

EASTERN VIRGINIA MEDICAL SCHOOL HEALTH SERVICES		DR.	GROUP #	MEDICAL RECORDS NO.	CHART #
PATIENT INFORMATION		<input type="checkbox"/> COURTESY ▶ TERMS			
<input type="checkbox"/> NEW <input type="checkbox"/> ESTAB.	DATE	PRIMARY CARE PHYSICIAN			PCP TELEPHONE NO. ()
PATIENT INFORMATION					
NAME (LAST)	(FIRST)	(MIDDLE)	AGE	BIRTH MO. DAY YEAR	SOCIAL SECURITY NUMBER
STREET ADDRESS, APT #, CITY, STATE, ZIP					HOME TELEPHONE NO.
OCCUPATION (INDICATE IF STUDENT)	EMPLOYED BY		WORK TELEPHONE NO.		CELL TELEPHONE NO.
HOW WERE YOU REFERRED TO EVMS HEALTH SERVICES? (PHYSICIAN, ER, PHONE BOOK, ETC.)				MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	
NAME OF NEXT OF KIN (not living with you)		RELATIONSHIP			TELEPHONE NO.
RESPONSIBLE PARTY INFORMATION					
RESPONSIBLE PARTY NAME (AND/OR SPOUSE)	(LAST)	(FIRST)	(MIDDLE)	DATE OF BIRTH MO. DAY YEAR	SOCIAL SECURITY NUMBER
STREET ADDRESS			CITY	STATE	ZIP
OCCUPATION		EMPLOYER			
EMPLOYER'S ADDRESS				WORK TELEPHONE NO.	
WAS AN ACCIDENT INVOLVED? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES ▶	DATE OF INJURY	TIME OF INJURY	WAS IT WORK RELATED?
PAYMENT/INSURANCE INFORMATION					
PLEASE CHECK IF APPLICABLE <input type="checkbox"/> NO INSURANCE		PLEASE CHECK: HOW WILL YOU BE PAYING? <input type="checkbox"/> CASH <input type="checkbox"/> CHECK <input type="checkbox"/> MC <input type="checkbox"/> VISA			
PRIMARY INSURANCE CARRIER NAME:			SUBSCRIBER NAME:		
ID #:			PLAN #:		
RELATIONSHIP TO SUBSCRIBER:	EFFECTIVE DATE:	EXPIRATION DATE:	IS A REFERRAL/AUTHORIZATION # REQUIRED?:		
SECONDARY INSURANCE CARRIER NAME:			SUBSCRIBER NAME:		
ID #:			PLAN #:		
RELATIONSHIP TO SUBSCRIBER:	EFFECTIVE DATE:	EXPIRATION DATE:	IS A REFERRAL REQUIRED?:		
OTHER INSURANCE INFORMATION:					

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I HEREBY AUTHORIZE ANY MEMBER OF THE EASTERN VIRGINIA MEDICAL SCHOOL HEALTH SERVICES (EVMS HEALTH SERVICES) OF THE MEDICAL COLLEGE OF HAMPTON ROADS AND/OR THEIR DESIGNATES TO PROVIDE MEDICAL TREATMENT, RELEASE OF INFORMATION PERTAINING TO TREATMENT FOR INSURANCE PURPOSES, AND TO RECEIVE DIRECT INSURANCE PAYMENTS FOR PROFESSIONAL TREATMENT OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED, UNLESS PAYMENT ARRANGEMENTS HAVE BEEN ESTABLISHED. THE UNDERSIGN AGREES TO BE RESPONSIBLE FOR VALID REFERRAL FORMS, REQUIRED BY THEIR MANAGED CARE CARRIER, OR THEY WILL BE FINANCIALLY RESPONSIBLE FOR THE ENTIRE BALANCE DUE. THE UNDERSIGN AGREES TO BE RESPONSIBLE FOR COURT COSTS, 25% ATTORNEY'S FEES ASSOCIATED WITH COLLECTION PROCEDURES BROUGHT BY EVMS HEALTH SERVICES AND A \$20 RETURN-CHECK CHARGE, SHOULD THAT BECOME NECESSARY. IF MY INSURANCE CARRIER DOES NOT PAY MY CLAIM, I GIVE EVMS HEALTH SERVICES MY PERMISSION TO ALLOW VIRGINIA INSURANCE COMMISSIONER'S OFFICE TO BE CONTACTED ON MY BEHALF.

_____ (INITIALS) I HAVE RECEIVED (HAVE BEEN OFFERED) THE EVMS PRIVACY NOTICE WHICH DESCRIBES HOW MY HEALTH INFORMATION MAY BE USED OR DISCLOSED BY EVMS AND ITS AFFILIATES.

PATIENT'S OR RESPONSIBILITY PARTY'S SIGNATURE

EVMS HEALTH SERVICES WITNESS SIGNATURE