IN ORDER FOR US TO PROVIDE YOU WITH COMPREHENSIVE, FAMILY ORIENTED HEALTH CARE, PLEASE SUPPLY THE FOLLOWING INFORMATION.

# PATIENT INFORMATION

## PATIENT INFORMATION

LAST NAME | FIRST NAME | MIDDLE INITIAL | SOCIAL SECURITY NO.

ADDRESS & MAILING ADDRESS | CITY | STATE | ZIP CODE

SEX ☐M ☐F | MARITAL STATUS ☐S ☐D ☐M ☐W | DATE OF BIRTH / / | Consent to Text: ☐Yes ☐No | Preferred #: ( )

HOME PHONE ( ) | WORK PHONE ( ) | CELL PHONE ( ) | I prefer that TPMG leave a message on my: ☐Home Phone ☐Work Phone ☐Cell Phone

EMAIL ADDRESS | PRIMARY CARE PROVIDER | OCCUPATION

EMPLOYER | EMPLOYER'S ADDRESS | CITY | STATE | ZIP CODE

RACE ☐Native Hawaiian or other Pacific Islander ☐More than one race ☐Other race ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐White | ETHNICITY ☐Hispanic or Latino ☐Not Hispanic or Latino | PREFERRED LANGUAGE

## RESPONSIBLE PARTY SKIP IF SAME AS ABOVE

LAST NAME | FIRST NAME | MIDDLE INITIAL | DATE OF BIRTH / / | SOCIAL SECURITY NO.

ADDRESS & MAILING ADDRESS | CITY | STATE | ZIP CODE

HOME PHONE ( ) | WORK PHONE ( ) | CELL PHONE ( )

RELATIONSHIP TO PATIENT | OCCUPATION | EMPLOYER

## SPOUSE

LAST NAME | FIRST NAME | MIDDLE INITIAL | DATE OF BIRTH / / | SOCIAL SECURITY NO.

## EMERGENCY

EMERGENCY CONTACT AT DIFFERENT ADDRESS | RELATIONSHIP | PHONE ( )

ADDRESS | CITY | STATE | ZIP CODE

## PHARMACY

PHARMACY NAME | PHONE ( ) | FAX ( )

ADDRESS | CITY | STATE | ZIP CODE

## INSURANCE PLAN

**For your convenience, we will assist you or supply you with the information necessary to file your medical insurance. Please allow us to copy your insurance cards.**

☐PRIMARY INSURANCE | ☐SECONDARY INSURANCE | SELF PAY ☐Yes ☐No

**PLEASE PROVIDE OUR OFFICE WITH ADVANCE NOTICE IF YOU SHOULD NEED TO CANCEL YOUR APPOINTMENT. FAILURE TO SHOW FOR YOUR SCHEDULED APPOINTMENT MAY RESULT IN A FEE TO THE RESPONSIBLE PARTY THAT IS NOT COVERED BY YOUR INSURANCE PLAN.**

**I WAS REFERRED TO THIS PRACTICE BY:**

### DEEMED CONSENT

Under Virginia law, if any employee or agent of the practice is exposed to your blood or other body fluids in a manner which may transmit human immunodeficiency virus (HIV) or hepatitis B or C viruses, you shall be deemed to have consented to testing for infectious with HIV or hepatitis B or C viruses. In addition, you shall be deemed to have consented to the release of such test results to the person who was exposed.

**HIPAA Acknowledgement: All patients must initial one of the following:**

**_____ I hereby acknowledge that I have been provided with a copy of the TPMG Notice of Privacy Policies.**

**_____ I hereby acknowledge that I have been provided with a copy of the TPMG Notice of Privacy Policies but decline to accept it at this time.**

SIGNATURE OF PATIENT / RESPONSIBLE PARTY | RELATIONSHIP OF PATIENT | DATE

### FINANCIAL AGREEMENT AND INSURANCE ASSIGNMENT

I have authorized treatment to patient by any TPMG provider and/or any affiliated medical staff member(s). I further authorize release of any and all medical and/or billing information as is necessary for third party reimbursement from my insurance carrier, Tricare or Medicare. I authorize direct payment from said insurer(s) to this practice. I accept responsibility for payment of all treatment that the payor determines does not constitute covered services as well as attorney's fees of 33 1/3% and any other related costs of collection should such action become necessary.

SIGNATURE OF PATIENT / RESPONSIBLE PARTY | RELATIONSHIP OF PATIENT | DATE

## MEDICARE PATIENTS ONLY

BENEFICIARY NAME

HCN#

**IF YOU ARE A MEDICARE PATIENT,** ***THIS SECTION MUST BE COMPLETED FOR PROPER PROCESSING OF YOUR ACCOUNT WITH THIS PRACTICE.***

I request that payment of authorized Medicare benefits be made either to me or on my behalf to TPMG for any services furnished me by their physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

BENEFICIARY SIGNATURE | DATE