LIBERTY UNIVERSITY | HEALTH CENTER

cvfp
Better Health. Better Life.

Patient Registration Form

Payment is expected at time of service

Your Physician ____________________

Office Use Only Patient Chart # ____________________

Social Security #____________ Patient's Last Name____________ First Name____________ Initial____

Date of Birth____________ E-mail Address____________

Mailing Address____________ City____________ State____ Zip ______

Physical Address____________ City____________ State____ Zip ______

Home Phone____________ Work Phone____________ Ext.______ Cell Phone____________

Sex: ☐ Male ☐ Female Religion Type (optional)____________ Patient Employer____________

Marital Status: ☐ S ☐ M ☐ D ☐ W Language: ☐ English ☐ Spanish ☐ Other

Race ☐ Asian ☐ American Indian ☐ Black/African American ☐ Caucasian ☐ Hispanic ☐ More than one race ☐ Other________

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Refuse to Report

Patient Nickname____________ Patient Maiden Name____________

Spouse____________ Spouse Social Security #____________

Spouse Employer____________ Spouse Phone (Work)____________ (Home)____________ (Cell)____________

Emergency Contact____________ Relationship to Patient____________

Emergency Contact Telephone (Home)____________ Work)____________ (Cell)____________

Person Responsible for Payment____________ Relationship to Patient____________

Mailing Address (if different from above)____________

Social Security #____________ Date of Birth____________ Telephone (Home)____________

Employer's Name ____________

Employer's Address____________

Work Telephone____________ Cell Phone____________ E-Mail____________

Primary Insurance Carrier____________

Address____________

Name of Policyholder____________ Policyholder DOB:____________ Sex: ☐ M ☐ F

Relationship____________ Policy #____________ Group #____________

Secondary Insurance Carrier ____________

Address____________

Name of Policyholder____________ Policyholder DOB:____________ Sex: ☐ M ☐ F

Relationship____________ Policy #____________ Group #____________

Authorization For Treatment and Financial Agreement— I hereby agree that, as a condition of receiving treatment by Central VA Family Physicians, I will abide by all rules of the practice including keeping regularly-scheduled appointments, following physician orders regarding care, treatment, medication and testing as well as following up with consultants and abiding by the office's requirements concerning the timely payment for professional services, and that failure to follow any of these conditions may result in my termination as a patient from the practice. I authorize Treatment of and agree to pay all fees and charges for such treatment. I agree to pay all charges upon presentment thereof. I acknowledge that all proceeds of insurance are assigned to this office where applicable and that this office assumes no responsibility for the collection of any proceeds of insurance. I hereby authorize the release of any pertinent information to my insurance company and any other doctors involved in my treatment. If my account becomes assigned to a collection agency, I agree to pay all collection agency, I agree to pay all collection agency fees, court costs, and attorney fees. I agree that this authorization shall be valid until rescinded in writing or replaced by an updated agreement. You agree, in order for us to service your account or to collect any amounts you may owe us, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/we have read this disclosure and agree that Creditors Collection Service, Inc., may contact me/us as described above.

Patient's Signature____________ Date____________

If Minor, Parent or Guardian Signature____________ Date____________