PATIENT INFORMATION

Name: _____

Sex: _____ Date of Birth: _____

Social Security #:_____

Address: _____

Apt # _____ City: _____

State: _____ Zip: _____

Primary Phone: _____

Primary Phone Type: Cell Home Work

Secondary Phone: _____

Secondary Phone Type: Cell Home Work

Email: _____
(Email addresses listed here are used for appointment reminders and newsletters only)

Preferred Contact Method: Cell Home Work Email

Race: _____ Ethnicity_____

Preferred Language: _____

Employer: _____

Relationship Status: Married Single Divorced Other

PARENT/GUARDIAN INFORMATION (REQUIRED IF PATIENT UNDER 18 YEARS OF AGE)

Name: _____

Relationship to patient: _____

Sex: _____ Date of Birth: _____

Social Security #:_____

Address: _____

Apt # _____ City: _____

Primary Phone: _____

Phone Type (Circle one): Cell Home Work

EMERGENCY CONTACT [ ] Same as Parent/Guardian

Name: _____

Relationship: _____

Phone number: _____

_____

Patient Signature

_____

Parent/Guardian Signature (If other than Patient)

_____

Date

PRIMARY INSURANCE

Ins Co. Name: _____

Member ID: _____

Group #:_____

Phone number: _____

Do you have any other insurance? _____NO _____YES

PRIMARY POLICYHOLDER

[ ] Same as Patient [ ] Same as Parent/Guardian [ ] Other

Relationship to Patient: _____

Name: _____

Sex: _____ Date of Birth: _____

Social Security #:_____

Address: _____

Apt # _____ City: _____

State: _____ Zip: _____

Primary Phone: _____

Phone Type (Circle one): Cell Home Work

Employer: _____

GUARANTOR

The individual responsible for payment of charges incurred for services rendered at our office. If this is someone other than the Primary Policyholder, please list their information below.

Relationship to Patient: _____

Name: _____

Sex: _____ Date of Birth: _____

Address: _____

Apt # _____ City: _____

State: _____ Zip: _____

Primary Phone: _____

Phone Type (Circle one): Cell Home Work

New Patients: How did you hear about VHP or VP?

- ☐ Google
- ☐ VHP Website
- ☐ Advertisement
- ☐ Health Fair
- ☐ Employer
- ☐ E-mail
- ☐ D Magazine
- ☐ Insurance Website
- ☐ Direct Mail
- ☐ Angie's List
- ☐ Physician Referral
- ☐ ZocDoc, 1-800 Doctors, RateMD
- ☐ Family/Friend:_____
- ☐ Another Patient: _____
- ☐ Other:_____

Patient Medical History

Name:_____ **Date:**_____

Please Circle any illness or condition you have had:

ADD
Abnormal Pap smear
Alcoholism
Allergies
Anemia
Anxiety
Arthritis
Asthma
Back pain, chronic
Breast cancer
Colon polyp
Depression (current)
Depression (past)
Diabetes Type I
Diabetes Type II
Diabetes, gestational
Diverticular disease
Eczema
Endometriosis
Erectile dysfunction
Fibromyalgia
Genital herpes
Heart disease
Glaucoma
Hemorrhoids
High cholesterol
High blood pressure
Irritable bowel
Kidney stones
Low thyroid
Migraine
Obesity
Osteoporosis
Osteopenia
Postmenopausal
Prostate enlargement
Reflux
Rheumatoid arthritis
Seizure disorder
Sleep apnea
Stroke
Tobacco use

SURGERIES
Appendix
Ear Tubes
Gall bladder
Heart bypass
Hernia repair
Knee ACL
Knee other
Lumbar back
Neck C-spine
Shoulder
Tonsils

Women
Breast augmentation
C-section
Hysterectomy
Tubal ligation

Other: _____

Family History (Please include any medical illnesses and cause of death)

Father:_____

Mother:_____

Siblings:_____

Other:_____

Social History (Please circle Yes or No)

Occupation:_____

Tobacco Use: YES/NO - Type:_____

Alcohol Use: YES/NO - How Often:_____

Exercise: YES/NO - How Often:_____

Routine Health Screening (Most recent Dates)

Colonoscopy: _____

Mammogram: _____

Pap Smear: _____

Bone Density: _____

Tetanus Booster:_____

Medications (Please include "over the counter meds" as well)

Name	Strength	How Often

Drug Allergies (include reaction):_____

Non-drug Allergies (include reaction)**:**_____

Pharmacy Name & Location: _____

AUTHORIZATION and CONSENT AGREEMENT

Thank you for reviewing our Financial and Office Policies and Notice of Privacy Practices. Please sign in the spaces provided below to acknowledge receipt of this information, and to enter your authorized contacts.

ASSIGNMENT of BENEFITS

I authorize direct payment to be made to the physicians of Village Health Partners (VHP) or Village Pediatrics (VP) for any and all medical or surgical services rendered. I also authorize the release of any medical records for the purpose of my healthcare services.

FINANCIAL AND OFFICE POLICIES

I have read and understand the Financial and Office Policies of VHP and agree to abide by its guidelines.

HIPAA

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I can request a copy of this notice at any time. I have the right to review the notice prior to signing this consent.

I have had the opportunity to receive and review the Notice of Privacy Practices of Village Health Partners and Village Pediatrics.

APPROVED HIPAA CONTACTS

Disclosure of Protected Health Information

Keeping information private is important to us and by default we will only disclose information related to the patient's **Billing Account** and **Medical Conditions** to the **patient** or **legal guardian**. Please note, in order to share protected health information with your spouse they must be listed as an approved contact.
The following names are people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for VHP to share my protected health information with:

Contact Name	**DOB**	**Relationship to Patient**
Contact Name	**DOB**	**Relationship to Patient**

CONSENT and AGREEMENT

I have carefully reviewed this document and agree to fully comply with guidelines defined herein related to the Assignment of Benefits, Financial Policy, HIPAA Policy and Approved HIPAA contacts. The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any personal health information.

Patient's Name (Please Print)	**Patient's DOB**
Signature of Patient, Parent, or Legal Guardian	**Date**

VILLAGE HEALTH PARTNERS

CONSENT TO TREAT A MINOR

By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

This is a legal document. With it you may appoint anyone who is over the age of 18 years of age to be responsible for your child when you are unable to accompany them to their medical appointment.

Minor's full name _____ Date of Birth: _____
Last Name First Name Middle Name

For those occasions when you may not be with your child, please list those individuals who may give us consent to see your child:

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

o Check here if you wish to give consent for the minor to receive medical care without an accompanying adult, which shall be in effect for:
o _____, days only, or
o indefinitely, until revoked by written communication.

Please be advised that we will not be able to perform any invasive procedures unless a parent or legal guardian accompanies the minor to their appointment. If such services need to be performed, another appointment will need to be scheduled in which the parent must be in attendance.

It is the policy of this office that the adult presenting the child or the child alone for treatment is responsible for payment of the patient portion at the time of service.

I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand.

X_____ _____ _____
Parent's/Guardian Signature Relationship to Patient Date

Patient Portal Consent – Access to Your Child's Record

To sign up for access to your child's record through our secure patient portal, please complete this form. Your child's chart will be accessed through your account. If you do not currently have an account, one will be created for you. Please note, your child's record may only have one managing parent/guardian at any given time and all communications will be sent only to that account manager.

Parent/Guardian Information: (All sections required)

Name (last, first, middle initial) _____

Relationship to Patient: _____

Date of Birth: _____ Phone Number: _____

Address: _____

Please provide the email address you would like them to be notified of secure messages

Email Address: _____

To avoid duplicate accounts for you and your family, tell us if you, the parent/guardian, is a patient at Village Health Partners, you may already have an account to which we will link your child's record to.

- ☐ I am patient with Village Health Partners and have a patient portal account
- ☐ I am a patient with Village Health Partners and do not have a patient portal account
- ☐ I am NOT a patient with Village Health Partners

The following are age range limitations for our secure patient portal. These age range limitations do not affect any legal right you have to access your child's record by other means. To request a paper copy of your child's record, contact our office.

- If your child is **age 0-17**, you will be granted full access to your child's record through the portal.
- Once your child reaches **age 18**, you will no longer have access to their record unless they take the required steps to request that you be granted access.

Please provide the following information for each child: (All fields are required. If you have more than 4 children for whom you are requesting access, please request another form).

A. Name (last, first, middle initial): _____
   Date of Birth: _____
B. Name (last, first, middle initial): _____
   Date of Birth: _____
C. Name (last, first, middle initial): _____
   Date of Birth: _____
D. Name (last, first, middle initial): _____
   Date of Birth: _____

- I understand that the patient portal is intended as a secure online source of confidential medical information. If I share my user ID and password with another person, that person may be able to view me or my family member's health information.
- It is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.
- I understand that the patient portal contains selected, limited medical information from me or my family member's medical record and that it does not reflect the complete contents of my medical record. I also understand that a paper copy of my records may be requested from the clinic.
- I understand that my activity within the patient portal may become part of my medical record.
- I understand that access to the patient portal is provided by VHP/VP as a convenience to its patients and has the right to deactivate access to the portal at any time for any reason. I understand that use is voluntary and I am not required to use the portal.
- By signing below, I acknowledge that I have read and understand this Patient Portal Communication Consent and agree to its terms.

_____ _____

Signature **Date**

Financial and Office Policies

[illegible]

Patient Responsibility: [illegible]

Proof of Insurance: [illegible]

Co-pay, coinsurance and deductibles: [illegible] Payment not made at the time of service will incur a $25 processing fee.

Payment made in full at time of Service: [illegible]

Claims submission: [illegible]

Nonpayment: [illegible]

Returned Checks: [illegible]

After-Hours Fee: [illegible]

Late Arrivals: [illegible]

No shows: [illegible] Failure to do so will result in a $25 no show fee that is not covered by your insurance. A third no show may result in dismissal from the practice.

Prescriptions: [illegible]

Insurance Carriers Requiring Referral: [illegible]

[illegible] [illegible]