
Staff Initials / Date

**RAPPAHANNOCK FAMILY PHYSICIANS
PATIENT INFORMATION**

Full Name: _____ Date of Birth: _____
Address: _____ Home Phone: _____
City/State/Zip Code: _____ Social Sec. # _____
Marital Status: _____ Gender: _____
Employer: _____ Work Phone: _____
Employer's Address: _____

SPOUSE INFORMATION

Full Name: _____ Date of Birth: _____
Address: _____ Home Phone: _____
City/State/Zip Code: _____ Social Sec. # _____
Marital Status: _____ Gender: _____
Employer: _____ Work Phone: _____
Employer's Address: _____

GUARANTOR'S INFORMATION (If different from Patient)

Full Name: _____ Date of Birth: _____
Address: _____ Home Phone: _____
City/State/Zip Code: _____ Social Sec. # _____
Marital Status: _____ Gender: _____
Employer: _____ Work Phone: _____
Employer's Address: _____
Previous Employer: _____

MEDICAL INSURANCE INFORMATION

Primary Carrier: _____
Name of Policy Holder / Subscriber: _____
Policy / Subscriber Number: _____ Group Number _____ Contract Number _____
Address: _____
Secondary Carrier: _____
Name of Policy Holder / Subscriber: _____
Policy / Subscriber Number: _____ Group Number _____ Contract Number _____
Address: _____

OTHER INFORMATION

How were you referred to our office? _____
Relative to contact in case of an emergency: _____
Address: _____
Home Telephone: _____ Work Telephone: _____
At which of our offices will you be seen at all the time? _____
(Chatham, North Stafford, Lake of the Woods, Courthouse, or Fredericksburg)

(OVER)

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT

I authorize treatment of and agree to pay all fees and charges for such treatment. I agree to pay all charges promptly upon presentment thereof. I hereby authorize the release of any pertinent information to my insurance company. I acknowledge that payments will not be delayed or withheld because of any insurance coverage or because of the pendency of claims thereon. I acknowledge that all proceeds of insurance are assigned to Rappahannock Family Physicians where applicable and that Rappahannock Family Physicians assumes no responsibility for the collection of any proceeds of insurance.

If my account becomes assigned to a collection agency, I agree to pay all costs of collection, including agency fees, court costs, and reasonable attorney fees.

SIGNATURE: _____ DATE: _____

**NOTICE OF STATE LAW COMPLIANCE
In the Event of Health Care Worker or Patient Exposure
DEEMED CONSENT FOR AIDS, HEPATITIS B OR HEPATITIS C TESTING**

Virginia law requires health care providers to notify you that AIDS, Hepatitis B or Hepatitis C testing on a sample of your blood may be done if a health care worker is exposed to your blood or body fluids.

As a health care provider under the Virginia Code Section 32.1-45.1, whenever any health care worker associated with or working for Rappahannock Family Physicians, or any person employed by or under the direction or control of Rappahannock Family Physicians, is directly exposed to body fluids of a patient in a manner which may, according to the current guidelines of the Centers for Disease Control, transmit human immunodeficiency virus (HIV), Hepatitis B or C viruses, Rappahannock Family Physicians will proceed to test the patient's blood for HIV (AIDS), Hepatitis B or C viruses and to provide the test results to the patient through his or her physician and to the health care worker(s) who was/were exposed.

The statute also provides that any patient who is directly exposed to the body fluids of a health care provider in such a manner which may, according to the current guideline of the Centers for Disease Control, transmit HIV or Hepatitis B or C viruses, the person whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with HIV, Hepatitis B or C viruses. Such person shall also be deemed to have consented to the release of such test results to the patient who was exposed.

SIGNATURE: _____ DATE: _____