

Ashcake Family Physicians**Demographic Information**

Patient's Name: _____ DOB: _____ Last 5 of SSN: _____

Address: _____

Phone: Mobile _____ Home _____

Treatment Permission

I consent and understand the following: 1. The physician taking care of me, the clinical staff and technical employees may give any treatment or perform any procedures as advised for your care and treatment. 2. You have the chance to discuss other plans for treatment. 3. In the event a healthcare worker is exposed to your blood or body fluid in a way that may transmit HIV, Hepatitis B or C virus, you consent to the testing of blood and/or body fluids for these infections. You further agree to report those findings to the exposed healthcare worker.

HIPAA - Permission to disclose private health information

I give permission to the persons listed below to receive private health information. I understand this is legally binding and I may revoke my authorization at any time by submitting a written request.

Name of Individual	Revocation Date	Patient's Initials
_____	_____	_____
_____	_____	_____
_____	_____	_____

Billing Agreement

- **It is the responsibility of the guarantor to present accurate insurance information at the time of service.** Failure to do so could result in you paying any charges otherwise covered by your insurance. If you do not present a card when checking in, you will be REQUIRED to sign a waiver.
- You allow the release of information to the insurance company or their agents which may be necessary to determine coverage.
- At the time of service, you agree to pay any required co-pay, co-insurance and/or deductibles. You further agree to pay any charges not covered by your insurance.
- Unpaid balances will be billed to the above address.
- You are responsible for paying all fees in full unless you receive prior approval.
- You are responsible for remembering all appointments. There is a 25.00 fee if an appointment is not cancelled 24 hours in advance. *This includes same day sick appointments.*
- Past due accounts will be turned over to a collection agency. You will be responsible for the account balance plus 33% and legal fees. This last resort will result in you and ALL members of your household being dismissed from the practice.

If the patient is a minor, as required by the Commonwealth of Virginia, please provide the following information:

Parent/Legal Guardian's name _____

Telephone # _____ I am authorized to give treatment permission _____

By signing this form, I acknowledge that I have read this form in its entirety and understand all sections.

Patient or legal representative's signature _____

Printed Name: _____ Date: _____