NVPCCA PATIENT REGISTRATION FORM

TODAYS DATE:

PATIENT DEMOGRAPHICS (PLEASE PRINT)

First Name	M.I.	Last Name	Primary Language	Date of Birth	Age

Address	Apt #	City	State	Zip

Please check the box that best corresponds with your primary phone number:

Home Phone #: ❑	Work Phone #: ❑	Cell Phone #: ❑	Best Method for Appointment reminders:	SSN
( )	( )	( )	❑ Call ❑ E-mail (please provide) ❑ Text E-mail:_____	

Marital Status:
❑ Single
❑ Married
❑ Divorced
❑ Separated
❑ Widowed
❑Other_____

Sex
❑ M
❑ F
❑ Other

Emergency Contact Name & Phone Number:

Relationship to the Patient:

Race: (*Required by the Federal Government for for the use of Electronic Medical Records)
❑ White ❑ Asian
❑ American Indian ❑ Black/ African American
❑ Native Hawaiian/Pacific Islander
❑ Declined ❑ Other _____

Ethnicity
❑ Hispanic
❑ Non- Hispanic
❑ Declined

Family Doctor:	Family Doctor Phone #:	Referring Doctor: (Required)	Referring Doctor Phone #:

Preferred Pharmacy
Name, Address & Tel #: _____

Mail Order Pharmacy Name (If Applicable): _____

RELEASE OF HEALTH INFORMATION

I understand that NVPCCA may use and disclose my health information for those purposes disclosed in NVPCCA's Notice of Privacy Practices, a copy of which I may obtain upon request. I authorize NVPCCA, or its physicians to transmit my health information electronically, via U.S. mail, or facsimile in conformance with NVPCCA's Notice of Privacy Practices or pursuant to an authorization. I release NVPCCA and its physicians from any liability associated with a misdirection of transmission or communication of health information, or failure to receive such a transmission or communication via any medium. With my signature below, I also authorize Northern Virginia Pulmonary & Critical Care Associates, P.C. to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

ASSIGNMENT OF BENEFITS

With my signature below, I authorize Northern Virginia Pulmonary & Critical Care Associates, P.C. to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim. I hereby authorize any of the above insurance carriers with whom I have a policy to make payment directly to Northern Virginia Pulmonary & Critical Care Associates, P.C. If such amounts due to NVPCCA are not paid after reasonable notice, that account shall be deemed delinquent. In the event that I default on payment of my account, I agree to be responsible for collections fees and interest due on amounts in default, including court costs and attorney's fees. If the debt is assigned to a third party for collections, I agree to be responsible for collection fees and interest due on amounts in default. This assignment will remain in effect until revoked by me in writing. I understand that I have primary financial responsibility for all charges whether or not paid by my insurance company. I authorize the release of any medical information necessary to process these claims. Further, I acknowledge receipt of and agree to abide by Northern Virginia Pulmonary & Critical Care Associates, P.C. Financial Policy.

_____ _____
Signature of Patient or Patient's Representative Date

TO ALL MEDICARE & MEDIGAP PATIENTS:

I request that payment of authorized Medicare & Medigap benefits which are payable to me be paid directly to NVPCCA or its physicians on my behalf, for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to be released to the centers for Medicare and Medicaid Services to determine these benefits or the benefits payable for related services.

_____ _____
Signature of Patient or Patient's Representative Date

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NVPCCA INSURANCE FORM

Today's Date:

Check box if you are:

❑ Self-Pay (No need to fill out remainder of page) ❑ Worker's Compensation (Fill out Worker's Compensation section)

WORKER'S COMPENSATION

Company Name:	Case Manager Name & Contact Phone Number:	Patient Social Security #:

Policy #:	Date of Injury:	Claim Mailing Address:

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Name: _____ Effective Date:_____

Member ID# : _____ Group #: _____

Is the insurance plan thru an employer? ❑ Yes ❑ No

Is the policy holder the patient (Self)? ❑ Yes ❑ No

If no, please provide the policy holders information: →

Specialist Copay: $ _____

Policy Holder:

Insured Name: _____ DOB: _____

SSN: _____ Sex: ❑ M ❑ F ❑ Other _____

Relationship to Patient: ❑ Child ❑ Spouse ❑ Other _____

Is the address the same as the patient?
❑ Yes ❑ No (If no, please provide address below)

Address: _____

_____
City State Zip

SECONDARY INSURANCE

Insurance Name: _____ Effective Date:_____

Member ID# : _____ Group #: _____

Is the insurance plan thru an employer? ❑ Yes ❑ No

Is the policy holder the patient (Self)? ❑ Yes ❑ No

If no, please provide the policy holders information: →

Specialist Copay: $ _____

Policy Holder:

Insured Name: _____ DOB: _____

SSN: _____ Sex: ❑ M ❑ F ❑ Other _____

Relationship to Patient: ❑ Child ❑ Spouse ❑ Other _____

Is the address the same as the patient?
❑ Yes ❑ No (If no, please provide address below)

Address: _____

_____
City State Zip

TERTIARY INSURANCE

Insurance Name: _____ Effective Date:_____

Member ID# : _____ Group #: _____

Is the insurance plan thru an employer? ❑ Yes ❑ No

Is the policy holder the patient (Self)? ❑ Yes ❑ No

If no, please provide the policy holders information: →

Specialist Copay: $ _____

Policy Holder:

Insured Name: _____ DOB: _____

SSN: _____ Sex: ❑ M ❑ F ❑ Other _____

Relationship to Patient: ❑ Child ❑ Spouse ❑ Other _____

Is the address the same as the patient?
❑ Yes ❑ No (If no, please provide address below)

Address: _____

_____
City State Zip

For all Medicare patients:

Please check box if you are you currently:

❑ Enrolled in Hospice Name _____ Telephone #:_____

❑ Skilled Nursing Facility Name _____ Telephone #:_____

If you are 65 or older, are you or your spouse working? ❑Yes ❑ No

FOR OFFICE USE ONLY:

INITIALS:

Northern Virginia Pulmonary & Critical Care Associates, P.C.
Office Policies & Procedures

ACCEPTED INSURANCES
Northern Virginia Pulmonary & Critical Care Associates, P.C accepts most major insurance plans. It is your responsibility to verify that the physician and/or facility in which you are seeking treatment is covered by your insurance plan. Failure to provide complete insurance information may result in the denial of your claim. Your insurance company may also require you to supply certain information to them directly. It is your responsibility to provide this information and you may be held responsible for any services denied.

WORKERS COMPENSATION
It is your responsibility to provide our office staff with all the information required for the submission of a workman's compensation claim. Failure to obtain this information may result in rescheduling your appointment or the need to pay in full at the time the service is rendered.

FINANCIAL POLICY AND MISC FEES
We collect all co-pays at the time of service. For your convenience, we accept cash, check, and/or credit cards. If you are unable to pay your bill in its entirety, please contact our billing office to discuss payment options. If your account becomes delinquent and you have not established or met payment options with our billing office, your account will be turned over to a collection agency. Non-Sufficient Funds (NSF) checks are subject to a $25.00 fee, in addition to fees from your bank.

REFERRALS
Obtaining referrals and verifying their validity for each visit is the responsibility of the patient. All referrals must be hand carried to our office or faxed to the office prior to your appointment. Should you come to an appointment without the proper referral, your appointment will be rescheduled for a later date and you may be held responsible for any charges incurred.

CANCELATIONS/NO SHOWS
Patients that fail to provide 24 hours' notice to cancel or reschedule an office appointment, are subject to a $50.00 missed appointment fee and any patients that fail to provide a 48 hour notice to cancel or reschedule an office test (Pulmonary Function Test/ Methacholine Challenge Test) are subject to a $100.00 fee. This fee is not covered by your insurance plan and is your responsibility. Please be sure to update your phone number and contact information with our staff at every visit.

LATE ARRIVALS
Any established patient that arrives more than 15 minutes late may be asked to reschedule their appointment. All new patients are required to arrive 30 minutes prior to the scheduled appointment time in order to complete paperwork and registration. New patients who fail to arrive 15 minutes prior to the scheduled appointment time with completed forms may be asked to reschedule.

MEDICAL RECORDS
Current reports and dictations generated in our office will be transmitted to your referring physician electronically. Requests for medical records must be made in writing and may take up to two weeks to complete. Disability forms and legal paperwork are subject to a charge of $25.00 or more.

PRESCRIPTION REFILLS/RENEWALS AND PRIOR AUTHORIZATIONS
Prior authorization and prescription requests take 2-3 business days to process. Please remember to monitor your refill dates and plan accordingly. It is strongly recommended you check the status of your prescription with your pharmacy before contacting the office.

By signing below, I acknowledge that I have reviewed, understood, and may receive a copy of this form upon request. I will comply with the policies and procedures explained in the OFFICE POLICIES & PROCEDURES form.

_____	_____	_____
Signature of Patient or Representative	Relationship to Patient	Date