optimum care
URGENT CARE/PRIMARY CARE

PATIENT REGISTRATION FORM

882 Garrisonville Road
Stafford, Virginia 22554
Ph: 540.318.6464 Fx: 540.628.0179

Reason for visit? _____

Is this your first time? ☐ Yes ☐ No

Last Name: _____ First Name: _____ MI: _____

Sex (check one): ☐ Male ☐ Female Date of Birth: _____ Age: _____

Address: _____ Apt#_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone (Ages 18+ only): _____

Email: _____ Permission to receive informational emails? ☐ Yes ☐ No

Marital Status: (check one): ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Race: (check one): ☐ American Indian ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ White ☐ Decline

Ethnicity: (check one): ☐ Hispanic/Latino ☐ Not Hispanic ☐ Decline Preferred Language: _____

For your convenience we dispense medications at our clinic. However, if you were to choose to purchase your medication from the pharmacy of your choice, which pharmacy would you choose?

Name of pharmacy_____ Location _____

Who is Your Primary Care Physician? (Physician seen in the last two years for routine/primary care)

Name: _____ Specialty? ☐ Internal ☐ Peds ☐ GP/Fam ☐ OBGYN ☐ Other _____

City _____ Phone: _____ Fax: _____

Would you like us to send them a courtesy summary of today's visit notes for your chart there? (check one): ☐ Yes ☐ No

Social Security Number: _____

Emergency Contact: Name: _____ Phone: _____

Relationship to Patient: (check one): ☐ Spouse ☐ Parent ☐ Sibling ☐ Other: _____

Employer Information: Name: _____ Phone: _____

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

Patient Record of Disclosures / Acknowledgement of Notice of Privacy Practices

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I acknowledge that a copy of the current Notice of Privacy Practices is posted in the reception area and that I can request a copy for my personal use at any time.

Indicate your preferred method of communication with us. (check one): ☐ Home Phone ☐ Cell Phone ☐ Email
Indicate your message preference. (check one): ☐ OK to leave detailed message ☐ Leave call-back number only ☐ OK to text

Signed: _____ Date: _____

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Insurance Information

(check one): ☐ Health Insurance ☐ No Insurance / Self Pay ☐ Employer Paid Service ☐ Worker's Compensation

Financially Responsible Party (check one): ☐ Patient/Self ☐ Spouse ☐ Mother ☐ Father ☐ Other: _____

Insurance subscriber (check one): ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Other: _____

Insurance Carrier Name: _____

Insurance Holder's Name: _____ Insurance Holder's Date of Birth: _____

Address (if different from above): _____ Apt#:_____

City: _____ State: _____ Zip Code: _____

Insurance Holder's Phone (if different from above): _____ Cell Phone: _____

Patient's Financial Responsibility Statement

INSURANCE COVERAGE

We do our best to only accept patients' insurance plans that we are contracted with, but it is ultimately the responsibility of the patient to fully understand their plan's benefits including coverage, deductibles, co-payments, co-insurance and participating provider network. **I understand my plan details and accept financial responsibility for all services received, including any charges not covered by my insurance.** Initial: _____

INSURANCE OR SELF-PAY

If your insurance has a high deductible or co-insurance, you may choose to not bill your insurance and pay the Self-Pay price instead. You must decide this before receiving services. Self-Pay fees are due up front at the time of service and no insurance billing will be done on your behalf later. Self-Pay is not an option retroactively or once you have chosen to proceed under your insurance plan.

(check one):

☐ **I wish to use my health insurance. I authorize payment of insurance benefits directly to Optimum Urgent Care.** Initial: _____

☐ **I DO NOT want to use insurance. I wish to Self-Pay for this visit instead.** Initial: _____

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Physician-Patient Arbitration Agreement

Article 1: Agreement to Arbitrate. It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Virginia law, and not by a lawsuit or resort to court process except as Virginia law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must Be Arbitrated. It is the intent of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including without limitation, claims for the loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law. A demand for arbitration must be communicated in writing to all parties. Each party shall an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory common law.

Each party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of Virginia law applicable to healthcare providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgement or summary adjudication in accordance with Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions. All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the Virginia Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation. This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect. If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to emergency treatment) patient should initial below. If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in effect and shall not be affected by the invalidity of any other provision.

Effective as of the date of first medical services: _____
Patient's or Patient's Representative's Initials

I understand that I have a right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I was offered a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ Date: _____
Patient's or Patient's Representative's Signature

By: _____
Print Patient's Name

(A signed copy of this document is to be given to the patient upon request. Original to be filed in patient's chart.)

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INSURANCE AUTHORIZATION AND COLLECTION ASSIGNMENT AGREEMENT

I hereby authorize this office to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company to be made to the above named provider. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical records, to my insurance company in order to determine insurance benefits to which I may be entitled. Either myself or my insurance at any time in writing may revoke this authorization. In the event my account is referred to Commonwealth Financial Solutions, Inc. for collections, I agree to pay all costs incurred in collecting the amount due, including an additional amount of 33 1/3 percent as attorney's/commission fees.

_____

Responsible Party's Name (Printed)_____

Responsible Party's Signature _____