~ NORTHERN VIRGINIA FAMILY MEDICINE ~

PATIENT REGISTRATION

*PATIENT INFORMATION:

FIRST_______________________ M.I______ LAST ______________________ DOB______/______/_________ SEX________

SSN_____________________________________ MARITAL STATUS (CIRCLE ONE) MARRIED SINGLE

ADDRESS____

CITY____________________________________ STATE______________________ ZIP CODE______________________________

HOME (___________) _____________________________________ CELL (___________) _____________________________________

WORK (___________) _____________________________________ EMPLOYER _____________________________________

EMAIL____

*PRIMARY INSURANCE INFORMATION (INSURANCE CARD REQUIRED AT EACH VISIT)

INSURANCE CO NAME_______________________________ POLICY #____________________________ GROUP #________________

SUBSCRIBERS NAME____ SUBSCRIBERS DOB______/______/_________

SUBSCRIBERS SSN____ EFFECTIVE DATE OF COVERAGE______/______/_________

SUBSCRIBERS ADDRESS____

CITY____________________________________ STATE______________________ ZIP CODE______________________________

SUBSCRIBERS EMPLOYER____

*SECONDARY INSURANCE INFORMATION

INSURANCE CO NAME_______________________________ POLICY #____________________________ GROUP #________________

SUBSCRIBERS NAME____ SUBSCRIBERS DOB______/______/_________

SUBSCRIBERS SSN____ EFFECTIVE DATE OF COVERAGE______/______/_________

SUBSCRIBERS ADDRESS____

CITY____________________________________ STATE______________________ ZIP CODE______________________________

SUBSCRIBERS EMPLOYER____

*PARENT/ SPOUSE/ EMERGENCY CONTACT INFORMATION

NAME____RELATIONSHIP TO PATIENT______________________________

ADDRESS____

CITY____________________________________ STATE______________________ ZIP CODE______________________________

HOME (___________) _____________________________________ CELL (___________) _____________________________________

WORK (___________) _____________________________________ EMPLOYER _____________________________________

I authorize my insurance benefits to be paid directly to the physician and I agree to be financially responsible for all changes incurred. I hereby consent to the release and re-disclosure of my medical records to enable or facilitate the collection, verification, or settlement of my account for any amounts due from me or any third-party payer, Health maintenance organization, insurer or other health benefit plan. This consent applies to Northern Virginia Family Medicine (NVFM), or any of its affiliates or agents, lenders, or any third-party servicer acting for NVFM or any of its affiliates.

I agree to pay for services rendered to me or the above-named patient at the time of service or upon receipt of the first statement mailed by NVFM. If I fail to meet my financial commitment to NVFM and it becomes necessary to take further action to collect on the above-named patients account, I agree to pay all costs and expenses incurred in such collection processes, including attorney and collection agency fees. The fee NVFM charges to turn accounts over to a collection agency is $25.00. I further agree to pay for any missed appointments of which I did not notify the medical office within a reasonable time.

I authorize NVFM to test my blood for hepatitis and/or the AIDS virus, if in their opinion, an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration.

I ______________________________________ (Print Full Name), AS THE FINANCIALLY RESPONSIBLE PARTY TO THE ABOVE NAMED PATIENT AGREE TO THE AFOREMENTIONED STATEMENTS AND AUTHORIZED PAYMENT OF MEDICAL BENEFITS TO NORTHERN VIRGINIA FAMILY MEDICINE FOR SERVICES RENDERED.

*SIGNED____ DATE ______/______/_________

NORTHERN VIRGINIA FAMILY MEDICINE, PC

*AUTHORIZATION TO DISCLOSE MEDICAL/FINANCIAL INFORMATION

This authorization permits Northern Virginia Family Medicine, PC to disclose any Medical/Financial information on my:
________ Home answering Machine/ Voice Mail
________ Cell Answering Machine/ Voice Mail
Or mailed to my home address (as provided on my registration sheet). I understand that as a patient, I am responsible for updating and correcting any changes in the above information in my file.

I authorize the following individuals to receive any medical/financial information regarding my care at Northern Virginia Family Medicine, PC:

_______________________________________ Relationship to Patient: _______________ Phone: ________________________

_______________________________________ Relationship to Patient: _______________ Phone: ________________________

_______________________________________ Relationship to Patient: _______________ Phone: ________________________

I understand that as a patient, I have the right to revoke this authorization in writing, except to the extent that action be taken in reliance on this authorization or, if applicable, during a contestability period. In order for revocation of this authorization to be effective, Northern Virginia Family Medicine, PC must receive the revocation in writing.

The revocation must include:

1) The patient's name, address and patient number, if applicable
2) The effective date of this authorization and recipients of the protected health information according to this authorization.
3) A statement of the patient's desire to revoke this authorization
4) The date of the revocation and the patient's signature

Northern Virginia Family Medicine, PC will accept written revocation of this authorization via certified U.S. mail, facsimile at 703-369-5003, or personal hand delivery. All revocations must be sent to Northern Virginia Family Medicine, PC, to the attention of the Office Manager, Jennifer Moses, and are not effective until received.

I fully understand and accept the terms of this authorization. I understand I am responsible for changing this information with the office if there are any changes.

____ ______/______/_________
Patient's Signature

____

Patient's Name (Please Print)

Northern Virginia Family Medicine
Dr. Parimal Desai, MD
Andrea Carter, PA-C ~ Tara Smith, PA-C ~ Priscilla A. Serrano, PA-C

9001 Digges Rd Suite105
Manassas, VA 20111
Ph: 703-369-5000
Fax: 703-369-5003

24805 Pinebrook Rd Suite 317
Chantilly, VA 20152
Ph: 703-722-1000
Fax: 703-722-3797

General Waiver

I accept financial responsibility for any amounts not covered by my insurance including, but not limited to: non-covered procedures, co-pays, co-insurance amounts and deductibles.

____ ______/______/________
Patient's Signature

I understand that NVFM requires patients to be seen every three months for routine medications. If I am not able to come into the office due to an extenuating circumstance, I am aware that calls for medical advice and/or medication refills may result in a charge to me and/or my insurance provider.

____ ______/______/________
Patient's Signature

PCP Waiver

I understand that my insurance may require Northern Virginia Family Medicine, **Dr. Parimal Desai** be listed as my Primary Care Physician, currently or in the future. Failure to do so on my part may result in financial repercussions and I accept responsibility should this occur.

____ ______/______/________
Patient's Signature

NORTHERN VIRGINIA FAMILY MEDICINE, PC

Notice of Privacy Practices
Acknowledgement of Receipt

9001 Digges Rd Suite 105
Manassas, VA 20110
703-369-5000

24805 Pinebrook Rd Suite 317
Chantilly, VA 20152
703-722-1000

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Northern Virginia Family Medicine. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

If you have any questions about our Notice of Privacy Practices, please as to speak with the office manager.

I acknowledge receipt of the Notice of Privacy Practices of Northern Virginia Family Medicine.

Signature: ____ Date _____/_____/_______

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

(STAFF USE ONLY)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts make to obtain the individual's acknowledgement. And the reasons why acknowledgement was not obtained:

____

____

____

____

Signature of provider representative: ______________________________Date_____/_____/_______

NORTHERN VIRGINIA FAMILY MEDICINE, PC

CANCELLATION POLICY

Dr. Desai and staff appreciate your patronage and look forward to caring for you as a patient. We strive to accommodate all of our patient needs and respect that you too, have a busy schedule. An unfortunate reality is that sometimes people make appointments and do not show up or give us 24-hour notice. To cut back on this and be fair to all our patients, we are instituting the following cancellation policy:

- Missed office visits will be charged a $50.00 No Show/Same Day Cancelation fee.
- Please be aware this fee if incurred is NOT covered by insurance.
- Multiple missed appointments (3 or more) may result in dismissal of patient from practice.

By signing below, you agree to adhere to this policy.

With regards,
Dr. Desai and Staff

____ ______/______/________

Patient's Signature Date