Valley Health Clinic, INC.

Welcome to our office!

Please take a few minutes to fill out and sign this registration form to properly serve your care needs. Thank you for choosing us as your care provider!

Patient Information **Today's Date**: ___/___/____

_____ _____ ____/____/_____ **M F** _____-____-_____

First Name **Last Name** **Date of Birth** **Sex** **Social Security#**

_____ _____ _____ _____

Street Address **City** **State** **Zip Code**

( )_____-_____ ( )_____-_____ **May we contact you by text to this mobile phone**?

Home Phone Number **Mobile Phone Number** Yes ☐ No ☐

E-mail:_____

Marital Status: **S M D W P**

How did you hear about us?: ☐Ad ☐Physician ☐Word of mouth ☐Patient in Practice ☐Insurance

_____ _____ ( )____-_____

Pharmacy Name **Pharmacy Address** **Pharmacy Phone#**

_____ _____ ( )____-_____

In case of emergency contact name **Relationship** **Phone Number**

Responsible Party

Do you have medical insurance? Yes ☐ No ☐ Name of insurance:_____

Do you have vision insurance? Yes ☐ No ☐ Name of insurance:_____

_____ ____/____/_____ _____

Insurance Primary Subscriber Name **Date of Birth** **Relationship to patient**

_____-_____-_____ ( )____-_____ _____

Social Security# **Phone Number** **Employer**

Privacy Notice HIPAA Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996. I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out: Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment), Obtaining payment from third party payers (example: my insurance company), The day-to-day healthcare operations of Valley Health Clinic, Inc. I have also been informed of and given the right to review and secure a copy of our Notice of Privacy Practice, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

_____ x_____ ____/_____/_____

Print Patient Name **Signature of patient/guardian** **Date**

_____ _____

Name of Person(s) you'd like to authorize to receive/discuss medical/financial info **Relationship**

May we call you for appointments, test results, to provide alerts, and leave messages? Yes ☐ No ☐

COLLECTION POLICY

In the event that my account is not paid, I agree to pay collection costs and/or a reasonable contracted lawyer to collect this amount. I understand that an additional charge of $15.00 can be added when co-payment is not made at the time of service. A $10.00 fee will be added to cover the cost of billing accounts that exceed 60 days from the date of service. Those exceeding 90 days of the date of declaration are susceptible to an interest of 1%. Cancellations are to be requested 24 hours before the appointment. There will be charge of $50.00 for late cancellations or missed appointments. There is a charge of $40.00 for returned checks. I understand that if I do not keep my account up to date it can result that Valley Health Clinic, Inc. will not provide additional services unless it is a serious emergency if necessary. Valley Health Clinic, Inc will notify me in writing.

_____ x_____ ____/_____/_____

Print Patient Name **Signature of patient/guardian** **Date**