EmergiCare of Harrisonburg
Registration Form and Financial Policy

Section 1. **Patient Information**

Name: _____Suffix: _____
Gender: _____ SSN_____-____-_____ Date of Birth: _____/_____/_____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Phone: (_____) _____ Cell Phone: (_____) _____
Email Address: _____
Employer/School: _____ Work Phone: (____) _____
Emergency Contact: _____ Phone: (_____) _____
Relationship to Emergency Contact: _____
How did you hear about us? _____
Check Appropriate Box: ☐ Minor ☐Single ☐Married ☐Widowed ☐Divorced

Section 2. **Parent/Guardian Information (IF UNDER 18)**

Relationship to Patient: ☐Parent ☐ Other
Name: _____
Address: _____
City:_____
Phone:(_____) _____ Email:_____ Date of Birth: _____/_____/_____
Employer:_____ Work Phone: (____)_____

Section 3. **Financial Policy**

Payment is required at the time of service if our facility is not in network with your insurance company. Services rendered during your visit will be submitted to your insurance company, employer, or third-party payer. There is no guarantee of payment until they receive and process the claim. Any copay, coinsurance or deductible that is overcharged shall be reimbursed to the patient within 60 days from the time your insurance carrier notifies us. Any amount that was not collected at the time of service, that your insurance carrier deems your responsibility, will be sent to you as a bill. Any account balance not paid within 90 days will be referred to our collection agency. In the event that my account is turned over for collections, I agree that I will be responsible for all collection fees, interest, and legal fees associated with collecting my account. Returned check will be accessed a $30 fee and any bank charges.

Section 4. May we leave a message if you are not home? ☐ Yes ☐ No

May we discuss your health and billing information with a family member, spouse or other person involved in your care or payment for your treatment or services rendered (other than third-party payer)? ☐ Yes ☐ No
If yes, please name the individual(s)

_____

_____

Section 5. I agree that by providing my cell phone number below that I will be receiving my statements via text which could result in charges to me via my phone provider.

I have read the information on this form. I have had the opportunity to ask questions and have them answered to my satisfaction. I understand and agree to all terms above unless otherwise noted. I certify that I am the **patient** or **patient's legal representative** with authority to sign this document on the patient's behalf. By signing, I have read the HIPAA Notice on the back.

_____ _____

Please Circle One: Signature of Patient /Legal Guardian / Agent under Durable Power of Attorney for Healthcare. **Date**

182 Neff Ave. Suite W12 Harrisonburg, Virginia 22801 Phone: (540) 432-9996 Fax: (540) 432-9997

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HIPAA Privacy Notice. Effective: March 2023

This notice is provided to you pursuant to the privacy regulations enacted as a result of the HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT OF 1996 (HIPAA). This joint notice of privacy practices describes how your medical information may be used and disclosed and how you can get access to your information. This notice applies to all your medical information created or maintained by the members of EmergiCare of Harrisonburg.

A. Our Commitment to Your Privacy

The terms of this Notice apply to all your Protected Health Information (PHI) created or maintained by EmergiCare. We reserve the right to change this Notice at any time. Any change to this Notice will be effective for all the PHI we already have about you, as well as for any PHI we receive in the future. This notice of privacy practices is NOT an authorization; rather it describes how our organization may use and disclose your PHI to carry out treatment, payment and healthcare operations and for other purposes as permitted or required by law. It also describes your rights to access and control your PHI.

"PHI" means information that identifies you individually; including but not limited to demographic, information that relates to your past, present or future physical or mental health condition and/or related health care services.

B. Use and Disclosure of Your PHI ******We NEVER market or sell personal information**

1. Treatment
2. Payment
3. Health Care Operations.
4. Appointment Reminders, Check-In and Results.
5. Treatment Options and Health-Related Benefits and Services.
6. Disclosures to Family or Friends. (Durable Power of Attorney/Personal Representative)
7. Disclosures Required by Law.
8. Public Health Reporting.
9. Health Oversight Activities.
10. Lawsuits and Disputes.
11. Law Enforcement.
12. Deceased Patients. (Medical Examiner/Coroner)
13. Organ and Tissue Donation.
14. Serious Threats to Health or Safety.
15. Military, National Security, and other Specialized Gov. Functions (If you are in or involved in national security or intelligence).
16. Worker's Compensation.
17. If you are an Inmate.
18. If you are a minor, to your parents/guardian (unless otherwise prohibited by law).

C. Your Privacy Rights Regarding PHI

1. Request copy of this Privacy Notice
2. Confidential Communications
3. Request a Correction or Amendment of PHI
4. Accounting of Disclosures and Notice of Breach.
5. Request for Restrictions.
6. Health Information Exchange Opt-Out.
7. Right to File a Complaint to HHS for HIPAA Violation.

Privacy Official: Tae, tae.emergicare@gmail.com