CMH Physician Services, LLC

Patient Demographics

PLEASE PRINT CLEARLY

Patient's name: _____ Social Security #: _____

Date of birth: _____ Primary phone #: _____Secondary phone #: _____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Email address: (print clearly): _____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Declined ☐ Other:_____

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ Declined ☐ Other:_____

Mailing address: _____City, State: _____Zip: _____

Patient's employer: _____Work phone #: _____

Preferred Pharmacy: _____ City, State: _____

Primary Care Doctor: _____ Phone #: _____

Spouse's name: _____ Social Security #: _____

Spouse's date of birth (If he/she is the primary insurance holder): _____

Responsible party: _____ Relationship to patient: _____

Emergency contact name: _____ Phone number w/area code: _____

Relationship to patient: _____ DOB: _____

If patient is a minor, are parents: ☐ Married ☐ Divorced ☐ Custodial Parent: _____

Custodial parent home phone w/area code: _____Work phone w/area code: _____

Custodial Parent SS#: _____ Date of birth: _____

Is this a work-related visit? ☐ Yes* ☐ No If yes, date of injury: _____ Claim #: _____

***If this is a work-related visit you will be required to complete the Worker's Compensation/Insurance Form**

_____ _____

Patient's or Insured's Signature (If patient is a minor, must have responsible party signature) Date

CMH Physician Services, LLC
1755 North Mecklenburg Ave., South Hill, VA 23970
Phone: (434) 584-2273 Fax: 1st floor: (434) 584-5561

Release of Information

Patient's Name: _____ Date of birth: _____

I give permission for CMH Physician Services, LLC, to discuss my medical information and healthcare concerns with the following individuals:

1. _____ _____
   Name Phone number

   _____
   Relationship to patient

2. _____ _____
   Name Phone number

   _____
   Relationship to patient

3. _____ _____
   Name Phone number

   _____
   Relationship to patient

4. _____ _____
   Name Phone number

   _____
   Relationship to patient

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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Financial Policy

- As with any other business, it is necessary for us to receive payment for the services we provide to ensure we can continue providing these services for you at reasonable prices.
- **Your copayment (copay) is due at check-in.** The copayment is a fixed fee defined in your insurance policy that is paid each time a medical service is accessed. Most copayment amounts should be listed on your insurance card. Please be prepared to pay the copayment at check-in to avoid being rescheduled.
- If you do not have insurance, there will be a $150 prepayment due towards the charge for services prior to being seen. You will also be required to sign a payment plan before being seen.
- Please note that any procedures, lab work, etc., that you have done outside of this office or that is sent for interpretation, is not included in your office visit(s). You will receive a separate invoice for these charges directly from the facility providing the service.
- If you have an outstanding balance with us and you have not arranged a payment plan, then you will be required to make a payment on the balance and sign a payment plan for a monthly amount. This includes accounts that have been sent to a collection agency.
- Payment plans are available for patients needing to make special arrangements to pay off their bills. These arrangements should be made in advance of receiving services.
- Please feel free to ask questions and discuss financial matters with our financial staff in the business office.
- For your convenience, we accept Visa, Mastercard, American Express, Debit Cards, Cash, personal check and money orders.
- If you do not show for a scheduled appointment, you may be charged a $50 no show fee, which must be paid before your next visit. We reserve the right to dismiss any patient from the practice after three consecutive no-show appointments.
- A $50 return check fee will be charged for all returned checks. Insurance does not cover this charge. We use ChecXchange for all NSF checks. If ChecXchange obtains payment, we will adjust the $50 fee from your account.
- We charge $15 to complete forms, $.50 per page for medical records. This payment is due PRIOR to completion. Insurance **does not** cover this charge.
- We participate with many insurance companies; however, we do file claims to most insurance companies on your behalf. If your insurance company is one in which we do not participate, you are responsible for payment of your account. You should always contact your insurance company with questions you may have prior to arranging an appointment to be seen.
- Parents and guardians of minor children will be held fully responsible for the account unless notified with appropriate documentation.
- You, the patient, hereby authorize the payment of medical benefits to CMH Physician Services, LLC, for services rendered. You are financially responsible for services not covered by insurance carriers. Furthermore, you agree to pay all collection costs, attorney fees and other collection costs that may be incurred to enforce the collection of any amounts outstanding.
- You, the patient, hereby authorize CMH Physician Services, LLC, to release any information necessary to complete and process your insurance claims.

Printed name of patient: _____

Patient signature: _____Date: _____