Alesia W. Griffin, M.D., F.A.A.F.P.
1413 Kempsville Road, Chesapeake, VA 23320

ATLANTIC CARE ASSOCIATES
FAMILY CENTERED MEDICINE OF CHESAPEAKE

Patient Registration

Patient Information

Patient Name_____ Prefix: Mr. ☐ Ms. ☐ Mrs. ☐ Suffix: _____
Last First Middle

Birth/ Maiden Name _____ Date of Birth _____ Sex: Female ☐ Male ☐

Social Security #_____ Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐

Race_____ Ethnicity:_____ Preferred language:_____

Driver License No._____ Exp. Date_____ State Issued _____

Home Telephone :_____ Cell Telephone:_____ Other Telephone: _____

I want online access to my record and results (patient portal) ☐ yes ☐ no Preferred Contact Method_____

Email Address:_____ (Required to receive portal access)

Mailing Address if different from Street Address

Street Address _____ Address: _____

City, State, Zip _____ _____

☐ Employer / ☐ School Name: _____ City, State, Zip: _____

Employer Telephone: _____

All patients over 18 are responsible for any charges not covered by his or her insurance carrier. **If the patient is under the age of 18, please complete the following information**:

Responsible Party Last Name: _____ First Name:_____ Middle Initial:_____

Social Security #:_____ DOB: _____ Sex: Female Male Telephone # _____

Bill to Address: _____ Relationship to patient:_____

City, State, Zip:_____

Insurance Information

Name of Primary Insurance Carrier:_____ Policy ID#:_____ Group_____

Subscriber's Name:_____ Subscriber's SSN:_____ DOB:_____

Subscriber's Sex: Female Male Relationship:_____

Name of Secondary Insurance Carrier:_____ Policy ID#:_____ Group_____

Subscriber's Name:_____ Subscriber's SSN:_____ DOB:_____

Subscriber's Sex: Female Male Relationship:_____

Emergency Contact Information

Name of Emergency Contact:_____ Relationship:_____ Telephone #_____

☐ **I would like to authorize the general discussion of my health information with another person. Please give me the authorization form.**

☐ **I would not like to authorize the general discussion of my health information with another person at this time.**

Signatures

Patient or Guardian Signature:_____ Date:_____

Witness Signature:_____ Date: _____

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Patient Consent

INSURANCE AUTHORIZATION AND ASSIGNMENT:

Medicare Patients
I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents as needed to determine benefits or the benefits payable for related services. This assignment still remains in effect until revoked by me in writing.

All Patients
I request Atlantic Care Associates. P.C. and their designees to provide medical services to me. I authorize the release of all medical information pertinent to my medical care to insurance companies and consultants. I authorize the direct payment of benefits to Atlantic Care Associates, P.C.

BALANCES DUE AND BILLING QUESTIONS: Once payment has been received from my insurance company, any balance remaining on my account will be payable by me upon receipt of my statement. Charges not billed to my insurance company are due prior to leaving the office (i.e. co-payments and deductibles). I have been informed that a $50.00 fee may be charged for missed appointments and for appointments cancelled without a 24-hour advance notice. A fee of $50.00 will be applied to my account for any returned checks. The **Returned Check Fee** is only payable in cash or by money order. Furthermore, I agree to pay all costs of collecting amounts due, including reasonable late fees, collection agency fees at a maximum of 30% of the debt, attorney fees at 33 1/3% of the debt and any court costs that may be incurred. I understand that there is a fee and interest at the legal rate applied to accounts referred for collections. I agree to be financially responsible for all charges.

PRIVACY PRACTICES AGREEMENT: A copy of Atlantic Care Associates' Notice of Privacy Practices (version effective 3/1/2013), either in electronic or paper format, has been made available to me. I consent to the uses and disclosures of my health information as outlined in the Notice.

RELEASE OF INFORMATION: I hereby authorize the release of any and all medical and/or charge information as is necessary for the third party reimbursement from any governmental agency or insurance payer involved in the payment of my treatment. I authorize the release of any and all medical information to any physician and/or hospital involved in my care. In addition, I authorize the use of information from my medical record for the purpose of clinical quality improvement if such information is provided as required by applicable law in a manner that sufficiently protects my anonymity. I also authorize the taking and use of photographs. I understand that these photos will become part of my medical record. If a patient does not return to the practice or request their medical record to be transferred within six (6) years from the date of their last communication with the practice, their medical record may be destroyed without further notice.

NOTICE OF DEEMED CONSENT FOR INFECTIOUS DISEASE TESTING: A law was enacted in Virginia in 1989 which authorized health care providers to test their patients for HIV/HBV and HCV antibodies when the health provider is exposed to the body fluids of a patient in a manner which may transmit human immunodeficiency virus (HIV), hepatitis B virus (HBV), or hepatitis C (HCV). Pursuant to this law, in the event of such an exposure, I have consented to such testing, and consented to the release of the test results to the health care provider who may have been exposed. I am aware that I would be informed before any of my blood would be tested for HIV/HBV/HCV antibodies. Pursuant to this provision, the testing would be explained to me and I would be given the opportunity to ask questions.

CONTACT: By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual if I am unavailable at the number provided by me.

E-PRESCRIBING: Atlantic Care Associates, P.C. has implemented e-prescribing for its patients. E-prescribing involves the ability for the practice to send prescriptions electronically to pharmacies. In addition to being fast, secure and convenient, the e-prescribing process also allows the health care provider to access critically important information about their patient's current and past medications from pharmacy benefit managers and community pharmacies. This information helps alert the provider to other potential medication issues with their patients and can improve safety and quality. By signing this form, **I consent to the practice requesting and using my medication history from other health care providers or third party pharmacy benefit payers for treatment purposes in connection with the e-prescribing process.**

ACKNOWLEDGEMENT/ CERTIFICATIONS: I have read and agree to the terms of this **PATIENT CONSENT**. I certify that I understand the contents of this form. Furthermore, I permit a copy of this document to be used in place of the original.

Each undersigned represents that he/she has read and fully understands the meaning and effects of this entire agreement.

Patient/ Guardian's Name (please print):_____

Patient/Guardian's Signature:_____ Date:_____

Witness:_____ Date:_____

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Health Questionnaire

Name: _____ Date: _____

Past & Family History – please list any medical conditions, current or in the past, for:

You	
Mother	
Father	
Sister	
Brother	
Grandmother	
Grandfather	

Medications -please list medications (with dosages) you are currently taking:

	Preferred Pharmacy name & phone #:

Hospital Admissions (not including pregnancies)

Year	Illness or Operation

Other Physicians Please list other treating providers along with their specialty (i.e. Dr. Ike Jones- Cardiologist):

Allergies

- ☐ Penicillin
- ☐ Codeine
- ☐ Sulfa
- ☐ Other_____
- ☐ No known allergies

Advanced Directive (Living Will)

- ☐ Yes
- ☐ No

Birth Control used:_____

	Mammogram	Physical Exam	Pap/pelvic	Eye Exam	Prostate Exam	Colonoscopy	Bone Density
Date of last							
Normal or Abnormal?							

Social History

- ☐ Alcohol _____drinks/week Alcohol type_____
- ☐ Coffee/Tea _____ cups/day
- ☐ Smoking/Tobacco _____ cigs/cigars daily for_____ # of years
- ☐ Exercise _____mins _____ days per wk
- ☐ Street Drugs ☐ Yes ☐ No Type:_____

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Office Policies

Please initial in all spaces marked "_____int." and sign and date the last page of this form.

Financial Policy

Each insurance plan has specific benefits, requirements and rules that must be followed by providers and patients. Please familiarize yourself with this information for each of your health insurance plans.

Patients are responsible for the payment of all services provided by our office. It is our policy to file, with many insurance companies, as a courtesy to you if we have **accurate** and **complete** insurance information. The balance is still your responsibility if we have not received payment from the insurance company within 30 days. If we receive duplicate payment from the insurance company, we will then prepare a refund for any overpayment and send it to you.

Since we are not party to the agreement between you and your insurance company, we ask that you assist us in contacting them in the event that services are not paid within 30 days. If you have an HMO plan, it is your responsibility to make sure that your insurance plan has Dr. Alesia Griffin listed as your primary care physician by the date of your appointment. Any claim denials that result from a different PCP being on file with your insurance company are fully the responsibility of the patient or guarantor. _____ int.

Insurance co-payments, co-insurance and deductibles are due at the time of the visit. You may be asked to reschedule your appointment if you do not have your co-payment. Cash, personal checks and credit cards (Visa, Mastercard) are accepted forms of payment. There is a $50 fee for returned checks. _____int.

Insurance companies do not waive copays for non-preventive related treatment. Per the Board of Medicine, preventive care is for screening purposes only and DOES NOT include treatment of illness/health problems/symptoms. If you come in for a physical exam/preventive care visit and also complain of a symptom, illness or health problem, you will be required to pay your copay for the illness-related portion of your visit. _____int.

Patients who do not have insurance that we accept or who are uninsured, are considered "SELF PAY" patients. For these patients, payment is due in full at the time of service. This will assist us in reducing the cost of billing and operation expenses. _____int.

In our partnership with you to provide efficient health care, we ask that you:

- Provide us with current and updated information on yourself and your insurance company and keep all changes up to date. _____int.
- Discuss your account balance only with the front desk or contact the billing department. **Please do not discuss the financial aspects of your care with the physician(s) or physician's assistant(s)**. It is important for them to be allowed to practice medicine and provide patient care. Please work with the office staff on any account questions or problems you may have. If they cannot help you, or answer your questions to your satisfaction, then please do not hesitate to contact the office manager. _____int.
- Note that in the event you file Bankruptcy, our office will no longer treat you and will forward your medical records to the provider of your choice. _____int.
- Note that we reserve the right to make adjustments to your account in the event that services rendered are inadvertently not billed and/or collected. Some visits performed by the nursing staff, without seeing a doctor, are considered an office visit and fees will be charged accordingly. _____ int.

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Missed/Canceled Appointments **No Shows or cancellations WITHIN 24 hours will result in a no show fee of $50.00.** This fee is billed directly to you and must be paid prior to scheduling another appointment.

Late Arrivals If you arrive late for an appointment, you may be asked to reschedule. We will try our best to work you back into the schedule but will honor on-time patient's appointments first.

Prescription refills To reduce errors, prescription refills will be provided at routine follow up visits only. Please do not let yourself run out of your medications. Schedule an appointment for medication refills well in advance of taking the last of your medications.

No prescriptions will be refilled after hours or on the weekend.

Referrals Patients who would like a new referral must be evaluated by one of our providers. Updates for established referrals will be processed within 48 hours after receiving the patient's request. Authorized referrals to urgent care facilities will be processed within 12 hours.
Backdated referrals will not be issued.

Result Notification Lab result notifications usually occur 10 to 14 business days after the date the labs were drawn. Radiology result notifications usually occur 3 to 5 business days after testing.

Medical Records Medical records are protected under HIPAA regulations. All requests for medical records must be made in writing with signed consent. You can request your medical records by filling out the Medical Record Request form. Once your request is received, please allow up to 10 business days to honor your request. There is a fee for medical record reproduction based on the number of pages for the personal copy or permanent transfer of your records. You will be contacted when your records are ready for pick up.

Fees for Letters and Forms Please be advised that due to the time required to dictate and complete letters and forms there will be a fee for this service. These costs are considered non-covered by insurance companies and will be your personal responsibility.
Documentation of treatment, based on your visit, is required for completion of all letters and forms. The practice reserves the right to deny completion of any form(s) or letter(s) should there be lack of medical documentation.

There is a pre-paid form fee of $10 per page for each medical leave form. Once the form and payment are received, it takes approximately 5 business days for each form to be completed.

Office Etiquette Please refrain from using cell phones in the reception area or while in the room with the physician. Small children should be accompanied at all times by their guardian.
Please refrain from eating and drinking in the reception area to maintain a clean and comfortable environment.

I have read, understand and agree to the above office policies.

_____ _____
Print Patient Name Date

_____ _____
Patient/Guardian Signature Date