Patient Registration Information & Consent

Today's Date: _____ How did you hear about us? _____

Name: _____ *Date of Birth:* _____ *SSN#:* _____
First *Middle* *Last*

Maiden Name: _____ Sex: ◯ Male ◯ Female

Address: _____
Number Street City and State Zip Code

Phone Numbers:
Home: _____ Work: _____ Cell: _____
Marital Status: ◯ Single ◯ Married ◯ Widowed ◯ Separated

Email Address: _____ Employer: _____

Emergency Contact: _____ Relationship: _____ Phone number: _____

Preferred Pharmacy Name: _____ Location: _____

Primary Insurance Company Name: _____
Below, please give us the information for the person who is the primary insured, typically this is the person who works for the company that supplies the health insurance. If it is the same as the patient, you can just write "Same"

Name: _____ *Date of Birth:* _____ *SSN#:* _____
First *Middle* *Last*

Employer: _____

Secondary Insurance Company Name: _____

Below, please give us the information for the person who is the primary insured, typically this is the person who works for the company that supplies the health insurance. If it is the same as the patient, you can just write 'Same"

Name: _____ *Date of Birth:* _____ *SSN#:* _____
First *Middle* *Last*

Employer: _____

If financial responsible party is the same as patient check here: ◯

If not, complete the following:
Name: _____ Relationship to patient: _____

Address: _____
Number Street City & State Zip Code

Phone Numbers:
Home: _____ Work: _____ Cell: _____ Email
Address: _____ Employer: _____

The undersigned certifies that he/she has provided correct information on this form and understands that false statements or concealment of material fact may be prosecuted under applicable federal and state laws. The undersigned further certifies that he/she is the patient or the patient's legal representative, duly authorized to execute the above and to accept its terms.

Patient/Responsible Party Signature: _____ Relationship: _____

Financial Policy

Patient Name: _____ Date: _____

Thank you for choosing Mansilla Medical Practice as your primary care provider. We are committed to providing you with quality and affordable health care. Please read this payment policy, ask us any question you may have, and sign in the space provided. A copy will be provided to you upon request.

I. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan, we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but do not have an up-to date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-Payments and deductibles. All co-payments and deductibles must be paid at the time of service. If you have a policy that includes a deductible that has not been met, we will collect an upfront amount of $85 towards your deductible. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered insurance fraud. Please help us uphold the law by paying your co-payments each visit.

3. Non-covered services. Please be aware that some — and perhaps all — of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

5. Claims submission. We will submit your claims and assists you in any way we reasonable can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company, we are not part to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 60 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our providers will only be able to treat you on an emergency basis.

8. Collections. The undersigned agrees, whether signing as the patient or patient's representative, to accept payment responsibility for medical services not covered by insurance benefits and in the event of default, agrees to pay all costs associated with collection activities made to enforce payment, including attorney and collection agencies not to exceed 33.3%.

9. Missed Appointments. Our policy is to charge for missed appointments not canceled within 24 hours advanced notice. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointments.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for your understanding of our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Patient or Responsible Party's Signature: _____ Date: _____

Conditions to Registration & Acceptance as a Patient of Mansilla Medical Practice

Patient Name : _____ **Date:** _____

Consent to Medical Care: The undersigned requests and authorized the physicians and other health care providers of Mansilla Medical Practice and their professional staff to perform any medical diagnostic procedures and medical surgical care which in their professional judgement is deemed necessary to diagnosis and/or treat the condition(s) that have brought about my seeking medical services at the offices of Mansilla Medical Practice. I understand that the practice of medicine is not an exact science, that there are risks and benefits associated with receiving medical treatment and I acknowledge that no guarantees are made to me concerning the results of the medical examinations and treatments I receive by the providers and professional staff.

Release of Medical Records: Mansilla Medical Practice is authorized to disclose all or any part of the contents of the medical record of the patient named to such in companies, organizations or agencies that may be concerned with the payment of medical services provided to the patient. This is information which may result in a denial of insurance benefits or otherwise may not serve the interest of the registered patient.

Assignment of Benefits: I hereby request and authorize that any and all insurance benefits due for the medical services rendered to the registered patient, be paid directly to Mansilla Medical Practice. The undersigned whether signing as the patient or as representative for the patient, accepts responsibility for and agrees to pay for any health insurance co-payments, deductibles and co-insurance required under the terms of the insurance policies.

Deemed Consent: The undersigned acknowledges that the requested patient is informed of the provisions of Section 32.1-45 of the Code of Virginia 1950, that provide if any patient/health care provider is exposed to the bloody/body fluids of a health care provider/patient under the control or direction of Mansilla Medical Practice in a manner which may transit Human
Immunodeficiency Virus, Hepatitis B or C viruses, then the patient/health care provider shall be deemed to have consented to testing for HIV, Hepatitis B or C, and to the release of suck test results as provided by law.

Consent to Obtain External Prescription History: I authorize Mansilla Medical Practice and its providers to view my external prescription history via Surescripts (or any other) prescription service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by my providers and staff here at it may include prescriptions history for several years. I understand this will allow my providers to better coordinate my care and medication history to maximize the effectiveness and safety of my treatment plan.

Consent to Contact Via Email: To the extent that our medical records software allows it, we may be able to contact you via email to remind of appointments. I authorize Mansilla Medical Practice to use the email address I provided to contact me regarding my healthcare.

Patient/Responsible Party Signature: _____

Relationship of Responsible Party: _____