Quick Patient Registration Form

Patient Information:

Legal First Name: _____MI: ___ **Legal Last Name**:_____

Sex: M F **Date of Birth:**_____ **Primary Language:**_____

Marital Status: Married Single Partner Divorced Widowed

Race: _____ **Ethnicity:** _____

_____ _____ _____ _____

Address City State Zip Code

_____ _____ _____ _____

Home phone Cell phone Work phone Email

Preferred method of contact (circle one): Home Phone Cell Phone Work Phone Email

Would you like access to the patient Portal? Y N **May we text you?** Y N

Patient Insurance:

Insurance Information: Are you the Primary Cardholder: Y N

If No: **Name of Cardholder**:_____ **Relationship**_____ **DOB** _____

Do you have a Secondary Insurance: Y N

Name of Cardholder:_____ Relationship_____ DOB _____

Is this a Workers Compensation visit? Y N Your social security # _____

If yes: Description of Injury_____Date of Injury:_____

Employer Name:_____Address:_____

Phone:_____Fax_____Supervisor Name_____

Has treatment for today's injury been authorized? Y N If Yes, by whom?_____

Workers Comp Insurance Carrier – W/C Carrier Name_____Contact:_____

W/C Carrier Address_____

W/C Carrier Phone:_____W/C Carrier Fax_____W/C Claim #_____

Your Position/Job:

Pharmacy Information:

Pharmacy Name: _____

Address: _____ Phone: _____

Authorization to Discuss Health Information with Others and/or Leave Telephone Messages:

If we are unable to reach you when we telephone:

- May we leave such information on your answering machine? Y N
- May we leave such information with someone in your household? Y N
  - **If Yes**, please note specifically who: _____
- If you provided a work number, may we contact you at Work? Y N
- Is there someone you have given authority to schedule, confirm or cancel appointments for you? Y N
  - **If Yes**, please specify who: _____

Patient Signature:_____**Date/Time**

History Intake Form

Patient Name:_____Date of Birth:_____

Allergies:

Circle answers below:

Asthma	**Yes**	**No**	**Heart Disease/Heart Attack**	**Yes**	**No**	**Kidney Disease**	**Yes**	**No**
Diabetes	**Yes**	**No**	**High Blood Pressure**	**Yes**	**No**	**Stroke**	**Yes**	**No**
GI/Bowel Disease	**Yes**	**No**	**High Cholesterol**	**Yes**	**No**	**Thyroid Disease**	**Yes**	**No**
Cancer	**Yes**	**No**	**If Yes, specify:**					

List any other Major illness:

_____

_____

List any surgery:

_____

_____

Hospitalizations Date/Reason (other than surgery or Childbirth):

_____

_____

List any medications you are currently taking, including non-prescription, herbal and vitamins:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Family History, if you answer *Yes* list who in your family is affected:					
Cancer	**No**	**Yes:**	**Heart Disease**	**No**	**Yes:**
Diabetes	**No**	**Yes:**	**High Blood Pressure**	**No**	**Yes:**
Stroke	**No**	**Yes:**	**Kidney Disease**	**No**	**Yes:**

Social History				
Smoker		**Yes**	**No**	
If No, Did you ever Smoke		**Yes**	**No**	
Alcohol	**None**	**1-7 week**	**8-14 week**	**>14 week**

Other Significant Family History:_____

_____

Patient Signature:_____**Date/Time**_____

*Valley Medical Group is the "trading as" name for Valley Physician Services, Inc., Valley Medical Services, Inc.,, and Valley Physician Services, NY, PC

GENERAL CONSENT FOR TREATMENT

1. I, _____, hereby consent to treatment by the Valley Medical Group (VMG)* and its physicians, staff and/or agents. I understand that my treatment may include testing (for example, x-rays and blood tests), routine care and procedures (for example injections), and evaluation (for example, interviews and physical exams). This general consent does not include consent for invasive procedures (for example, surgery), which require a separate consent process. I understand that the practice of medicine is not an exact science and no guarantees have been made to me about the outcome of my care and treatment. I acknowledge VMG's authority to dispose of specimens taken for laboratory or pathology examination according to its usual procedures.

2. I understand and agree that VMG may have access to my medical and billing information. I understand that under the law this information may be used and disclosed for treatment, payment and healthcare operations. I understand and agree that the information disclosed about me may include information about and/or reference HIV/AIDS related diagnoses/conditions, drug or alcohol use or abuse, pain management and psychiatric or psychological information, reports, evaluations and diagnoses, as well as history and physical examinations results, consultations and treatment recommendations. VMG is authorized to disclose all or part of my information as set forth above, unless I object in writing.

3. I understand that in order to facilitate my care and treatment, VMG may need to access information about me, including my prescription history and information from my other providers and facilities where I have received care and services, such as specialists, diagnostic centers, and laboratories.

4. After treatment is received, I agree to follow the medical advice and instructions given by VMG and to continue treatment and follow-up care as recommended by VMG.

5. I understand and agree that I am financially responsible to pay for any services I receive in accordance with the regular rates and terms of VMG. I agree to make prompt payment to VMG for any and all charges not paid for by my health insurer or payor, to the fullest extent permitted by law.

6. I understand that my health insurer or payor may require that I obtain pre-certification and/or pre-authorization for the services provided to me, and that I am responsible for any charges for health care services that are not pre-certified and/or pre-authorized. I acknowledge that it is my responsibility to understand my insurance coverage requirements, benefits and limitations.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS GENERAL CONSENT FOR TREATMENT, AND THAT ANY QUESTIONS THAT I HAD ABOUT IT HAVE BEEN ANSWERED TO MY SATISFACTION BY THE STAFF OF THIS FACILITY.

_____ _____

Patient or Authorized Representative Signature | Date and Time

_____ _____

Name of Person Signing | Relationship to Patient

The patient is unable to consent because:

_____

*Valley Medical Group is the "trading as" name for Valley Physician Services, Inc. and Valley Medical Services, Inc. and Valley Physician Serivices, NY, PC

Valley Medical Group
Valley Health System

ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge by signing below that I have received or have been given the opportunity to receive a copy of Valley Medical Group Notice of Privacy Practices.

HIPAA

_____
Patient Name (please print clearly)

_____ _____
Patient/Guardian Signature Date and Time

_____ _____
Person Signing on behalf of the patient (please print clearly) Relationship to Patient

*Valley Medical Group is the "trading as" name for Valley Physician Services, Inc., Valley Medical Services, Inc., and Valley Physician Services, NY, PC

PATIENT RESPONSIBILITIES AND STATEMENT OF UNDERSTANDING

In the current healthcare environment, it is increasingly difficult for medical providers to be paid for their services. Dealing with insurance companies is also becoming more confusing to our patients. As a result, we would like to clarify your responsibilities as a Valley Medical Group patient.

Insurance Coverage

- Your insurance policy is a contract between you and your insurance company, not your provider.
- Changes to your insurance coverage must be communicated to our office at the time of service upon check-in.
- Your insurance company may require you to choose a primary care physician in order to receive "in network benefits". If you have chosen a Valley Medical Group physician as your PCP and his or her name does not appear on your insurance card, you must verify that your insurance company has the correct information before services are rendered.
- If your claim is processed incorrectly by your insurer, you give Valley Medical Group permission to appeal the claim on your behalf by your signature below.
- If your insurance plan requires a PCP and the Valley Medical Group physician is not your PCP, you may be responsible for deductibles, co-insurance, and other non-covered services.
- If your plan requires referrals from your Valley Medical Group PCP to specialists, it is your responsibility to obtain the referral from our office prior to your appointment with the specialists. Please be aware that non-emergent referrals can take up to two weeks to process. In addition, referrals will **NOT** be dated retroactively.

Financial Obligations

1. Co-payments are due at the time of service.
2. Valley Medical Group will bill participating insurance companies after verifying coverage. If claims are not paid, Valley Medical Group will bill you for services rendered.
3. Payment for non-covered services, deductibles, and co-insurance amounts are due within thirty (30) days of receipt of invoice.
4. If insurance payments are paid to you in error instead of Valley Medical Group, the payment must be forwarded to us. You may issue a personal check to Valley Medical Group. Be sure to include a copy of your insurance company's documentation or explanation of benefits.
5. If you do not have insurance that Valley Medical Group participates with, you are responsible for payment in full for today's services.
6. Processing fees may be imposed for non-payment of out-of-pocket expenses referenced in #1 and #5 above, and for checks returned by the bank for non-payment.
7. Valley Medical Group bills an additional fee for weekend and holiday visits.
8. If requested, you are responsible for providing your insurance company with any other insurance coverage, details of an injury, dependent student information, and other non-medical information. Failure to comply with an insurance company request for information will result in your being responsible for payment.

I HAVE READ AND UNDERSTAND THE INFORMATION AND MY RESPONSIBLITIES AS STATED ABOVE:

Patient/Guardian:_____ Date: _____

Witness:_____ Date: _____

A copy of this form is available upon request.

Valley Medical Group
Valley Health System

Date: _____

E-Prescribing/Medication History Consent Form

Patient Name: _____ Date of Birth: _____

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program. These include:

- Formulary and benefit transactions – gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notification – allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form, you are agreeing that Valley Medical Group* can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Valley Medical Group to enroll me in the e-Prescribe Program. I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Witness to Signature(s) Patient's or Authorized Representative's Signature

_____

Relationship to Patient

*Valley Medical Group is the "trading as" name for Valley Physician Services, Inc., Valley Medical Services, and Valley Physician Services, NY