PATIENT REGISTRATION

	PATIENT	Patient/Responsible Party – If Different
Legal Last Name		
Legal First Name, Middle		
Nick Name		
SSN		
Date of Birth		
Gender	☐ Male ☐ Female	**RACE:** ☐ Caucasian ☐ Asian
Marital Status	☐ Single ☐ Married ☐ Divorced ☐ Widow Preferred Language:_____	☐ African American ☐ Pacific Islander ☐ Native American ☐ Other ☐ Decline
	ETHNIC ORIGIN ☐Hispanic ☐ Non-Hispanic ☐ Decline	
Address		
Apt / Bldg / Suite #		
City / State / Zip		
Home Phone		
Work Phone		
Cell Phone		
Email Address		
Employer Name		
Address		
City / State / Zip		

EMERGENCY CONTACT	How Did you Hear About Us?	
Name		☐ Internet ☐ Drove By
Relationship		☐ Employer ☐ Word Of Mouth
Home Phone		☐ Family Member ☐ Coworker
Work Phone		☐ Physician ☐ Other
Cell Phone		Name_____ _____

	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company		
Primary Policy Holder Name		
Primary Policy Holder DOB		
Primary Policy Holder Sex	☐ Male ☐ Female	☐ Male ☐ Female

Authorization, Assignment of Benefits and Referral Medical Release

I hereby authorize the release of medical information including complete medical records, test results and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand this information will be used to review, investigate or make payment of a claim and to review records for quality improvement initiatives, audit compliance, utilization management and complaint resolution. I authorize payment directly to *Family Medicine Associates of Alexandria* and *Loudoun Medical Group* for all medical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all COPAYMENTS, CO-INSURANCE, DEDUCTIBLES and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the original.

SIGNED: _____ DATE: _____

Patient Consent Form

Authorization to Release Information to Family Members
Many of our patients allow family members such as their spouse, parents or others to call and request the results of tests and procedures. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your information released to family members you must sign this form. Signing this form will only give consent to release information to the family members indicated below.
You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Family Medicine Associates of Alexandria to release my medical information to the following individuals:

1. _____ Relation to Patient: _____

2. _____ Relation to Patient: _____

3. _____ Relation to Patient: _____

Authorization to Leave Messages with Household Members / Answering Machine / Voicemail / E-Mail
Frequently, it is necessary for the staff of *Family Medicine Associates of Alexandria* to leave messages for patients. The purpose of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss labs, pathology, medications or procedure results, or to ask a patient to call *Family Medicine Associates of Alexandria* regarding an issue or concern. At no time will a representative of *Family Medicine Associates of Alexandria* discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine, voicemail, or E-Mail. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

24 Hour Appointment Cancellation Policy

Family Medicine Associates of Alexandria has a 24 hour cancellation / rescheduling policy.
If you miss your appointment, cancel or change your appointment with less than 24 hours' notice, you will be charged $35.00. You may contact our office 24 hours a day.
This policy is in place out of respect for our providers and our patients. Cancellations with less than 24 hours' notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot.

	PATIENT	Patient/Responsible Party – If Different
Legal Last Name		
Legal First Name, Middle		
Date of Birth		

SIGNATURE OF PATIENT/GUARDIAN: _____ DATE: _____

Print Email