



Before your visit

Please take a few moments to print and then complete the following patient registration forms.

Bring the completed registration forms with you to our office on the day of your appointment, along with:

- A photo identification card
- Your insurance identification card(s)
- All necessary claim forms, completed and signed
- If you have insurance that requires an authorization or referral form, please obtain this prior to your visit.

We will need to include documentation of all of the above information into your medical record.

If you need to reschedule your appointment, please call your EVMS Health Services provider's office.



PATIENT INFORMATION SHEET

PATIENT NAME: _____

SS#: _____

REFERRED

BY: _____

Address: _____

City, State, ZIP: _____

Phone Number: _____

PREVIOUS (OR PRESENT PHYSICIAN): _____

Address: _____

City, State, ZIP: _____

Phone Number: _____

INJURY

Was an accident involved? Yes No

If yes, time and date of injury: _____

Patient's signature: _____

Date: _____



EVMS HEALTH SERVICES

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of EVMS Health Services. Our notice of privacy practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, the revised notice will be posted to our web site at www.evmshealthservices.org and available in any EVMS Health Services clinical department. You may also contact our Privacy Office at 757-451-6298 if you have any questions about our Privacy Practices or need a revised copy of the notice.

I acknowledge receipt of the Notice of Privacy Practices at EVMS Health Services.

Signature: _____ Date: _____

Print Name: _____ Telephone: _____

Social Security #: _____

Patient's Name (if not the same as above): _____

Indicate your relationship to the patient:

- Parent or guardian of minor patient
- Guardian or conservator if an incompetent patient
- Beneficiary or personal representative of deceased patient



ASSIGNMENT OF BENEFITS

Date: _____

Patient: _____

Insurance: _____

Subscriber ID#: _____

I hereby authorize any member of Eastern Virginia Medical School Health Services (EVMS Health Services) or the medical provider and/or their designates to provide medical treatment, release of information pertaining to treatment for insurance. Insurance Payments for professional treatment otherwise payable to me for services rendered, unless payment arrangements are made by the undersign agrees to be responsible for valid referral forms requirement by their managed care carrier. Or they will be responsible for the entire balance due. The undersign agrees to be responsible for the court costs, 25% attorney's fees association with collection action by EVMS Health Services and a \$20 return check charge, should that become necessary, if my insurance carrier does not pay my balance, my permission to allow Virginia Insurance Commissioner's office to be contacted on my behalf.

Dated at _____ this _____ day
of _____, 20 _____