Culpeper Medical Clinic
Walk-in & Primary Care

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: _____ **Ethnicity:** _____

Primary Care Provider: _____

Health Insurance Information:

Insurance: _____ **ID #:** _____

Subscriber Name: _____ **Subscriber DOB:** _____

HIPAA NOTICE:

Culpeper Medical Clinic Notice of Privacy Practices is available to you in its entirety in hard copy. I acknowledge that I have been offered this clinic's notice of Privacy Practices. Culpeper Medical Clinic's Notice of Privacy practices describes how medical information about you may be used and disclosed. It also explains how you can get access to this information, as well ad who to contact if you feel that your privacy rights have been violated.

Patient Signature: _____ **Date:** _____

Preferred Methods of Communication:

To reach you more effectively to confirm appointments, leave messages regarding your healthcare, and to discuss insurance billing issues, we are asking you to complete the following telephone contact information. While we prefer to NOT leave messages, we would like to ensure your medical information is properly protected as required by HIPAA guidelines. By providing the following information, you are authorizing the representatives of this clinic to leave messages with those individuals listed at the phone numbers you list below.

Please list the names of individuals with whom you authorize us to discuss your medical care:

1) _____ **Relation:** _____ **Phone:** _____

2) _____ **Relation:** _____ **Phone:** _____

Please list your personal contact 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: _____

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

Phone #1: _____ **Phone #2:** _____

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

Reason for Visit: _____

Allergies: (Please list type of reaction)

Food Allergy?	**Yes / No**	
Medication Allergy?	**Yes / No**	

Current Medications: Include prescription and non-prescription medicine

Medication	Dose	Frequency	Medication	Dose	Frequency

Past Medical History: Please Check any that apply to you

	Anemia		Cancer		High Blood Pressure		Thyroid Problems
	Anxiety		Diabetes		Hearing Problems		Alcohol Use
	Arthritis		Dyslipidemia		Heart Attack		Tobacco Use
	Asthma		GERD		Stroke		Substance Abuse
	Heart Disease		Gout		Limb Amputation		Nerve Pain
	COPD		Headaches		Vision Problem		Memory Problems

Other Medical History: _____

Routine Screenings: Please list the Month and Year of your…

Last Annual Physical		**Currently Pregnant?**	
Last Colonoscopy		**If Yes, How Far?**	
Last Prostate Check		**Last PAP Smear**	
Last Menstrual Cycle		**Last Mammogram**	

Past Surgical History:

Surgery		**When**		**Where**	
Surgery		**When**		**Where**	
Surgery		**When**		**Where**	
Surgery		**When**		**Where**	

Family Medical History: Please Check all that apply and List the Relation of person with condition

	Heart Disease			Thyroid Disease	
	Hypertension			Cancer	
	Asthma			Kidney Disease	
	Diabetes			Stroke	
	Cystic Fibrosis			Migraines	
	High Cholesterol			Osteoporosis	

Substance Use: Please answer honestly, All responses are strictly confidential

Do You Use?	Y/N	Type	How Much?	How Long?	When Quit?
Tobacco					
Alcohol					
Drugs					
Caffeine					

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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: _____ **DOB:** _____

Patient/Responsible Party Signature: _____ **Date:** _____

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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 completed insurance form at each visit. In special 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 I have read, understand and do hereby accept the terms of this agreement.

_____ _____

Patient Date Witness Date