Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT

Last Name:
First Name:
Middle Name:
Former Last Name:
Sex:
Date of Birth:
Social Security No.:
Address:
City: State:
Zip:
Country:
Home Phone:
Mobile Phone:

May we send you text messages? (Circle one) **Yes / No**

Work Phone:

Patient email:
Contact Preference (Circle one): Home, Work, Cell, Patient Portal, Mail
Usual Medical Provider:
Primary Language (Optional):

Race (Optional):

Ethnicity (Optional):
Marital Status**:**
Homebound? (Circle one): **Yes / No**
How did you hear about us?
What is your preferred laboratory?

What is your preferred pharmacy?
How do you want to receive your patient care summary? (Circle one): **Portal / Paper**

Guarantor Information (to whom statements are sent)

Patient's Relationship to Guarantor: ___________________________
Name:
Date of Birth:
Address:

Social Security No.:
Phone: ( ) _______ - _______________
Email:

Emergency Contact Information

Name:
Relationship:
Phone: ( ) _______ - _______________
Mobile Phone: ( ) _______ - _______________

Next of Kin

Name:
Relationship:
Phone: ( ) _______ - _______________

Mobile Phone: ( ) _______ - _______________

Employment

Employer Name:
Employer Phone: ( ) _______ - _______________
Usual Occupation
Usual Industry:

Privacy

Share your medical history with external resources? (Circle one): **Yes / No**
Consent to obtain medication history? (Circle one): **Yes / No**
Consent to call? (Circle one): **Yes / No**

Please review and complete information below or present insurance card at front desk

Primary Insurance Information

Insurance Plan Name:

Policy Holder (if other than patient)

Last Name:
First Name:
Middle Initial:
Address:
City: State: Zip:
Date of Birth:

Policy Information

Patient's relationship to policy holder:
ID/Certification No.:
Policy/Group No.:
Employer:

Secondary Insurance Information

Insurance Plan Name:

Policy Holder (if other than patient)

Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth:

Policy Information

Patient's relationship to policy holder:
ID/Certification No.:
Policy/Group No.:
Employer:

Workers Compensation Information

Insurance Payer Name:

Policy Holder (if other than patient)	Policy Information
Policy Holder Name:	Patient's relationship to policy holder (Circle one): **Employee / Other**
Employer:	Policy/Group No.:
Employer Address:	Issue Date:
Employer City, State and Zip:	Expiration:
Date of Injury:	Referring Provider:
Injured Body Part:	Primary Care Provider:
Side (Circle one, if applicable): **Right / Left**	
Description of Injury:	

Physicians at Valley View

CONSENT TO TREAT, PROMISE TO PAY FOR SERVICES AND ASSIGNMENT OF INSURANCE BENEFITS

CONSENT FOR TREATMENT AND/OR TRANSFER: Communication between your treating providers is important to make sure all care is complete, comprehensive, and well-coordinated. The undersigned consents to any medical, surgical, testing for illegal substances and drugs of abuse, behavioral health or psychiatric testing and services deemed medically necessary and performed by a PHYSICIANS AT VALLEY VIEW, his/her designee, behavioral health providers, or other healthcare providers and personnel staff. The undersigned authorize PHYSICIANS at Valley View, his/her designee, behavioral health providers or other healthcare providers and personnel staff involved in their care to exchange and disclose to one another medical information about the undersigned including, behavioral health information protected under federal and state law. This consent applies to records relating to diagnosis, treatment, lab and other results, prescriptions, medication reviews, personal and demographic information and any other medical information. The undersigned further consents to be transferred to another facility if such transfer is deemed appropriate by a PHYSICIANS AT VALLEY VIEW or other qualified personnel.

CONSENT TO BLOOD TESTING: In the event that a healthcare worker or emergency response personnel are suspected to have been exposed to my blood or body fluids or in the event that my illness (including infectious disease) requires such care that healthcare workers exposed to my blood or body fluids is likely, I consent to have PHYSICIANS AT VALLEY VIEW provide testing whether or not my blood contains contagious viruses. I understand that the information obtained from such tests will only be disclosed as necessary to adequately protect my own health and the health of my family, as well as the health of those healthcare personnel who may have been or may become involved in my treatment.

RELEASE OF INFORMATION: It is agreed that all records concerning my care visit remain the property of PHYSICIANS AT VALLEY VIEW. PHYSICIANS AT VALLEY VIEW may release confidential information, including behavioral health, psychiatric and drug or alcohol-related disease to health insurance providers liable for clinic charges for my care. PHYSICIANS AT VALLEY VIEW may also release such information to other healthcare providers if necessary to ensure proper care of patient. I also authorize my insurance carrier to release to PHYSICIANS AT VALLEY VIEW and PHYSICIANS AT VALLEY VIEW providers providing my care, information concerning my insurance coverage or benefits, if any, connected with this visit.

ASSIGNMENT OF BENEFITS – FINANCIAL RESPONSIBILITIES: I certify that the information given by me in applying for payment under the Social Security Act is correct. I authorize my insurance carrier to release information regarding my coverage to PHYSICIANS AT VALLEY VIEW. My right to payment for all procedures, tests, supplies and nursing/provider services including major medical benefits are hereby assigned to PHYSICIANS AT VALLEY VIEW. The assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to PHYSICIANS AT VALLEY VIEW. I understand that I am responsible for all charges regardless of insurance coverage and acknowledge that, in the event the insurance company does not pay in a timely manner, I will pay in full for all incurred charges. I also understand that as a courtesy to me, PHYSICIANS AT VALLEY VIEW will file my incurred charges with my primary & secondary insurance carriers. I understand that it is my responsibility to ensure that PHYSICIANS AT VALLEY VIEW has accurate, up-to-date information on my insurance coverage.

PROMISE TO PAY FOR SERVICES AND GRANT OF SECURITY INTEREST IN HEALTHCARE INSURANCE RECEIVABLES: In consideration of care and treatment provided to the patient, the undersigned, whether signing as a patient or responsible person agrees to pay PHYSICIANS AT VALLEY VIEW on demand all charges for services rendered in accordance with its regular rates on this date. I understand PHYSICIANS AT VALLEY VIEW does not require a third party guarantee as a condition of care or treatment in its clinic. By signing this agreement, the undersigned affirms that no unwritten oral agreement with PHYSICIANS AT VALLEY VIEW exists as of the date this agreement is signed. The undersigned acknowledges this written agreement may not be contradicted by any prior or contemporaneous oral agreement between PHYSICIANS AT VALLEY VIEW and undersigned. Further, should it become necessary to refer the account to an attorney to protect the interest of PHYSICIANS AT VALLEY VIEW through a collection proceeding, the undersigned agrees to pay reasonable collection costs incurred in such proceeding, including reasonable attorney fees. In the event pre-certification for treatment is required by any health plan or policy or insurance, the undersigned patient or responsible person is responsible for obtaining such pre-certification. The undersigned consents to being contacted by regular mail, by email, or by telephone (including mobile phone) regarding any matter related to the referenced account by the creditor, its successors or assigns. The undersigned agrees to be responsible for co-insurance payments, deductibles and/or any remaining balance not covered by insurance. To secure payment of the amounts due PHYSICIANS AT VALLEY VIEW for care the undersigned agrees and does not herby grant PHYSICIANS AT VALLEY VIEW a security interest in all healthcare insurance receivables.

TRANSFER OF PAYMENTS BETWEEN PROVIDERS AND CLINICS: I understand that payments from me to a VALLEY VIEW PHYSICIAN PRACTICE provider that results in a credit balance on my account may be transferred to another VALLEY VIEW PHYSICIAN PRACTICE provider in which I owe a balance on my account. Also, I understand that a credit balance on an account for which I am the

patient OR the Guarantor may also be transferred to another VALLEY VIEW PHYSICIAN PRACTICE provider for which I am also the patient OR the Guarantor.

LEAVING PHYSICIANS AT VALLEY VIEW PRIOR TO DISMISSAL/REFUSAL OF TREATMENT: I understand that if I leave PHYSICIANS AT VALLEY VIEW prior to examination and treatment or refuse treatment that this action could endanger my health including a worsening of the condition that caused me to come to PHYSICIANS AT VALLEY VIEW. Depending upon that condition, I understand I could suffer injuries including permanent impairment, disability, or even death.

ADVANCE DIRECTIVES: I acknowledge that I have been offered information regarding advance directives, such as a Living Will or Durable Power of Attorney for Healthcare Decisions, and understand PHYSICIANS AT VALLEY VIEW will provide additional information and necessary materials upon request.

PATIENT RIGHTS: I acknowledge that I have been informed of my rights and responsibilities as a patient of PHYSICIANS AT VALLEY VIEW (Please initial): ____________

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE FOREGOING, HAS HAD ANY QUESTIONS ABOUT THE ABOVE CONSENT, PROMISE TO PAY, ASSIGNMENT AND SECURITY INTEREST ANSWERED TO HIS/HER SATISFACTION, HAS RECEIVED A COPY OF THIS DOCUMENT, AND IS RESPONSIBLE AS, OR OTHERWISE DULY AUTHORIZED BY, THE PATIENT TO ACCEPT ITS TERMS.

Signature of Patient /Patient Representative	Relationship to Patient	Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of the PHYSICIANS AT VALLEY VIEW Notice of Privacy Practices dated DATE OF MOST CURRENT for review.

Signature of Patient /Patient Representative	Relationship to Patient	Date

RELEASE OF INFORMATION AUTHORIZATION

I hereby give permission to release my medical information to:

Name of Individual	Relationship to Patient	Signature of Patient	Date

MINOR CONSENT

Are there any custodial issues that impact authorization for medical care? If yes, please explain:

I authorize the following people to consent for evaluation and treatment of the patient named on this record:

Name of Individual(s)	Signature of Patient Representative	Relationship to Patient	Date

I authorize the minor on this record to present for evaluation and treatment, without being accompanied by a parent and/or guardian:

Signature of Patient /Patient Representative	Relationship to Patient	Date