GPW Health Center

Dedicated to Your Health!

PATIENT REGISTRATION FORM

PATIENT INFORMATION (PLEASE PRINT)		
Today's Date:	**Social Security Number:**	**Date of Birth:**
Last Name: **First:** **Middle:**		**Gender at Birth:** ❑ Male ❑Female ❑Unkown
Street Address:		**Cellular Phone Number:** ( )
City: **State:** **Zip Code:**		**Are you a relative of a current employee?** ❑Yes ❑No
E-Mail Address:	**If Under 18, Parent/Guardian's Name:**	
Sexual Orientation: ❑ Lesbian/ Gay ❑ Heterosexual (or straight) ❑ Bisexual ❑ Choose not to disclose ❑ Don't know ❑Other ❑ Unknown	**Gender Identity:** ❑ Female ❑ Male ❑ Transgender (Female-to-Male) ❑ Transgender (Male-to-Female) ❑ Other ❑ Choose not to disclose ❑ Unknown	
How Did You Hear About The Health Center? ❑Family ❑Friend ❑Flyer ❑Center Staff ❑Internet ❑UVA Hospital ❑Sentara Hospital ❑Stafford Hospital ❑Homeless Shelter ❑Schools ❑Local Organization ❑Health Fair ❑CSB ❑Other: _____		

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

FIRST AND LAST NAME:_____

PHONE NUMBER:_____

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

I grant the above person permission(s) to: ❑ share medical information ❑ make medical decisions ❑ renew medications ❑ discuss my billing account

PATIENT DEMOGRAPHICS (PLEASE ANSWER ALL QUESTIONS)

Ethnicity: ❑ Hispanic/Latina(o) ❑ Non-Hispanic/Latina(o) ❑ Prefer not to Report

Race: ❑ Black/African American ❑ White ❑ American Indian/Alaska Native ❑ Asian ❑ Native Hawaiian ❑ Other Pacific Islander ❑ More than one race ❑ Choose not to disclose

Preferred Language: If you prefer to communicate in a language other than English, please list preferred language:_____. ❑ **I request interpretation services**

Veteran? ❑ Yes ❑ No	**Current Housing Status?** ❑ Own ❑ Rent ❑ Staying with Family ❑ Staying with Friends ❑ Shelter ❑ Transitional Housing ❑Living In Car ❑ Living Outdoors ❑ Refuge ❑ Other_____

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

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

Revised: 07/16/2020

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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.

HIV, Hepatitis B & C Testing

In the event that Center staff comes in contact with my or my children's body fluids, I, _____,
(Initials)

consent to be tested for HIV, Hepatitis B and C.

Signature: _____

Patient/Parent/Legal Guardian Signature Date

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MEDICAL HISTORY

Patient Name _____ Birth Date_____

MEDICATIONS

Please List all Medications you are currently taking:

Medication	Dosage	How is Taken	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	

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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? ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Occupation:	

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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 GPW Health Center. The undersigned, having read and understood the agreement, accepts this financial responsibility agreement.

Signature: _____

Patient/Parent/Legal Guardian Signature Date

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PERMISSION TO RELEASE & EXCHANGE INFORMATION

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 family members, organizations and referral sources requesting it.

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

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

❑ I consent for an employee to discuss my billing account with my spouse, family member, or significant other. If allow, only those listed here: _____

Method of Contact:

Please select the method(s) the Center is allowed to contact you for appointment reminders, test results, billing, etc.

❑ I may be contacted by phone (at the numbers I provide)

❑ I may be contacted by text message

❑ I may be contacted by emailed.

Patient Portal:

The Patient Portal allows for patients to review existing appointments, lab results, medications, request prescription refills, medical history, patient statements and send secure messages to Center staff. To enroll in this internet-based option, please click the box below. The email address provided on the Patient Enrollment Form will be used as your log-in.

❑ Enroll me

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CENTER POLICIES

Patients can find the full text of Policies listed below on at each facilities Front Desk and on the GPW Website

Notice of Patient Privacy Practices

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.

Appointment Expectations:

All patients will be assigned an Appointment Arrival Time for each visit. 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.**

Appointment Confirmation

You must confirmed your appointment no later than 72 hours before to the scheduled Arrival Time. If the Center cannot confirm your appointment, it will be cancelled. We will do everything possible to reschedule your appointment depending on the availability of your Provider.

Late Arrival

Patients that **arrive** at the front desk **more than 30 minutes after their scheduled Arrival Time** may not be seen at their scheduled appointment. We will do everything possible to see patients the same day, depending on the availability of your Provider, or will reschedule your appointment .

Cancellation Policy

Patients that need to cancel or reschedule an appointment may do so by calling the Center or leaving a message at 703-680-7950. **Appointment cancellation requires 72-hour advanced notice.** Voicemail messages left 72 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 a (2) two year period, the patient will be limited to walk-in appointments only. Once the patient has completed (2) two walk-in visits, the patient can once against schedule future appointments.**

_____
(Initials)