

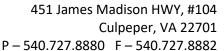
451 James Madison HWY, #104 Culpeper, VA 22701 P – 540.727.8880 F – 540.727.8882

Patient Information:							
Patient Name:		Date of Birth:					
Mailing Address:							
City:	State:	Zip Code:					
Marital Status:	Ethnic	ity:					
Primary Care Provider:							
Health Insurance Informatio	n:						
Insurance:		ID #:					
Subscriber Name:	Subscriber DOB:						
I acknowledge that I have be Clinic's Notice of Privacy pr and disclosed. It also explai contact if you feel that your	een offered this clinic's actices describes how rons how you can get acc privacy rights have bee		lpeper may be ad who	Medical used o to			
Patient Signature:		Date:					
Preferred Methods of Comm	nunication:						
healthcare, and to discuss in telephone contact information your medical information is following information, you a with those individuals listed	nsurance billing issues, on. While we prefer to N properly protected as rear authorizing the representations of the phone numbers	ents, leave messages regarding we are asking you to complete OT leave messages, we would equired by HIPAA guidelines. Esentatives of this clinic to leave you list below.  authorize us to discuss your needs	the fo like to by prov e mess	ensure iding the ages			
1)	Relation:	Phone:					
2)	Relation:	Phone:					
Please list your personal co	ntact information below	:					
Home Phone:		May We Leave a Message?	Yes	No			
Work Phone:		May We Leave a Message?	Yes	No			
Cell Phone:		May We Leave a Message?	Yes	No			
Email Address:							
Please List any Emergency	Contacts:						
Name:		Relation:					
Mailing Address:							
		Zip Code:					
Phone #1:	р	hone #2·					



Drugs Caffeine 451 James Madison HWY, #104 Culpeper, VA 22701 P – 540.727.8880 F – 540.727.8882

Pa	Patient Name: Date of Birth:											
Re	eason for Visit:											
ΑI	lergies: (Please	e list :	type of rea	ction)								
Fc	ood Allergy?		Yes / No									
M	edication Aller	gy?	Yes / No									
Cı	urrent Medicati	ons:				on-						
	Medication		Dose	Frequ	ency		Med	licatio	on	Dos	se	Frequency
Pa	ast Medical His	torv:	Please Ch	eck anv	that app	lv 1	to vou					
	Anemia		Car		ar app			ood F	ressure	Т	hyr	oid Problems
	Anxiety		Dial	betes			Hearing					hol Use
	Arthritis		Dys	lipidemia			Heart A	ttack		Т	oba	acco Use
	Asthma		GEI	RD			Stroke			5	Subs	stance Abuse
	Heart Disease	<u> </u>	Gou	ıt			Limb Amputation		Nerve Pain			
	COPD		Headaches				Vision Problem		Memory Problems			
Ro	ther Medical His	ngs: F		the Mont	th and Y							
	st Annual Phys						urrently					
	st Colonoscop						Yes, Hov					
	st Prostate Ch					Last PAP Smear Last Mammogram						
La	st Menstrual C	усіе				Lã	ast Mami	mogra	am			
Ps	st Surgical His	story:										
	rgery	otory.			Whe	en			Where			
	ırgery				Whe				Where			
Surgery			Whe		en		Where					
	ırgery				Whe	en			Where			
Fa	ımily Medical H	listor	y: Please (	Check all	l that ap	ply	and List	t the	Relation	of pe	rso	n with condition
	Heart Disease						Thyroid Disease					
	Hypertension						Cancer					
	Asthma						Kidney Disease					
	Diabetes						Stroke					
	Cystic Fibrosis						Migraines					
	High Cholesterol Osteoporosis											
e.	ubstance Use: I	Dless	a angwar l	noneetly	All roce	ac r	sees are	etrict	ly confid	antia		
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	cohol									+		



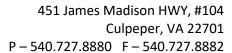


## **Contract for Services and Assignment of Benefits**

In consideration of Culpeper Medical Walk-In Clinic providing the patient named below with medical services, we the undersigned patient, sureties, and co-signers for the patient agree as follows:

- A.) In connection with third-party (insurance carriers, etc.) payment:
  - 1.) To authorize the practice to release information acquired in the course of examination and treatment for the purposes of insurance, Medicare and/or other insurance benefit payments.
  - 2.) To further authorize payment directly to the practice of physician(s)/authorized medical provider(s) accepting assignments for all medical benefits applicable and otherwise payable to the patient, but not to exceed the reasonable and customary charge for these services rendered by physician(s)/authorized medical provider(s).
  - 3.) That we hereby certify that this information given by us in applying for insurance payment is correct, and request that said payment of authorized benefits is made on the patient's behalf.
  - 4.) To authorize Culpeper Medical Walk-In Clinic to act on the patient's behalf as attorney in fact in (1) the collection of benefits from any reasonable third party through whatever means may be deemed necessary; and (2) in the endorsement of benefit checks made payable to me and/or the physician(s)/authorized medical provider(s) or practice.
- B.) To guarantee payment of all charges to the patient, regardless of granting extension of time for the payment of these charges or the practice acceptance of a note for the payment of these charges from either the patient or any third person or party.
- C.) That the payment for these services is due at the time of service.
- D.) A charge of \$35.00 will be added to your account for non-sufficient funds each time your financial institution processes your transaction for payment.
- E.) Please allow 24-48 hours for any prescription refill request to be processed. Request authorizations and referrals a minimum of 48-hours in advance of your scheduled appointment or earlier for those insurance companies that require a longer timeframe.
- F.) I understand that if, during the course of care, a health care provider is directly exposed to my blood or body fluids in a manner which may transmit blood-bourne pathogens (including HIV, Hepatitis, etc.), for the protection and well-being of the healthcare provider it is necessary that testing be done to my blood without charge to determine whether I am carrying these pathogens and under Virginia law, (Section 32.1-45.1 et.seq) I am deemed to have consented to said test(s) and to the release of the test results to the exposed health care provider. I also understand that health care providers are deemed to consent to the same test(s) and the release of the results to me should I be similarly exposed.

Patient Name:	DOR:
Patient/Responsible Party Signature:	Date:





## PATIENT FINANCIAL TERMS AND CONDITIONS

We are committed to providing you with the best possible care and service. If you have medical insurance, we are happy to assist you to receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy. It is ultimately your responsibility to pay the provider for services rendered and to assure that your insurance properly processes your claim and pays the provider. If this provider does participate with your plan, your obligation is to remit all relevant insurance policy information to the provider at the time of service. It is your responsibility to fully understand the terms and conditions of your insurance regarding the procedures for the filing of claims, what medical procedures and treatments your insurance does and does not cover, what amount, if any, your insurance will pay for medical services, and what your co-payment and deductible amounts may be.

Unless otherwise agreed upon by the provider, payment for services is due at the time services are rendered. We accept cash, checks, MasterCard, or Visa. We will be happy to help you process your insurance claim-form for your reimbursement. Any such request must be accompanied by a <u>completed</u> insurance form at each visit. In <u>special</u> circumstances we may accept assignment of insurance benefits.

Returned checks will be subject to a \$35.00 bad check fee, and any outstanding balances older than 30 days will be subject to interest charges of 1 1/2% per month. In the unfortunate event collection procedures are required to collect an outstanding account balance, the patient shall be responsible for the reasonable cost (35% of the past due balance) occurred collections agent/attorney as well as any fee's for filing court documents.

The undersigned hereby waives any defense he/she may have as to the Statute of Limitations barring future attempts to recover debts owed hereunder in the event of default.

We will gladly discuss your proposed treatments and charges, and will answer any questions relating to your insurance.

You must realize, however, that

- 1. Your insurance is a contract between you and the insurance company. We are not a party to that contract and therefore are not bound by its terms and conditions.
- 2. We are not bound by the fee payment structure of your insurance policy. You are responsible for whatever portion of our charges your insurance does not pay.
- 3. Not all services are a covered benefit in all contracts. These charges are your responsibility.

We must emphasize that as medical providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are happy to help you.

By my signature, I indicate that	at I have read, understand and o	do hereby accept the terms of the	nis agreement.
Patient	Date	Witness	Date