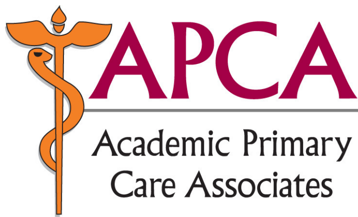

Patient Name: Last:_______________________________ First: ___________________________ Middle Initial:_____
Preferred Name: _______________________ SS#: ___________________________ DOB: ______________ Sex: M / F
Address: ___________________________________City: ______________________ State: ________ Zip: _________
Home #: _____________________________ Cell#: __________________________ Work#: _______________________
Email address: ____

Marital Status: Married _____ Single _____ Divorced _____ Widowed _____
Race: African American ___ American Indian ___ Asian ___ White ___ Hispanic ___ Pacific Islander ___ Other ___
Ethnicity: Hispanic ______ Non-Hispanic _____ Prefer Not to Report: ________ Preferred Language: ______________

Primary Care Physician: _______________________________________ Phone: _________________________________

Occupation: ____ Employer: _______________________________
Student Status: Full Time / Part Time Location: ____

Responsible Party Info: (if patient is a minor):
Name: ____ SS#: _________________________ DOB: ______________
Relation to Patient: _________________________ Home #: ____________________ Cell #:______________________
Mailing Address: _____________________________ City: ______________________ State: ________ Zip: ________

Is this a foster child? Yes / No If yes, Primary Caregiver/Legal Guardian's Name: ________________________________

Emergency Contact: ______________________________ Phone: ______________________ Relation: ______________

Do you have Medical Insurance? Yes / No
Primary Insurance:
Policy Holder Name: ____ DOB: ________________________
Policy Holder's Info: (if different from the patient):
Address: ___________________________________City: ______________________ State: ________ Zip: _________
Secondary Insurance:
Policy Holder Name: ____ DOB: ________________________
Policy Holder's Address: (if different from the patient):
Address: ___________________________________City: ______________________ State: ________ Zip: _________

Preferred Pharmacy: ____ Location: __________________________________

Patient (if 18 years or older) / Legal Guardian Signature: _______________________________________ Date:_______________
Demog Packet 4/13/15

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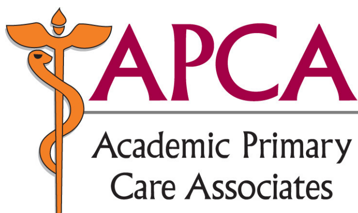

Patient Name: ____ DOB: ___________

Consent for Treatment

I hereby consent to medical treatment, diagnostic tests, laboratory, and other medical procedures, which the physician(s) or healthcare provider(s) of APCA/ASOM may consider or advise in my treatment, or in treatment of my dependent. This agreement will remain in effect until I choose to revoke it in writing.

Patient (if 18 years or older) / Legal Guardian Signature: ____________________________________ Date:_______________

Notice of Privacy Practices

I acknowledge that I have access to a copy of APCA/ASOM Privacy Practices and that it is my responsibility to read the notice to understand how my or my child(ren)'s Protected Health Information may be used.

I understand no authorization is required from me in order for APCA/ASOM to use my or my child(ren)'s Protected Health Information for purposes of treatment, payment or health care operations. Other uses or disclosures may require my written authorization. **If you would like a copy of APCA/ASOM's Privacy Practices, please ask a receptionist.**

Patient (if 18 years or older) / Legal Guardian Signature: ____________________________________ Date:_______________

Payment Agreement

I agree to be financially responsible for costs incurred in my or my dependents care. I understand that charges for services provided shall be paid for at the time of each visit. If medical claims are submitted to an insurance company by APCA/ASOM on my behalf, I understand that the copayment or deductible is due at the time care is rendered. I hereby authorize any benefits due me to be paid directly to APCA/ASOM (assignment of benefits). I understand and agree that I am financially responsible for all deductible amount s, co-insurance, non-covered services or services deemed as "non-medically necessary" by my insurance carrier. I agree that I am responsible for satisfying any conditions necessary for insurance or health benefits.

In consideration for medical services rendered, I (we) acknowledge that I (we) have received services rendered by APCA/ASOM and agree to pay for said medical services according to such terms.

Patient (if 18 years or older) / Legal Guardian Signature: ____________________________________ Date:_______________

Self-Pay Agreement

I agree to pay for medical services rendered at APCA/ASOM. I understand that there are payment plans or hardship forms available at my request. I understand that these plans will be based on my financial income and will be reviewed prior to approval.

Patient (if 18 years or older) / Legal Guardian Signature: ____________________________________ Date:_______________

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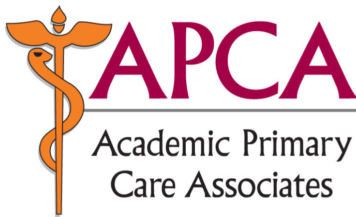


Patient Name: ____ DOB: ____________

Authorization to Treat in Absence of Parent or Guardian (optional)

If my child(ren) is/are brought in to the office by ____________________________________, I consent for my child(ren) to be treated and agree to be financially responsible for the cost of such care. I understand that by not signing this section my child(ren) cannot be seen at APCA/ASOM without myself or another legal guardian present.

Legal Guardian Signature: ____ Date: ____________________

Authorized Person(s) for Protected Health Information Disclosure

I hereby authorize APCA/ASOM to disclose any and all of my medical and Protected Health Information to the person(s) indicated below:

Name	Relationship	Phone #
____________________________	____________________________	__________________________
____________________________	____________________________	__________________________
____________________________	____________________________	__________________________
____________________________	____________________________	__________________________
____________________________	____________________________	__________________________

Patient (if 18 years or older) / Legal Guardian Signature: ______________________________________ Date:_______________

Authorization for Release of Confidential Health Care Information

This authorizes APCA/ASOM to request and receive from the Virginia Department of Health Professions any and all records held by the department relating to schedule 2-5 controlled substances dispensed to the patient named above. I understand that this authorization permits the Dept. of Health Professions to disclose confidential health care records to the prescriber named above (APCA/ASOM). A copy of this authorization shall be included with my original records. There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure as permitted or required by law. I understand that, if not previously revoked, this consent will expire one year after the date of my signature, unless otherwise specified.

Patient (if 18 years or older) / Legal Guardian Signature: ______________________________________ Date:_______________

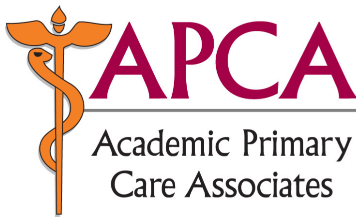
Notification of Appointments /Treatments

APCA/ASOM makes every effort to use your preferred method of communication for appointment reminders, clinical care including laboratory results or any other issues regarding your account with us. With this consent, APCA/ASOM may call my home, cell or other designated location and leave message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment or healthcare operations, such as appointment reminders, insurance items and calls pertaining to my clinical care, including laboratory results among others. We will use the information you have provided, and may consist of leaving messages on voicemail, email, letters, etc.

By signing below, you are giving permission for APCA/ASOM to leave messages on voicemail and speak with the designated person(s) that are listed on the PHI Disclosure.

Patient (if 18 years or older) / Legal Guardian Signature: ______________________________________ Date:_______________

If you choose not to be contacted by one of the methods above, you must notify APCA/ASOM in writing



Patient Name: ____ DOB: ___________

Late Cancellation and No-Show Policy

Late cancellation and no-shows for appointments unnecessarily delay the delivery of health care to other patients.

No-Show Policy:

- A no-show is defined as missing a scheduled appointment without calling us at least 24 hours in advance to cancel the appointment.
- Appointments scheduled for the same day you call will require at least one hour notice of cancellation.
- After the second no-show, a warning letter will be sent clarifying this policy and the potential consequences.
- If there is a no-show for three appointments within a six month period you may be dismissed from the practice.

  If you would like a copy of our "no-show" policy, please ask a receptionist.

Late Arrivals Policy:

If you are more than ten minutes late, you may be asked to reschedule your appointment. Every effort will be made to see the patient the same day.

Patient (if 18 years or older) / Legal Guardian Signature: ___________________________________ Date:_______________

APCA/ASOM Notice

APCA/ASOM is a teaching facility. This practice is a place where medical students come to learn how to be doctors. It is important for them to talk to people about their health and illnesses. This helps them understand how illnesses affect people and how they cope. We would be grateful if you could help us in this teaching. However, this is entirely voluntary. No one will mind if you would rather not see a student, change your mind, or want the student to leave at any time. You can also refuse to see particular students, such as those of a different sex or those you have met outside of the practice. Of course, the care provided to you by the practice will not be affected in any way. By signing this, I understand my rights as a patient regarding medical students being involved in my care.

Patient (if 18 years or older) / Legal Guardian Signature: _________________________________ Date:_____________

Are you (or the person being seen) a VCOM student or a VCOM student family member? Yes____ No____

Please note: If you answered yes to the above question, it is the policy of APCA/ASOM that no other medical student be involved in your or your dependents care. Please notify your nurse upon triage.

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