Virtua
Medical Group

ACKNOWLEDGEMENT OF RECEIPT FORM

Health Insurance Portability and Accountability Act, [HIPAA]

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name_____Date of Birth: _____
(Please Print)

By signing below, I acknowledge receipt of or the opportunity to review the Notice of Privacy Practices of Virtua Medical Group. In addition, by signing below, I authorize Virtua Medical Group to disclose my health information in conformance with the provisions of the Notice of Privacy Practices.

Signature:_____Date: _____

Phone Authorization

_____Yes, you have my permission to leave medical information on my answering machine. Please let us know which daytime telephone number is best to do so.

( )_____.

_____No, you do not have my permission to leave medical information on my answering machine.

To whom, other than yourself, may we speak regarding your medical condition?

Name_____Relationship _____

Phone# _____

Name_____Relationship _____

Phone# _____

I have the right to withdraw or revise my permission at any time in writing.

Signature:_____Date: _____

For Office Use Only:

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, indicate the reason why the acknowledgement was not obtained.

_____Individual refused to sign.

_____An emergency situation prevented us from obtaining the acknowledgement.

Signature of Virtua Representative: _____

Virtua

Medical Group

PATIENT REGISTRATION FORM

Date: _____

Name: _____ SS#: _____ Date of Birth: _____ Sex: M F
Last Name First Name MI

Marital Status: S M W D Phone #: _____ H C W Other Phone #: _____ H C W

[If we need to leave a message with medical/personal information, what number may we use?] H C W

Address: _____ City: _____ State: _____ Zip Code: ____

Email: _____ Preferred language: _____ Ethnicity: Hispanic Non-Hispanic Decline Race:

Caucasian Hispanic Bi racial African/American Asian Other Decline

Emergency Contact: _____ Relationship: _____ Phone #: ( ) _____

Employer/Address: _____ Work Phone: ( ) _____

Referring Physician: (if applicable): _____ Phone: ( ) _____

Pharmacy/Address/Phone: _____ ( ) _____

INSURANCE INFORMATION

Primary Insurance: _____ Group #: _____ ID #: _____

Subscriber: _____ Relationship to Subscriber: _____ Effective Date: _____

Subscriber's Date of Birth: _____ Subscriber's Social Security Number: _____

Secondary Insurance: _____ Group #: _____ ID #: _____

Subscriber: _____ Relationship to Subscriber: _____ Effective Date: _____

Subscriber's Date of Birth: _____ Subscriber's Social Security Number: _____

GUARANTOR INFORMATION

Guarantor/Responsible Party: _____ Relationship to Patient: _____
Last Name First Name MI

Address: _____ City: _____ State: _____ Zip Code: _____

SS#: _____ Date of Birth: _____ Phone ( ) _____

Guarantor's Employer: _____ Work Phone: ( ) _____

IF RELATED TO WORK OR INJURY

Type: Worker's Comp Auto Accident Legal /Employer Personal Injury Other

Claim #: _____ Date of Injury or Accident: _____ State of Injury or Accident: ____

Worker's Comp/Auto Accident Insurance Carrier: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Case Contact Person: _____ Phone ( ) _____

Attorney Practice Name: _____ Phone: ( ) _____

Address: _____ City: _____ State: _____ Zip Code: _____

Revised 3/11/16

PATIENT SIGNATURE ON FILE FORM

CONSENT FOR TREATMENT

Name: _____ **Date of Birth:** _____

I am either the patient who is seeking treatment or I am the person who is authorized to seek treatment for the patient. I consent to medical treatment and diagnostic procedures as provided by Virtua, its associated physicians, clinicians, and other personnel. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination at Virtua

MEDICARE

I request that payment of authorized Medicare benefits be made to either me or on my behalf to Virtua Medical Group for any services furnished to me by their physicians. I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or the party who accepts assignment.

In order to comply with Medicare regulations, please answer the following questions:

Are you or your spouse employed?	Y	N	Has treatment been authorized by the VA?	Y	N
Do you or your spouse have other insurance?	Y	N	Are you covered under the Black Lung Program?	Y	N
Are you disabled or have end stage renal disease?	Y	N	Is there Medigap coverage secondary to Medicare?	Y	N
Is illness/injury the result of an auto accident?	Y	N	Is there Insurance coverage primary to Medicare?	Y	N
Did illness/injury occur at work?	Y	N	Is there employer supplemental coverage secondary to Medicare?	Y	N

MEDIGAP (MEDICARE AND SECONDARY INSURANCE)

I request that payment of authorized Medigap benefits be made to either me or on my behalf to Virtua Health for any services furnished to me by their physicians. I authorize any holder of Medicare information about me to be released to _____ (Name of

COMMERCIAL ASSIGNMENT OF BENEFITS

I authorize payment directly to Virtua Medical Group for medical benefits including any Major Medical benefits otherwise payable to me under the terms of my policy, but not to exceed the balance due to the physicians. I understand and agree that I am financially responsible to the above party for charges not paid under my policy. I permit a copy of this authorization to be used in place of the original.

GENERAL

RELEASE OF INFORMATION

Virtua may disclose any or all parts of my clinical records to any insurance company or companies, or in the case of Worker's Comp claims, to my past or present employer(s), for purposes of satisfying charges billed by Virtua Medical Group. This authorization does not cover requests from other parties seeking information regarding my account. I acknowledge receipt of and/or the opportunity to review the Virtua Joint Notice of Privacy Practices which explains how protected health information will be used and disclosed.

I give consent to access all of my electronic medication information in connection with providing a list of current medications. I give consent to access all of my electronic immunization information in connection with providing my complete list of vaccinations.

GUARANTEE OF ACCOUNT

For and in consideration of services rendered by Virtua Medical Group to the below and named patient, the undersigned (jointly and several if more than one) guarantee payment of all charges incurred by all said patient in accordance with the policy of payment of such bills.

PATIENT BILL OF RIGHTS

- The patient Bill of Rights has been made available for me to review.
- I acknowledge receipt of the Health Information Exchange brochure.

☐You may **not** discuss my medical care with anyone other than me.

THE UNDERSIGNED CERTIFIES THAT EACH HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS.

_____	_____	_____
Patient Signature	**Patients Agents Representative/Guarantor Signature**	**Date**