

PATIENT INFORMATION

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

PATIENT INFORMATION	LAST NAME		FIRST NAME		MIDDLE INITIAL	SOCIAL SECURITY NO.		
	ADDRESS & MAILING ADDRESS					CITY	STATE	ZIP CODE
	SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	DATE OF BIRTH / /		Consent to Text: <input type="checkbox"/> Yes <input type="checkbox"/> No		Preferred #: ()	
	HOME PHONE ()		WORK PHONE ()		CELL PHONE ()		I prefer that TPMG leave a message on my: <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Cell Phone	
	EMAIL ADDRESS				PRIMARY CARE PROVIDER		OCCUPATION	
	EMPLOYER		EMPLOYER'S ADDRESS			CITY	STATE	ZIP CODE
	RACE <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American			<input type="checkbox"/> More than one race <input type="checkbox"/> Asian <input type="checkbox"/> White		ETHNICITY <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> 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 CONTACT AT DIFFERENT ADDRESS					RELATIONSHIP		PHONE ()	
EMERGENCY	ADDRESS					CITY	STATE	ZIP CODE	

PHARMACY	TPMG uses the Virginia Prescription Drug Monitoring Program in order to reduce the risk of prescription drug misuse.								
	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.								
	<input type="checkbox"/> PRIMARY INSURANCE			<input type="checkbox"/> SECONDARY INSURANCE			SELF PAY <input type="checkbox"/> Yes <input type="checkbox"/> 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
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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
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MEDICARE PATIENTS ONLY	BENEFICIARY NAME		<p>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.</p> <p>I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. 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.</p>
	HCN#		
	<p align="center">IF YOU ARE A MEDICARE PATIENT, THIS SECTION MUST BE COMPLETED FOR PROPER PROCESSING OF YOUR ACCOUNT WITH THIS PRACTICE.</p>		
		BENEFICIARY SIGNATURE	DATE