHC may disclose your PHI to a family member, other relative, or close personal friend who is involved in your medical care or to someone who helps pay for your care if the PHI disclosed is directly relevant to such person's involvement with your care, unless you tell us otherwise.
- **Law Enforcement.** GPWCHC may disclose your PHI for law enforcement purposes, as required by law or in response to a valid subpoena.
- **Lawsuits and Disputes.** GPWCHC may disclose your PHI in response to a court or administrative order. In addition, GPWCHC may disclose your PHI in response to a valid subpoena, discovery request, or other lawful process provided that efforts have been made to tell you about the request or to obtain an order protecting the information requested, as required by law.

PATIENT REGISTRATION FORM

- **Public Health Activities.** As required by law, GPWCHC may disclose your PHI for public health activities, including, but not limited to, the prevention of disease, injury, or disability; reporting births and deaths; reporting child abuse or neglect; reporting reactions to medications or product problems; notification of recalls; infectious disease control; notifying government authorities of suspected abuse, neglect or domestic violence. GPWCHC may disclose portions of your PHI to local, state and/or federal registry programs as required.
- **Research.** GPWCHC may disclose your PHI to researchers when the research has been legally approved and protocols have been established to ensure the privacy of your PHI.
- **Serious Threat to Health or Safety.** GPWCHC may use and disclose your PHI when GPWCHC deems it necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Workers' Compensation.** GPWCHC may disclose your PHI to workers' compensation or similar programs to the extent necessary to comply with laws relating to worker's compensation or similar programs.

Written Authority
Written Authorization Except as described above, GPWCHC will not use or disclose your PHI unless you authorize GPWCHC to do so, in writing, on the form provided by GPWCHC. You may revoke any prior authorization in writing. A written revocation will not apply to any previous use or disclosure of PHI made in good faith under a prior authorization. An Authorization form and Revocation of Authorization form are available on our website, http://www.gpwchc.org, or by contacting the GPWCHC Privacy Office at (703) 680-7950 ext. 3107.

Changes to This Notice
GPWCHC reserves the right to change this Notice and to make the revised Notice effective for PHI GPWCHC already has about you as well as any information GPWCHC receives in the future. A copy of the current Notice or a summary of the current Notice will be posted at patient service locations throughout GPWCHC and on our website, http://www.gpwchc.org. The effective date of the Notice will appear on the first page of the Notice or summary. In addition, each time you register at or are admitted to any GPWCHC entity for treatment or health care services as an inpatient or outpatient, GPWCHC will have available for you, at your request, a copy of the current Notice in effect.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with the GPWCHC Privacy Office at (703) 680-7950 ext 3107, or with the Secretary of the United States Department of Health and Human Services. **You will not be penalized or retaliated against in any way for making a complaint.**

Contact
If you have any questions about this Notice or your privacy rights, or wish to obtain a form to exercise your rights as described above, you may contact the GPWCHC Privacy Office at (703} 680-7950 ext 3107.

PATIENT REGISTRATION FORM

UNINSURED PATIENT NOT ELIGIBLE FOR DISCOUNT

*** patient copy ***

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_____ _____

Print Name Today's Date

_____

Signature

Revised: 02/07/2018