VIPMD
Patient Registration Form

Today's Date _____

Patient Name: _____DOB: _____ Sex: _____ Social Security #:_____

Address: _____ APT# _____

City: _____ State: _____ Zip: _____

Home: (_____)_____ Cell: (____)_____ Preferred Contact: Home / Cell

May information regarding health information and/or billing inquiries be left on answering machine? Y / N

Email Address: _____ May we send information here? Y / N

Providing your email will allow us to email you information to obtain access to your medical files in our patient portal.

Emergency Contact: _____Phone: (__)_____ Relationship:_____

Race: _____ Ethnicity: Hispanic/Non-Hispanic Preferred Language: _____

Primary Care Information

Physician Name:_____ Clinic Name:_____ Phone/Fax:_____

Are you are you here as a prospective patient for our primary care services? Yes/No

Providing this information will allow our systems to automatically send your medical file to your primary care physician

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Parent Information: (if patient is under 18)

Last Name: _____ First Name: _____ MI: ____ DOB:_____

Relationship to patient: _____ Gender (circle one): M / F Social Security #: _____-_____-_____

Address: _____ City: _____ State: _____ Zip:_____

Employer: _____ Home: (____)_____Cell: (____)_____Other: (_____)_____

Primary Insurance

Insurance Company: _____

Insurance Policy #: _____

Group #: _____

Policy Holder: _____

Relationship to Patient: _____

Insured DOB: _____

Insured Social Security #: _____

Secondary Insurance

Insurance Company: _____

Insurance Policy #: _____

Group #: _____

Policy Holder: _____

Relationship to Patient: _____

Insured DOB: _____

Insured Social Security #: _____

Internal note: Please request for patient to take picture of their insurance card & ID and send to office.

Our office will file to our contracted insurances for all reimbursable services. Please remember that you are responsible for all deductibles, copays, and non-covered service amounts according to your insurance contract.

Major Complaint: _____ **Date of Injury or Onset of Illness:**_____

How did you hear about us? _____

Did your injury happen on the job? _____ Date of Accident:_____ Did you report accident to employer? _____

Is your visit related to an Auto Accident? _____ Date of Accident:_____

If Auto Accident, which state? (please abbreviate) _____

SEE BACK

Chart # (internal use only) _____

Patient Consent Form HIPAA & Protected Health Information

I hereby consent to medical evaluations, testing and/or treatment provided to me by the staff of VIPMD. I also understand that VIPMD may use or disclose any Protected Health Information (PHI) necessary to carry out treatment, payment or healthcare operations. I authorize release of any information concerning me (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by submitting your request in writing toOnPoint Urgent Care

If you would like to receive a paper copy of our health disclosure policy please ask the front desk, we will be happy to provide it to you at any time.

Signature: _____ Date: _____

Financial Policy

I hereby grant permission to the VIPMD medical staff to perform such medical/surgical procedures they deem necessary. I authorize information and subsequent visits to be relayed verbally, written or faxed to my family doctor, commercial insurance company, employer, and/or work comp Insurance carrier, if applicable.

I understand that if I am a guardian accompanying a minor, I am responsible for payment. I understand that all accounts are due and payable at the time of service if Onpoint Urgent Care is not a participating provider with your insurance carrier.

I hereby authorize my representing Insurance Carrier to pay any benefits for my care to VIPMD directly, if VIPMD is a participating provider or if the is a Workers Compensation case.

I understand that even though I may have an insurance claim pending, I remain responsible for the account. VIPMD does not accept responsibility for collecting an insurance claim or for negotiating a disputed claim. If insurance claims are not paid in a timely manner, then the balance is my responsibility.

I read this policy and understand that, regardless of my insurance coverage I may have, I am responsible for payment of my account within 45 days. I agree that in the event that costs or fees are incurred in connection with the collection of my account I will pay all such costs and fees including collection costs, attorney's fee and court costs.

Signature: _____ Date: _____

WORK COMP PATIENTS ONLY – PLEASE READ AND SIGN

1. The EMPLOYEE is responsible to report the Work Comp injury to employer in writing, within four (4) days.
2. The EMPLOYER is responsible to fill out and mail a first report of injury to their insurance carrier within 10 days of injury notification.
3. The INSURANCE CARRIER is responsible to pay within 30 days of receiving the Work Comp bill.
4. If the EMPLOYER fails to file the first Report of Injury, the employee must file his/her own first report of injury or be responsible for the bill.
5. If the INSURANCE CARRIER "denies" the claim for any reason, the patient will be responsible for the bill.

Signature: _____ Date:_____

Patient Employer: _____ Position: _____

Employer's Address: _____ City:_____ State: _____

Zip:_____ Work Phone: (_____)_____ May we contact you at work? Y / N

Name of Employers Insurance: _____ WC Claim Number:_____

Drug Testing Required? Y / N Type of Testing: UDS / BAT Contact Name: _____.

VIPMD HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are **strictly confidential** and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	DOB:	Today's Date:

As a courtesy we will offer to electronically fax prescriptions (if any) to your pharmacy, please indicate which pharmacy you prefer and the cross streets so that we may accurately identify it during this process: _____

PERSONAL HEALTH HISTORY

Immunizations: ☐ Tetanus: Year_____ Tdap or Td? _____ ☐ Influenza: Year _____ ☐ Pneumonia: Year_____

List all past medical problems such as high blood pressure, diabetes, bronchitis, sleep apnea, etc.

☐ NONE			

List surgeries such as gallbladder removal, appendectomy, heart surgeries, back surgeries, etc. and the year of the surgery

☐ NONE			

List all medications currently being used including prescribed, OTC meds, supplements and oxygen

Name of Medication/Reason for Medication	Strength	How Often?	Name of Medication/Reason for Medication	Strength	How Often?
☐ NONE					

Allergies to *Medications*, *Foods* and/or *Environment*

Name of Medication/Allergen	Reaction You Had	Name of Medication/Allergen	Reaction You Had
☐ NONE			

The information provided will be entered into our electronic medical record. For your safety please be complete and accurate to the best of your ability. If you have of these forms within the last year please let our front desk know and we will pull it up for you to verify.

<u>*If you are experiencing chest pain or shortness of breath please alert front desk staff immediately*</u>

Initials:_____ **Date:**_____ **Initials:**_____ **Date:**_____

Initials:_____ **Date:**_____ **Initials:**_____ **Date:**_____

Initials:_____ **Date:**_____ **Initials:**_____ **Date:**_____