SENTARA®

Patient Registration Form

Date_____

PATIENT INFORMATION

Patient Name (Last)_____ (First)_____ (Middle)_____

Address_____ City_____ State_____ Zip_____

911 Address (if different from above)_____

Sex: M/F_____ Birth date_____ Age_____ Social Security #_____

Marital status: (circle one) S M W D Race: (circle one) Asian Black Native American White Other_____

Email Address:_____

Home Phone_____ Cell Phone_____

Employer_____ Work Phone_____ (Circle one): Full time Part time

Referring Physician_____

Emergency contact_____ Relationship to patient_____ Phone No._____

Spouse's Name (if applicable)_____ Spouse's Social Security #_____ Spouse's Birth date_____

Spouse's Employer_____ Work phone_____

Employer Address_____ City, State & Zip_____

Preferred method of reminder contact (please circle one): Mail/Letter Relay Health Phone:_____

(If patient is less than 18 years of age)
RESPONSIBLE PARTY (Circle one) Father Mother Guardian Other_____
(If different from patient information)

Responsible party's name_____ Responsible party SS#_____ Sex: M/F_____

Address_____ City, State & ZIP_____

911 Address (if different from above)_____

Responsible party Birth date_____ Responsible Party Employer_____

Employer Address_____ City, State & Zip_____

OTHER PARENT/GUARDIAN INFORMATION

Name_____

Address_____ City, State & ZIP_____

Relationship to Patient_____ Employer_____

Employer Address_____ City, State & Zip_____

SS#_____ Birth date_____ Sex: M/F_____

****

PRIMARY INSURANCE

Name of Insurance Company_____ Policy Holder_____

Pt. Relation to Policyholder_____ ID#_____ Group#_____

Ins. Phone No._____ Policyholder's Birth date_____ Sex: M/F_____

SECONDARY INSURANCE

Name of Insurance Company_____ Policy Holder_____

Pt. Relation to Policyholder_____ ID#_____ Group#_____

Ins. Phone No._____ Policyholder's Birth date_____ Sex: M/F_____

HAC Registration

Date Requested _____
Medical Record No. _____
D.O.B. _____
S.S. # _____
Acct. # _____
Date Completed _____

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Consent to Treat

I, the undersigned, hereby consent to and authorize the administration and performance of all treatments, the administration of any needed anesthetics; the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, the use of prescribed medication; the performance of diagnostic procedures; the taking and utilization of cultures and performance of other medically accepted laboratory test, all of which in the judgment of the attending physician or their assigned designees, may be considered medically necessary or advisable.

I fully understand that this consent applies to all Sentara Dominion Health Medical Associates affiliate practices. Practices included in Sentara Dominion Health Medical Associates are Sentara Halifax Family Medicine, Sentara Volens Family Medicine, Sentara Chase City Family Medicine, Sentara Clarksville Family Medicine, Sentara Southern Virginia Orthopedics, Sentara Southern Virginia Ear, Nose & Throat, Sentara Southside Hematology & Oncology, Sentara Halifax Dental Clinic, Sentara Halifax General Surgery, Sentara Halifax Pediatrics, Sentara Obstetrics & Gynecology and Sentara Behavioral Health Specialists.

I fully understand that this consent is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I hereby authorize Sentara Dominion Health Medical Associates affiliate practices to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to Sentara Dominion Health Medical Associates affiliate practices of benefits otherwise payable to me. I hereby authorize release of my medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be considered as valid as the original. Further, I acknowledge that if I am indebted for past due charges that I am financially responsible for those charges also.

I consent and authorize Sentara Dominion Health Medical Associates affiliate practices to collect my personal medical information in order to obtain and maintain on file the information necessary to verify and process electronic prescriptions. The received information can include prescription insurance eligibility, prescription insurance claims history, and prescription insurance formulary files

I consent and authorize Sentara Dominion Health Medical Associates affiliate practices to transmit prescription information to the pharmacy of my choice through a third party intermediary operating under a business associate agreement with the electronic prescription software vendor.

I further consent to these options:			
	Publish Data to Relay Health	YES	NO
	Transmit Data to Immunization Registry	YES	NO
	Receive Immunization Reminders from the Registry	YES	NO
	Should the Immunization Registry Protect Data	YES	NO
	Mail Order Prescriptions Preferred	YES	NO

Preferred Method of Contact: Mail/Letters Phone Call Relay Health No Preference

MEDICARE PATIENTS: I authorize Sentara Dominion Health Medical Associates affiliate practice to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to the appropriate Sentara Dominion Health Medical Associates affiliate practice.

In accordance with the provisions of Section 32.1-45.1 of the Code of Virginia, (whenever any healthcare provider, or any person employed by or under the direction and control of a health care provider, is directly exposed to body fluids of a patient in a manner which may, according to the current guidelines of the Centers of Disease Control, transmit human immunodeficiency virus), the patient whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus.

If there is an exposure, and the patient's test is positive, the attending physician will notify the patient, any person exposed and the Virginia Health Department and appropriate counseling will be offered.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient's Signature (or responsible party): _____

Date: _____

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Consent to Treat a Minor

I (we), the undersigned parent(s) or legal guardian(s) of _____, a minor, hereby consent to and authorize the administration and performance of all treatments, the administration of any needed anesthetics; the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, the use of prescribed medication; the performance of diagnostic procedures; the taking and utilization of cultures and performance of other medically accepted laboratory test, all of which in the judgment of the attending physician or their assigned designees, may be considered medically necessary or advisable.

I (we) fully understand that this consent applies to all Sentara Dominion Health Medical Associates practices.

I (we) fully understand that this consent is given in advance of any specific diagnosis or treatment. I (we) intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I (we) hereby authorize Sentara Dominion Health Medical Associates affiliate practices to release medical information to any of the patient's physicians or insurance companies that may be pertinent to his/her case. I (we) hereby authorize payment directly to Sentara Dominion Health Medical Associates affiliate practices of benefits otherwise payable to me (us). I (we) hereby authorize release of his/her medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided. I (we) understand that I (we) am (are) financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be considered as valid as the original. Further, I (we) acknowledge that if I (we) am (are) indebted for past due charges that I (we) am (are) financially responsible for those charges also.

I (we) consent and authorize Sentara Dominion Health Medical Associates affiliate practices to collect the patient's personal medical information in order to obtain and maintain on file the information necessary to verify and process electronic prescriptions. The received information can include prescription insurance eligibility, prescription insurance claims history, and prescription insurance formulary files.

I (we) consent and authorize Sentara Dominion Health Medical Associates affiliate practices to transmit prescription information to the pharmacy of my (our) choice through a third party intermediary operating under a business associate agreement with the electronic prescription software vendor.

I further consent to these options:	**Publish Data to Relay Health**	YES	NO
	Transmit Data to Immunization Registry	YES	NO
	Receive Immunization Reminders from the Registry	YES	NO
	Should the Immunization Registry Protect Data	YES	NO
	Mail Order Prescriptions Preferred	YES	NO

Preferred Method of Contact: Mail/Letters Phone Call Relay Health No Preference

In accordance with the provisions of Section 32.1-45.1 of the Code of Virginia, (whenever any healthcare provider, or any person employed by or under the direction and control of a health care provider, is directly exposed to body fluids of a patient in a manner which may, according to the current guidelines of the Centers of Disease Control, transmit human immunodeficiency virus), the patient whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus.

If there is an exposure, and the patient's test is positive, the attending physician will notify the patient's parent or legal guardian, any person exposed and the Virginia Health Department and appropriate counseling will be offered.

I (we) certify that I (we) have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Date of Birth: _____

☐ Parent
☐ Legal Guardian

_____ _____
Signature Date

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PERMISSION TO DISCUSS PERSONAL HEALTH INFORMATION (PHI)

Patient Name: _____

Date of Birth: _____

Account Number: _____

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signature of Patient, Parent or Guardian: _____

Date: _____

In order to obtain information by telephone, the party calling the practice must share the patient identifier with the staff.

Patient Identifier: _____ (Patient Date of Birth)

Reviewed 7/18

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HEALTH HISTORY

NAME:	DOB:	Age:	Today's Date:

PAST MEDICAL HISTORY

List **ALL** of your medical diagnoses/problems.
Example: High Blood Pressure, Diabetes, Anemia

List all past surgeries (be as specific as possible), include the date of the procedure (estimate if not known).
Example: ACL repair to right knee 1998, Hysterectomy 2009

Diagnosis/Problem	Treating Physician	Date	Surgery	Surgeon

PRESENT MEDICATIONS

List **ALL** medications that you are currently taking, including prescriptions, "over-the-counter" medications, vitamins and herbal supplements.

Name of medication: Example: Aspirin	**Dose:** Example: 81 mg	**Frequency:** Example: one tablet daily

ALLERGIES

Substance	Reaction	Severity	Onset Date

Revised July 2018

SENTARA®

It's all online!

POWERED BY RelayHealth

My Halifax Medical Record (RelayHealth) is a convenient, secure way you can communicate with your physician online.

You can request an appointment, lab results and medication refills.

By using My Halifax Medical Record (RelayHealth) you are able to maintain a secure, electronic file of you and your family's personal health information.

Stay informed about events to help you focus on good health.

To sign up simply provide us with the following information and we will get you started.

In a few days you will receive an email from us. All you have to do is open and follow the easy instructions to getting connected. Soon our front office, nurses, office manager and yes your physician will only be a click away. To learn more visit www.sentara.com, choose your hospital location and click on Patient Login at the top of the page.

Patient Name _____

E-mail Address _____

Provider's Name _____

Date_____

Revised July 2018

SENTARA®

No-Show Policy
Primary Care Offices

SENTARA DOMINION HEALTH MEDICAL ASSOCIATES

It is the policy of Sentara Dominion Health Medical Associates to monitor and manage appointment no-shows. Any patient who fails to arrive for a scheduled appointment or fails to cancel an appointment the same day is considered a no-show unless there are unforeseen circumstances that are out of the patient's control. A patient who is a no-show more than three times in one year may be dismissed from the Practice.

Procedures

1. A patient is notified of the no-show policy at the time of initial registration. The no-show policy is provided in writing upon the patient's arrival.

2. A patient's appointment status is automatically or manually updated by marking the system "N" for no-show when patient fails to arrive for a scheduled appointment without notifying the practice unless there are unforeseen circumstances that are out of the patient's control.

3. By the end of the same day the appointment is missed, the provider will review the patient's chart.

4. "No-Show" is noted in the patient's chart and the provider determines the following:

    a. No Follow-up Necessary
    b. Follow-up Urgent—locate patient immediately
    c. Follow-up Necessary—contact patient and schedule visit in _____ days

5. If this is a patient's first missed appointment, the Practice will attempt to call the patient. If the patient cannot be reached, a letter will be mailed to the patient.

6. If this is a patient's second missed appointment, the Practice will attempt to call the patient and mail a letter to the patient.

7. If this is a patient's third missed appointment, the Practice will attempt to call the patient and the patient may be dismissed from the Practice.

_____ _____

Patient Signature Date

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FINANCIAL POLICY

Sentara Dominion Health Medical Associates

It is the policy of SDHMA to have a financial policy that clearly outlines patient and practice financial responsibilities. We are committed to providing our patients with the best possible medical care in a comfortable, personal and cost effective manner.

Payment is expected at the time of service.

Payments made to SDHMA practices may be made by cash, check, or credit. All co-pays, co-insurances, deductibles, uninsured payments, self-pay and any current statement balances are due at the time of service. We do our best to include all charges at the time of service. Occasionally, charges may be added or modified based on the provider's assessment and treatment provided.

Self Pay & Uninsured

Patients with no insurance are expected to pay a co-payment of $60 at the time of service, unless prior satisfactory arrangements have been made. Uninsured patients will receive a 50% discount toward total charges and receive a statement for any additional balance due. Self-pay balances are due in full at the time of service.

Insurance Billing

Insurance claims are filed as a courtesy to our patients. You are expected to pay $30 toward your co-insurance, co-pay or deductible and the balance for any non-covered services at the time of service. We expect payment in full within 60 days for services billed to insurance. **It is your responsibility to pay any balance older than 60 days** and to follow up with your insurance company for reimbursement. If we receive a payment from your insurance company after your balance has been paid, we will issue you a refund. **It is your responsibility** to contact your insurance company if a claim is denied, paid at a lower rate than you expected or if it has not been paid within 60 days. If we have made an error, we will gladly resubmit a corrected claim.

Third Party Litigation

Our office will not become involved in disputes arising from Third Party Claims (i.e., automobile accidents, liability claims, Worker's Compensation) with the exception of Medicare or Medicaid. *Patients with any type of liability coverage or personal injury claim are not eligible to apply for Patient Financial Assistance through SDHMA.

Credit

Patients who are financially able are expected to pay for medical services. Special consideration will be made to patients who are financially unable to pay for medical services. Budget and payment plans are available for accounts based on individual needs.

Financial assistance is available for qualified patients. If you feel that you may qualify for assistance, please notify the front office staff.

Adequate information will be obtained on each new patient so that the account can be processed properly.

Details of when and how the fees for services are to be paid will be on an individual basis.

Itemized bills are available per patient/guarantor request

After carrying out all our policies on granting credit, we will take the necessary steps within the realm of ethical medical public relations to seek payment from those who are able to pay. We do this in fairness to our patients who pay their accounts.

Credit Balances/Refunds

Patient refunds will not be processed until all active or past due accounts are paid in full. Refunds less than $15.00 will not be refunded unless specifically requested by the patient/guarantor or insurance company.

FINANCIAL AGREEMENT

- I have read the policies above and understand them.
- I agree to promptly pay all fees and charges for treatments provided to me and/or my family.
- All insurance payments for services rendered are assigned to this office.
- I understand that it is my responsibility to contact my insurance company should a claim be denied or not paid in full.
- I promise that I will pay all charges in full within 60 days after receipt of insurance payment.
- I understand that charges may occasionally be added or modified based on the provider's assessment and treatment provided.
- I understand that I am financially responsible for all charges, whether or not they are covered by my insurance.
- I authorize this clinic to release to my insurance carrier any medical information needed to obtain payment for services rendered.
- I understand that if I disagree with any charges, I will contact this office in writing within 30 days of the billing date.
- If my outstanding balance has to be referred to a collection agency or attorney for collection, I agree to pay all reasonable collection costs including late charges, interest, court costs and/or attorneys fees.
- I authorize SDHMA and its agents, the use of any telephone number including wireless numbers, provided to them or published, to message or contact me regarding my accounts.

NOTICE

Do not sign this agreement before you read and agree to the conditions set forth above. You may request a copy of this agreement for your records.

Signature _____ Relationship_____
Patient/Responsible Party if minor

Date _____