COUNTRYSIDE FAMILY PRACTICE

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Date: _____

Patient Name: _____ Date of Birth:_____ SSN:_____
Last First Middle

Address: _____ Home Phone: (__)_____

City: _____ State: _____ Zip Code:_____ Work Phone: (__)_____

Sex: (M/F)_____ Employed: (Y/N)_____ Employer Name:_____

***Emergency Contact:_____ Phone #: (__)_____
Relationship to Patient :_____

*******Are you here for a Workman's Comp. related matter? (Y/N)_____*******

You must provide all billing information prior to your appointment or payment is due at time of service.

Responsible Party/ Insurance Policy Holder Information:

Name: _____ Date of Birth: _____ SSN: _____

Address: _____ Home Phone: (__)_____

City: _____ State: _____ Zip Code: _____ Work Phone: (__)_____

Relationship to Patient: _____

Primary Insurance:

Insurance Carrier: _____ Effective Date: _____

ID#: _____ Group#: _____ Phone: (__)_____

Claims Address: _____ City: _____ State:____ Zip Code:_____

Secondary Insurance:

Insurance Carrier: _____ Effective Date:_____

ID#:_____ Group#:_____ Phone: (__)_____

Claims Address: _____ City: _____State:____ Zip Code:_____

*****INSURANCE CARD MUST BE PRESENTED AT YOUR APPT OR PAYMENT IS EXPECTED AT TIME OF SERVICE*****

PATIENT CONSENT

I, _____, understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination, test results, diagnosis, treatment, and any plans for care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that upon request I will be provided a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restrictions to the use of disclosure of my health information:

_____

As part of my healthcare treatment, I understand the office may try to contact me by phone.

Please initial the following:

- It is___/is not___ acceptable to leave a message regarding my protected health information including test results on my answering machine.
- It is___/is not___ acceptable to leave a message regarding my protected health information including test results with a member of my household.
- It is___/is not___ acceptable to discuss my protected health information with my emergency contact that I have listed in the event that the office cannot reach me at the phone numbers that I have provided.
- It is___/is not___ acceptable for a member of my household to pick up written Rxs.

By signing and dating below I fully accept/decline the terms of this consent.

_____(Signature) _____(Date)

COUNTRYSIDE FAMILY PRACTICE FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service. Your understanding of our financial policy is an essential element of your care and treatment. If you have any questions, please feel free to discuss them with a member of our staff.

Unless yourself or your health insurance carrier makes other arrangements in advance, payment is due at the time of service. For your convenience, we accept Visa, MasterCard and Discover.

YOUR INSURANCE

We have made arrangements with many insurers and other health plans. We will bill those plans with which we have made an agreement and *will collect any required co-payments at the time of service.*

In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. In this case, charges for your care and treatment are due at the time of service.

Should your account ever become delinquent you will be responsible for all collection and legal fees as well as your outstanding balance.

MINOR PATIENTS (UNDER 18 YEARS OF AGE)

For all services rendered to minor patients, the adult accompanying the patient to their appointment is responsible for payment.

MISSED APPOINTMENTS

In order to provide the best possible service and availability to all of our patients, it is our policy to charge our office visit fee for any appointments not cancelled at least 24 hours prior to the scheduled appointment. Please call us as early as possible if you know you will need to reschedule your appointment.

I have read and understand the financial policy of the practice and agree by its terms. I also understand and agree that such terms may be amended by the practice at any time.

_____(Signature of patient/responsible party)

_____(Printed name) _____(Date)

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NOTICE OF DEEMED CONSENT TO HIV BLOOD TESTING

A law was enacted in Virginia in 1989 which authorizes healthcare providers to test their patients for HIV antibodies **IF/WHEN** the healthcare provider is exposed to body fluids of a patient in a manner which may transmit Human Immunodeficiency Virus (HIV).
Pursuant to this law, in the event of exposure, you will be deemed to have consented to such testing, and to have consented to the release of the test results to the healthcare provider who may have been exposed. However, you will be informed before any of your blood would be tested for HIV antibodies pursuant to this provision. The testing would be explained and you would be given the opportunity to ask any questions you might have.

I HAVE READ AND UNDERSTAND THE ABOVE "NOTICE OF CONSENT"

_____(Signature) _____(Date)

_____(Printed Name)

PROVISIONS FOR ATTORNEY FEES AND PROPER VENUE

Remedies Available Upon Default Under Agreement: In the event of default of non-performance of any term or provision under this agreement, it is agreed that in the event the account is forwarded to an attorney for collection, Countryside Family Practice shall be entitled to recover its costs for collection, including but not limited to attorney's fees of 33 1/3% of all unpaid sums, as well as interest on the unpaid principal balance at the rate of eighteen percent (18%) per annum.

It is further agreed that in the event of any dispute arising under this agreement, such matters shall be resolved through the filing of the appropriate legal action in any court of competent jurisdiction in Fauquier County, Virginia.