CHURCHLAND INTERNAL MEDICINE – **PATIENT REGISTRATION FORM**

PATIENT INFORMATION

Last name:_____First name:_____MI:_____SSN:_____

DOB: ____/____/____Sex:_____Marital Status:_____Former name:_____

Address:_____City:_____State:_____Zip:_____

Phone numbers - Home:_____Work:_____Cell:_____

Is your ethnicity Hispanic or Latino?_____Race:_____Primary Language:_____

Emergency Contact:_____Phone:_____Relationship:_____

GUARANTOR/RESPONSIBLE PARTY INFORMATION - (if other than self)

Name:_____SSN:_____DOB: ____/____/____Relationship:_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

INSURANCE INFORMATION

Primary Insurance:_____Policy ID:_____Effective:____/____/____

Primary Policy Holder:_____DOB: ____/____/____SSN:_____

Secondary Insurance:_____Policy ID:_____Effective:____/____/____

Primary Policy Holder:_____DOB: ____/____/____SSN:_____

FINANCIAL POLICY

Please be advised that the patient is ultimately responsible for payment of services provided to you by *CHURCHLAND INTERNAL MEDICINE, LTD.*

As a courtesy to our patients, we will file the appropriate claim forms to your insurance carrier. It is your responsibility to provide *CHURCHLAND INTERNAL MEDICINE, LTD.* with your correct and/or updated insurance information at ***every*** visit. Upon filing claims to your carrier, the standard of 30 days is allowed for your carrier to adjudicate and/or reimburse *CHURCHLAND INTERNAL MEDICINE, LTD.* If your carrier does not remit payment or denial within 30 days, the balance of your account will be due in full by you. Any balance of unpaid claims due to incorrect insurance information provided or failure to update insurance information to *CHURCHLAND INTERNAL MEDICINE, LTD.,* will be your responsibility. If you are unable to settle your account balance at that time, please contact our office at 757-484-5113. *CHURCHLAND INTERNAL MEDICINE, LTD.* requires a signed agreement specifying the terms of repayment for any account with an outstanding balance. In the event of payment default, the entire balance of your account will become due and payable immediately. If collection proceeding and/or litigation is initiated, you may be liable for collection fees (50% of your balance due), attorney fees and court costs required to enforce collection of your debt.
Thank you, The Physicians of *CHURCHLAND INTERNAL MEDICINE, LTD.*

If you are a self-pay patient, payment is due in full and will be collected on the day services are rendered. New patients can expect the first visit to cost $127.00 without doing any other services, such as lab work or X-Rays. We will collect for the visit when you sign in. Depending on what or if additional services/procedures are done, this can increase the amount that you will be responsible for, and will be collected when you check out. This may be satisfied by check, credit card or cash. Please note: We charge a fee of $50.00 for any returned check. If you are an established patient and come in for your visit or to utilize sick call, be prepared to pay when you check in. Payment is due on the day services are rendered. If you are not prepared to pay at the time of the visit, we will gladly reschedule your appointment for a time that is more convenient for you.

I authorize my insurance benefits be paid directly to the physician. I also authorize [Name of Practice] or insurance company to release any information required to process my claims. I (print your name), _____, attest that the above information is true to the best of my knowledge. I have also read, understand and agree to the terms outlined above.

Patient or guarantor signature _____ Date _____

CHURCHLAND INTERNAL MEDICINE – **NOTICE AND CONSENT FORM**

NOTICE OF CONSENT FOR PRESCRIPTION HISTORY

I grant permission to Churchland Internal Medicine physicians to view my prescription history.

Signature_____ Date_____

Printed Name_____Relationship to Patient_____

NOTICE OF PRIVACY PRACTICES

I have received or read and understand Churchland Internal Medicine's "Notice of Privacy Practices". This notice provides information concerning the use and disclosure of your protected health information by our physicians and staff, in accordance with the Health Insurance Portability and Accountability Act (HIPPA).

In order for Churchland Internal Medicine to comply with Federal Guidelines, I have **circled** my instructions for the following statements:

Messages concerning appointments and/or billing information may be left on my voice mail at: HOME WORK BOTH

Messages concerning appointments and/or billing information may be faxed to me at: HOME WORK BOTH

Appointment reminders may be mailed to my home: YES NO

My medical condition, including the results of diagnostic testing can be discussed with the following individuals:

Name_____ Phone_____ Relationship_____

Name_____ Phone_____ Relationship_____

Name_____ Phone_____ Relationship_____

These instructions may be used until I notify Churchland Internal Medicine, in writing, of any changes.

Signature_____ Date_____

Printed Name_____ Relationship to Patient_____

CHURCHLAND INTERNAL MEDICINE "PATIENT PORTAL"

Access your medical information online or send secure messages directly to the office staff through our online Patient Portal. If you are interested please provide your e-mail address below.

_____**Yes**. I would like to have access to the Patient Portal. e-mail address:_____

_____**No Thank you.** I'm not interested at this time. Patient Initials:_____Date:_____

Churchland Internal Medicine LTD

2994 Churchland Blvd
Chesapeake, VA 23321
P: 757-484-0500
F: 757-686-2805

Sarala Krishnagiri, MD
Shirin Zev, MD
Zahan Zev, MD

Financial Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

As a courtesy, Churchland Internal Medicine verifies your benefits with your insurance company we have on file. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your insurance plan. If your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received.

It is the policy of Churchland Internal Medicine that payment is due at the time of service unless other financial arrangements are made in advance. We require all patients to pay their deductible, co-pay and/or coinsurance payment at the beginning of each visit. At the conclusion of your visits with us you may be billed for any outstanding balances. If there is a credit, you will be provided a refund promptly or be asked if you would like to use it for future appointments.

If you are covered by health insurance, please provide your insurance information to the front office staff and we will verify your coverage as a courtesy. You are responsible to provide new, up-to-date insurance cards to our office at the time of service. Accepting your insurance does not place all financial responsibilities onto our practice, and you will be held accountable for any unpaid balances by your insurance plan.

Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are **100 percent** responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment.

We highly recommend you also contact your insurance carrier and check into your coverage. Do not assume that you will not owe anything if you have more than one insurance policy.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of Patient or Responsible party Date

Additional Financial Policy Information

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. If you provide us with an insurance card but the coverage is inactive, payment in full for each visit is required until active coverage has been received and verified. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 5 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. A**greements.** If you have an outstanding balance and you are unable to pay in full, you must sign a payment plan agreement to stay in "good faith" with Churchland Internal Medicine. We understand the hardships you may be going through, and we want to work with you to resolve your balance. You can also sign our Good Faith Policy to schedule a payment with us if you are unable to make payment.

9. **Fees.** We charge $50 for returned check. If you are forwarded to our collection agency or lawyer, you may be liable for collection fees (50% of your balance due), attorney fees and court costs required to enforce collection of your debt.

CHURCHLAND INTERNAL MEDICINE – **PERSONAL MEDICAL HISTORY**

Please indicate if you have had any of the following conditions:

Childhood Illnesses	Yes	No	Age at onset
Asthma			
Rheumatic Fever			
Scarlet Fever			
Other			
Adult Illnesses	**Yes**	**No**	**Age at onset**
Arthritis			

Adult Illnesses cont'd.	Yes	No	Age at onset
Heart Disease			
High Blood Pressure			
Stroke			
Thyroid Disease			
Tuberculosis			
Ulcers			
Hiatal Hernia			
Kidney Stones			
Migraine Headaches			

If applicable to you, please complete the following:

Surgical Procedures:	**Date:**	**Hospital:**

Serious Injuries or fractures:	**Date:**

Allergies to Medications:	**Reaction:**

Please provide the last date you received the following preventive services.

Screenings for:

Diabetes (hbA1c): ____/____/____
Diabetic Neuropathy: ____/____/____
Prostate Cancer (PSA): ____/____/____
Osteoporosis (Bone density): ____/____/____
Breast Cancer (Mammogram): ____/____/____
Cervical Cancer (PAP Smear): ____/____/____
Colorectal Cancer (Fecal Occult test): ____/____/____

Vaccinations for:

Influenza: ____/____/____
Pneumonia: ____/____/____
Tetanus: ____/____/____
Shingles: ____/____/____

Procedures:

Diabetic Retinal Eye Exam: ____/____/____
Colonoscopy: ____/____/____

Social History:

Have you ever smoked cigarettes?_____ Amount/day:_____
Have you ever smoked cigars?_____ Amount/day:_____
Have you ever smoked pipe?_____ Amount/day:_____
When did you stop smoking?_____
Do you drink alcoholic beverages?_____ Amount/day:_____

CHURCHLAND INTERNAL MEDICINE – **FAMILY MEDICAL HISTORY**

	MOTHER	FATHER	SPOUSE	SIBLING	SIBLING	SIBLING	CHILDREN	CHILDREN	CHILDREN
AGE									
HEALTH STATUS: **G** - GOOD **F** - FAIR **P** - POOR									
ASTHMA									
EMPHYSEMA									
ANEMIA									
ARTHRITIS									
TUBERCULOSIS									
CANCER									
DIABETES									
STROKE									
HEART DISEASE									
HYPERTENSION									
THYROID DISEASE									
AGE AT DEATH									
CAUSE OF DEATH									

Additional Comments:_____

Churchland Internal Medicine LTD

2994 Churchland Blvd
Chesapeake, VA 23321
P: 757-484-0500
F: 757-686-2805

Sarala Krishnagiri, MD
Zahan Zev, MD
Shirin Zev, MD

How Did You Hear About Our Practice?

Patient Name: _____

Appointment with Dr. _____

Appointment Date: _____

1. Your Health Insurance Company: _____
2. Local Newspaper/Magazine Name: _____
3. Mail Box Flyer/Postcard: _____
4. A Friend, Coworker, or Family Member Name: _____
5. Radio/TV _____
6. Another Physician: Physician Name: _____
7. Hospital ER: Name of hospital: _____
8. Health Fair: _____
9. Other: _____

Thank you for choosing Churchland Internal Medicine. We will make every effort to earn your confidence and goodwill. If you have any feedback or concerns, please see the Practice Manager, Sherry Moore

Churchland Internal Medicine LTD

2994 Churchland Blvd
Chesapeake, VA 23321
P: 757-484-0500
F: 757-686-2805

Sarala Krishnagiri, MD
Shirin Zev, MD
Zahan Zev, MD
Katerina Basiliadis, FNP

Authorization for Use/Disclosure of Protected Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider; the released information may no longer be protected by federal privacy regulations. I understand if my record contains information related to substance abuse, HIV and/or mental health, the information will be released with my medical records.

Patient's Name: _____ **Date of Birth:** _____ **SSN:** _____
(Last 4 digits)

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Name of Provider or Practice providing information: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Name of Provider or Practice receiving information: Dr. _____

Churchland Internal Medicine
2994 Churchland Blvd.
Chesapeake, VA 23321

This request and authorization apply to:

☐ All healthcare information ☐ Pathology Reports ☐ X-Ray Reports

☐ Office Notes ☐ Laboratory Test ☐ Procedure Reports

☐ Healthcare information relating to the following treatment, condition or specific dates listed below:

_____ _____ _____

_____ _____ _____

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

Churchland Internal Medicine, and its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the information to the extent indicated and authorized herein.

Signature: _____ Date: _____
(Patient or Authorized Representative)

Print Name: _____ Relationship to patient: _____