WINCHESTER FAMILY PRACTICE, PC

WELCOME TO OUR OFFICE TODAY'S DATE: ____________

Patient Name: ____
First Middle Last

Date of Birth: ______________________ SSN: ______________________

Physical Address: ____
Street City State Zip

Mailing Address: ____
P. O. or Street City State Zip

Phone Numbers: (Home) __________________ (Work) __________________

(Cell) __________________ (Email) __________________

Employer: ____

Race: __________ Ethnicity: __________________ Language: ______________

Emergency Contact / Relationship: ______________________________

Phone Number: ____

Insurance Policy Holder Name (if different from above): ______________________

Date of Birth: ______________________ SSN: ______________________

Employer: ____

CONSENT TO TREAT A MINOR

If patient is a minor, please sign below to authorize treatment with or without the presence of a parent or guardian, as considered necessary by the medical providers of Winchester Family Practice, PC.

____
Patient or Parent/Legal Guardian

CONSENT TO SHARE INFORMATION

I authorize the release of any necessary information, including medical information to my insurance carrier and to other healthcare providers that are directly involved in my care. A copy of the authorization may be used in place of the original. This authorization may be revoked by me at any time in writing.

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Patient or Parent/Legal Guardian

PAYMENT / INSURANCE INFORMATION

- ☐ I have provided a copy of my current insurance card (s).
- ☐ Self Pay – Services provided are payable in full at the time of visit, unless other arrangements have been made with the office prior to appointment.
  - I pay for my healthcare out of pocket.
  - I do not have the insurance information to bill.
  - I have insurance that Winchester Family Practice, PC does not participate with.

I certify that the information I have provided is correct. If I have health insurance I authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to Winchester Family Practice, PC. I am financially responsible for any unpaid balance. If my unpaid account is turned over for collection, I understand I will be responsible to pay all reasonable costs of collection, including attorney's or collection agency's fees.

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Patient or Parent/Legal Guardian

OFFICE POLICIES

- Schedule all appointments.
- Co-pays, as required by your insurance, are payable on the day of service.
- Failure to make monthly payments on an outstanding balance may result in termination.
- Allow **2 weeks** for us to dictate on Diatell the results of any non urgent labs or test.
- For Rx refills please call your pharmacy and have them fax us a request. Allow a **5 to 7 day** turnaround time for all refills.
- A 24 hour advance notice is required for all cancelled appointments. If you do not call, there is a $25.00 fee for missed appointments.

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Patient or Parent/Legal Guardian

WINCHESTER FAMILY PRACTICE, PC

PERSONAL HEALTH INFORAMTION CONSENT FORM

Name: ______________________________ Date: ______________

Winchester Family Practice may discuss my medical condition/information with the following:

	Yes	No
Spouse	**O**	**O**
Parents	**O**	**O**
Children	**O**	**O**
Friends	**O**	**O**

If YES was Checked to any of the above, please list the person's name and their relationship to the patient below:

Name of Person	Relationship

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of Winchester Family Practice PC's Notice of Privacy Practices.

______________________________ ______________

Signature of Patient or Personal Representative Date

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Relationship to patient if signed by personal representative

1440 Amherst Street · Winchester · VA 22601 Phone (540) 450-3339 Fax (540) 450-3338